Investigation into the Governance and Management of Kingston General Hospital

Report Submitted to

The Honourable George Smitherman

Minister of Health and Long-Term Care

by Graham Scott, Investigator

June 16, 2008

Table of Contents

EXECUTIVE SUMMARY

Introduction

On February 27, 2008 in response to a request from the South East Local Health Integration Network (SE LHIN, "the LHIN") for assistance in addressing issues at Kingston General Hospital (KGH), the Minister of Health and Long-Term Care (MOHLTC) announced the appointment of Graham Scott as an Investigator to "investigate and report on issues related to the management and governance of Kingston General Hospital." The review was prompted by a myriad of financial and service problems and other challenges being faced by the hospital in meeting the needs of patients including a mounting deficit, unsustainable growth of the working capital deficit, and an impasse between the hospital and the LHIN.

The work of the Investigator and his team began in the midst of a period of deep disagreement between the SE LHIN and KGH as to the need for additional base funding to permit KGH to resolve growing service issues that the hospital had been addressing through planned deficit budgeting.

Summary of Key Findings

Hospital Financial Position

- On February 27, 2008, the hospital projected a year-end (2007-08) operating deficit of approximately $13.5 M**,** more than double the operating deficit of $6M in 2006-07. At that time, the hospital also projected an additional $27.5M deficit for 2008-09. In April 2008, KGH expected to end 2007-08 with a $10.6M deficit.

- In October 2007 KGH had reached the limit of its existing line of credit of $25M and was forced to obtain a temporary increase in the line to $40M. This increase was rapidly drawn on and in March of 2008 – had it not been for the support of the SE LHIN – the hospital would not have been able to meet its financial commitments to the staff (i.e., payroll) and suppliers. Currently, KGH remains in a very tenuous position with regard to meeting its obligations and is dependent upon the renewal of loans from the SE LHIN.

- From 2003-04 to 2007-08 KGH received a 33.4% increase in its base funding from the MOHLTC – representing the second largest increase among the province's eight acute Academic Health Science Centres (AHSCs). During this same period, patient volumes remained relatively flat. Assuming that KGHs base funding is appropriate (a premise which KGH does not accept) relative to the other AHSCs, the hospital has been fairly funded.

- Additional government revenue (supplemented by KGH deficit funding and the full utilization of the hospital's working capital line) combined with no significant growth in patient volumes should have resulted in greater operational stability. In fact, the hospital has experienced growing clinical challenges and staff morale problems impacting both retention and recruitment.

- In the examination of the patient care and financial problems surrounding the hospital, it is important to understand that KGH did not inadvertently slip into its negative financial

position. The decision to incur a deficit was made deliberately by the Board on the advice of Senior Management as a 'strategy' for responding to the hospital's service problems.

Hospital Performance

- KGH can be more efficient. The performance indicators suggest that there is considerable room to improve performance that would free sufficient beds to address a number of current patient care access problems.
- KGH's clinical performance has not improved, and not materially changed. Effectively KGH is in the same clinical situation today as it was with the Peer Review report in 2006. Senior Management should have addressed these performance flaws and acted on them, particularly given the fact that they had been identified in earlier reviews.
- The length of stay (LOS) for the average patient is increasing.
- KGH has serious problems with maintenance and capital repair. These problems require high priority attention from the Ministry including an immediate infusion of money.

Hospital Management

- The picture painted in this report is one of a lack of effective leadership at the Senior Management level within KGH. The leadership team has failed to ensure the health and well being of the organization. While it may be argued that additional resources are required in the future, the strategy of spending now, with disregard for the fiscal health of the organization and the consequences therein, demonstrate a lack of management prudence that needs to be addressed.
- Leadership is all about inspiration and vision. Successful leadership teams are those that provide a compelling vision for an organization both for the people in it and the people who come to it. A vision is something that people can rally around, see themselves being part of and share in achieving. Leadership and management are not the same. While KGH refers to its Senior Management as the Executive Committee, this is not a *leadership team*. New leadership is required.

Hospital Governance

- The KGH Board of Directors is the final authority and expectations of Board performance and oversight have grown considerably in recent years. The KGH Board, while dedicated and hard working, has not kept pace with these changes and consequently the decisions of the KGH Board of Directors have contributed significantly to the current situation which precipitated this Investigation.
- The Board has, in a genuine desire to advance the interests of patients, lost its focus on its equal responsibility to effectively oversee management and to ensure financial viability of the organization. While the current Board has made mistakes in judgment, an increasing number of Directors understand and accept the need for change in their oversight and decision-making and are committed to renewal. The Investigator and his team have concluded that the majority of the Board of Directors have learned from their experience and

should be given the opportunity to demonstrate this commitment provided that a full governance renewal process is undertaken.

Conclusions & Recommendations

- There are compelling reasons to believe that KGH has considerable potential to excel as an Academic Health Sciences Centre and provide high quality patient care to the entire SE LHIN region. This cannot be accomplished without a strong vision for the future; a vision that does not currently exist. The hospital needs to rebuild its mandate on a fresh new vision as a tertiary, academic centre that can meet the opportunities and leadership challenges needed to achieve regional integration in partnership with other health care providers. The best interests of a hospital and the community it serves have not been advanced by adopting the old tactics of demanding additional funds or running-up deficits with the belief that they will eventually be bailed out. The best interest is to be aware of broader system expectations and to take seriously the new accountability requirements arising from the legislation in order to advance the hospital strategy on a very focused and businesslike basis.

- KGH has had to apply more operational funding to maintenance and repair than is reasonable. The major capital redevelopment project is urgently needed and should be given every priority by the hospital, the MOHLTC and the LHIN.

- KGH may have a good case for additional operating funds. However, the question of how much additional funds are required is far from clear. The failure of KGH to make its case on operational funding and the lack of answers to a number of issues arising from this review makes it impossible to answer the question of how much more money should be added to the current base budget of the hospital. Until the new KGH management has prepared its recovery plan and submitted its Performance Improvement Plan, the MOHLTC should support the LHIN in providing ongoing bridge funding so that KGH can meet its obligations to patients, suppliers and staff.

- The belief that deficit budgeting is an appropriate practice to meet patients care needs is well intended but shortsighted. There are many programs that can be better delivered when a hospital has maintained the financial discipline that permits it to exercise discretion in providing additional services in the best interest of a patient. When a hospital has exhausted its financial flexibility, as is now the case with KGH, there is no opportunity to introduce a new or enhanced treatment that might benefit the patient. This kind of flexibility is particularly important in an academic health science centre which must serve as a centre of innovation.

- The sum of these conclusions and recommendations is that KGH Board needs a period of renewal and KGH Senior Management needs a strong and fresh start if it is to meet the reasonable expectations of the communities it serves, the LHIN, and other partners – including the medical school and the other health care providers in the region. If there is a sad reality in the conclusions, it is the lost time and opportunity to better serve patients and the running-up of substantial debt which will limit the flexibility of the hospital as these matters are addressed and corrected.

Governance

1. The Lieutenant-Governor–in-Council should immediately appoint a Supervisor for KGH under the *Public Hospitals Act*. The Supervisor would:

- Temporarily assume the responsibilities of the KGH Board of Directors. During this period, the current Board of Directors will remain in place and serve in an advisory capacity to the Supervisor. Upon completion of the Supervisor's mandate, the Board of Directors will reassume their full governance authority.
- Lead the process for the selection of a new Chair of the KGH Board of Directors.
- Appoint a temporary CEO for KGH (pending selection of a permanent CEO) to begin the implementation of the changes which are necessary to support more effective and efficient operations.
- Appoint, in consultation with new Board Chair and the Board of Directors, a permanent CEO who brings previous experience as a CEO of an academic health science centre with a track record of strong leadership, team building and system orientation.
- Oversee the governance renewal process of the KGH Board of Directors.

The Supervisor would step down on the completion of the governance renewal process and the appointment of the permanent CEO.

2. As an immediate priority in governance renewal, the Supervisor should establish a Nominations Committee to assist the Supervisor in selecting a new Board Chair. The Nominations Committee should be comprised of:

- the Supervisor (as Chair);
- at least two community leaders (appointed by the Supervisor);
- one member appointed by the KGH Board of Directors; and
- the current Chair of the KGH Board of Governors Nominating Committee.

3. Following the appointment of the new Board Chair by the Supervisor, a governance renewal program should be implemented to assist the Board in fulfilling its account-abilities and strengthening its governance structures and processes to ensure improved performance in the future. Priorities for governance renewal are to:

- Revise the title and responsibilities of the Board of Governors (the members of the Corporation) to clearly differentiate its roles and responsibilities from those of the Board of Directors of the hospital;
- Redefine the scope of the Board Chair's position and distribute some of the Chair's current responsibilities among the Board of Directors;

- Revise the Principles of Governance to include a clear statement of Board Accountabilities;
- Align the statement of responsibilities of the Board of Directors with the new expectations under the *Local Health System Integration Act* and define the relationship between the Board of Directors and the Board of Directors of the SE LHIN;
- Establish Board policies that are aligned with the responsibilities of the Board of Directors;
- Support the Board of Directors on appropriate levels of engagement to strengthen their oversight of hospital performance;
- Complete the process initiated by the Board in 2008 to ensure that the size and composition of the Board is aligned with best practice, minimizes the potential for conflict of interest and reflects the regional role of KGH;
- Clarify the governance relationship between the KGH Board of Directors, Queen's University and the medical school;
- Renew the process for nomination of Directors to achieve greater transparency,
- Review the current membership of the Board of Directors and appoint Directors as required to fill vacancies, ensuring that the Board reflects a diversity of regional perspectives and appropriate skills and expertise;
- Review the scope of responsibilities and size of the Board Standing Committees and the processes related to in-camera matters.
- Significantly reduce and focus the documentation provided to the Board of Directors and Board Standing Committees; and
- Reduce the demand on Directors' time commitment to the hospital.

4. Following the completion of the governance renewal process and recruitment of a permanent CEO, the new Board Chair and CEO should lead the Board of Directors in developing a new vision for KGH that provides focus and opportunity for the future.

Management

Analysis & Reporting

5. The CEO initiate a review of all performance indicators and make greater use of internal performance analysis to ensure that the hospital can maintain the highest performance standards in serving the public. This work should include:

- An immediate external review of length of stay with particular attention to the large number of outliers.

- An external review of ALC patients in cooperation with Providence Care and the CCAC to assess admission and discharge practices and the large number of outliers. This review should involve the LHIN and be coordinated with the provincial initiative on ALC management.

- An external review of the bed and operating room management systems and implement adjustments based on best practice experience at other peer hospitals.

- Involvement of program leadership in a comprehensive review of hospital policies to ensure greater clarity and their effective engagement in the functioning of the hospital.

6. The CEO initiate a review of all reporting practices to ensure that an accurate portrayal of KGH performance is provided to provincial and federal agencies charged with performance reporting. This work should include implementation of a full case costing system.

Leadership & Human Resources

7. The CEO build an effective, accountable leadership team that:

- demonstrates fiscal accountability in serving the community,

- establishes targets and monitors hospital productivity and performance, and

- effectively engages program leaders in the functioning of the hospital and encourages teamwork and creativity at the program management level.

8. The CEO engage in a comprehensive review of the staff morale problem particularly with regard to the retention of nurses and develop an immediate action plan for responding to these issues.

Funding

9. The CEO develops a recovery plan to achieve a balanced budget for approval by the Board as the basis for the development of the Performance Improvement Plan for submission to the SE LHIN.

10. Pending the submission of the Performance Improvement Plan including the hospital's need for additional resources, the SE LHIN (supported by the MOHLTC) should continue to provide bridge funding to KGH to allow it to meet its obligations to suppliers and staff.

11. On the completion of the Performance Improvement Plan, and its approval by the SE LHIN, the MOHLTC should flow additional funds to the LHIN to address any shortfall in KGH base funding.

12. The MOHLTC should provide the SE LHIN with an additional $5M to add to KGH's base funding immediately to address the impact on the operating budget related to ongoing maintenance costs and to cover the costs associated with carrying out the reviews and their implementation.

13. The MOHLTC should provide KGH with $15M in one-time funding to assist the hospital in addressing own funds urgent facilities repairs.

14. The MOHLTC should place high priority on the KGH capital renewal project to minimize the amount of future stop-gap expenditures required to maintain aging and deteriorating buildings.

External Relationships

15. KGH and HDH should continue to work to integrate their management and operations to provide a progressive model of integration that seamlessly serves patients in Southeastern Ontario.

16. The MOHLTC provide resources to support an independent study of SEAMO to determine the most effective performance accountability structure.

17. SEAMO should adopt the same signatories' process in place in the other AHSC AFPs.

INTRODUCTION

The Kingston General Hospital (KGH) has impressive historic roots serving South Eastern Ontario since 1832. The hospital has had an affiliation with Queen's University for over a century and one half. From a hospital building that once served as the Parliament of Canada, KGH has grown to a hospital with 454 beds, 4,100 employees and medical staff, and a budget of over $300 million. As one of Ontario's Academic Health Science Centres (AHSC), KGH is a key tertiary/specialty care provider in South Eastern Ontario and is an important link in the network of AHSC's across the province. The hospital also has an important relationship with the Hotel Dieu Hospital (HDH) as well as other hospitals in the region.[1]

The relationship between KGH and Queen's University Faculty of Health Sciences ("medical school") is one of mutual importance and interdependence. This collaborative relationship is fundamental to the ability of KGH to provide tertiary and specialized services to residents of Kingston and South Eastern Ontario. The failure of either party to meet its health care obligations would jeopardize the ready availability of tertiary/ specialty care for the population in the region. Should KGH not function effectively and efficiently to provide the acute care setting and specialized programs which are essential to the medical school, the very survival of academic medicine in Kingston would be at risk. Conversely, without the availability of academic medicine KGH would be unable to provide the current depth of tertiary/specialized care to the population it now serves.

The Investigator and his Team

On February 27, 2008, Graham Scott was appointed by the Lieutenant Governor-in-Council as Investigator to report on issues related to the management and governance of KGH. Mr. Scott is the President of Graham Scott Strategies Inc. His public service has included the position of former Deputy Minister of Health in Ontario, interim CEO of Cancer Care Ontario, Supervisor of the Sudbury Regional Hospital, and Investigator of the Muskoka Parry Sound Board of Health and Chair of the Task Force on the Academic Health Science Centres Alternate Funding Plan.

In the interest of moving quickly to assess the situation and make recommendation to ensure the future stability of KGH, the Investigator appointed a small team to assist in the review. The team consisted of:

- ***Janet Davidson, Lead, Hospital Management***. Ms. Davidson is the CEO of Trillium Health Care in Mississauga, and the former Chief Operating Officer of Vancouver Coastal Regional Health Authority and former CEO of the Toronto East General Hospital.
- ***Kevin Empey, Lead, Finance and Performance***. Mr. Empey is the Executive Vice President of the University Health Network in Toronto and Treasurer of the Canadian Institute for Health Information. He has extensive expertise in issues related to hospital finance and strong knowledge of health performance data.

[1] HDH was not included in the Investigator's Terms of Reference so the comments included in this report relate only to the role of HDH as it impacts on KGH

- ***Maureen Quigley, Lead, Governance***. Ms. Quigley is President of Maureen Quigley and Associates and has extensive experience working with health sector organizations including the OHA, hospitals the Ontario Ministry of Health and Long-Term Care (MOHLTC), and LHINs on health governance and policy matters.

The Investigator had prior experience working with each of these individuals and was confident that they would provide him with the support and expertise required to proceed with the review.

Process for Review

The review consisted of the following:

- A review of extensive documentation provided by KGH and the South East Local Health Integration Network (SE LHIN) including previous reports and reviews.
- A series of interviews with the leadership of KGH including all members of the Board of Directors, the Management Executive Committee ("Senior Management"), physicians, and other key staff.
- A series of interviews with the Chair of the Board and staff of the SE LHIN, the Dean and key staff of the medical school, and other knowledgeable parties with experience in working with KGH.

In addition, other individuals came forward voluntarily to share their perspectives with the team. In all, approximately 50 individuals were interviewed and some re-interviewed on numerous occasions. The team met frequently to discuss the key observations arising from the review and to develop the recommendations and final report arising from their review.

SECTION 1: BACKGROUND & CONTEXT

The New Health Care Environment

The optimal use of health resources through system integration has long been recognized as crucial to an effective health system that is focused on patient care. Achieving greater system integration has not been easy. A key challenge restricting progress on this front relates to the culture change required to overcome the lack of co-ordination and cooperation needed among traditional silo-oriented institutions.

KGH and the medical school are located at the population and transportation centre of the SE LHIN. With Quinte Health Care to the west, Brockville Hospital to the east and Smith Falls and Perth Hospitals to the north, the geography of the LHIN is well designed for service integration. Achieving the vision of an integrated system in the SE LHIN could not only provide the highest quality of service to the region, but could also create a medical environment that would establish KGH, the medical school, the surrounding system of hospitals, the Community Care Access Centre (CCAC) and other providers as a model of regional care delivery and health care management. KGH is a hospital with incredible potential. It is the anchor tertiary/specialty acute care facility in South Eastern Ontario that is well positioned to partner with the medical school, and other providers in the region to build a successful integrated health care model in Canada. The combined strengths of the medical school, and KGH should be expected to provide the residents of Southeastern Ontario with quality tertiary/specialty acute care and all the residents of Kingston and the immediate surrounding area with quality secondary care.

While the geographical features of the region and the potential strength and value of KGH and the Queen's medical school are seen as critical success factors for advancing integration of health services, there are hurdles that must be cleared. Given the importance of KGH to effective integration in the LHIN it is, however, in the interest of both KGH and the LHIN to make every effort to work together effectively to improve patient care in the region.

LHINs & the Changing Hospital Governance Environment

The creation of Local Health Integration Networks (LHINs) in Ontario has fundamentally changed the accountabilities and funding relationships governing hospitals in the province. Such changes are difficult for all concerned particularly during the current transition period where the relationships between LHINs, hospitals and other health service providers continue to evolve.

LHINs are challenged with finding their own way to address the needs of health service providers in an environment that had been marked by an often combative, but established, relationship with the Ministry of Health and Long-Term Care (MOHLTC) regional offices. The creation of new relationships combined with a number of policy areas requiring re-definition has resulted in tensions between the LHINs as the new funders and their Health Service Providers (HSPs). The type of strategies employed by HSPs and the LHIN in building the new relationship can make a big difference in achieving an effective start.

At the same time, the *Commitment to the Future of Medicare Act, 2004* (CFMA) and the *Local Health System Integration Act, 2006* (LHSIA) have resulted in substantial new accountability ground rules for Ontario's hospitals and other HSPs. In recent years, hospital boards have been challenged to meet new standards of governance and demonstrate greater accountability to the public for quality of care and to the taxpaying public, government and private donors for strong financial stewardship.

Prior to the introduction of the balanced budget requirement in the Hospital Services Accountability Agreement (H-SAA) under Section 23 of the CFMA, some hospitals prided themselves in being efficient and fiscally responsible. Others, however, were content to give in to pressures that resulted in them incurring substantial deficits and accumulated debt requiring 'bail outs' by the government of the day. The old mantras chanted to government by hospitals in financial difficulty were essentially the same: *"you asked us to deliver care so it is your job to pay for it,"* and *"we're under-funded compared to our peers."* These were very subjective chants supported by little objective information but often accompanied with considerable local political support. In any case, the government of the day was faced with the need to bail-out hospitals to keep them operating or fail in its undertaking to provide appropriate care. More seriously, some hospitals saw having a deficit as a strategy to get what they felt they deserved. On many occasions, hospitals ended up being bailed out by government – sometimes at the expense of more fiscally responsible hospitals.

Successive governments have pledged to *"not cover hospital deficits"* only to find themselves trapped in a situation that left them little choice but to give in. Over the years, a number of steps were taken to strengthen the ability of the government to deal with such situations. For example, the *Public Hospitals Act* was amended on a limited basis with this in mind including the addition of Investigator and Supervisor powers to help cope with this dilemma. This was followed by the CFMA in 2004, which put considerable emphasis on accountability and was designed, in part, to put teeth into the expectation that hospitals would adhere more closely to good governance and accountability practices.

The message was heard clearly and embraced by the Ontario Hospital Association (OHA) which has put considerable investment in protecting the concept of independent corporate governance of hospitals by underling the importance of quality governance and leadership. Through its extensive education programs, the OHA has played a major and constructive role in guiding both hospital trustees and management in making the changes necessary to meet both the spirit and letter of the legislation to enhance accountability in performance and integration of services. Their programs provide valuable guidance to assist hospitals in achieving greater quality and efficiency related to the financing and delivery of health care. Hospitals that have not adapted to this new environment are at a growing disadvantage in comparison with their peers.

While the MOHLTC devolved authority and accountability for most hospital funding to LHINs in April 2007, the system remains in a period of transition. Many hospitals have come to grips with the new legislated requirements for accountability under the CFMA and have undergone considerable change while others have been slower to abandon previously established approaches. A number of hospitals have invested considerable effort in developing case costing approaches and utilizing management information to better manage their affairs while positioning themselves to make their cases for additional funding. Others have remained more

traditional in their demands and expectations and continue to make weakly supported cases. Some continue to spend and simply expect that additional money will be forthcoming.

Since 2006, in requiring hospitals to balance their budgets the MOHLTC and now the LHINs have repeatedly requested that hospitals *"balance budgets by cutting administrative expenses, not clinical services."* This strategy assumes that there is administrative "fat" that can be cut and that these cuts will be sufficient to balance the budget without hurting front line clinical service delivery. This strategy combined with the legislated requirements of the CFMA to enter into an H-SAA has had a major effect on focusing hospitals to achieve greater efficiencies.[2] However, it is important to realize that hospitals were not at the same starting point in terms of their efficiency position. Historically, some had remained very fiscally responsible and were already considered 'lean' leaving little opportunity to achieve continued efficiencies. Other hospitals had greater opportunities to realize greater efficiencies by improving their management and operations.

This report summarizes the key findings and recommendations arising from the review of the Investigator and his team. The main sections of the report are as follows:

Section 2: The Current Situation

Section 3: The Evidence

Section 4: Hospital Management

Section 5: Hospital Governance

Section 6: KGH & External Relationships

Section 7: Conclusions & Recommendations

[2] LHINs have assumed the Minister's rights and obligations under all of the current funding and accountability agreements with health service providers. The agreements assigned to the LHINs include the Hospital Accountability Agreements (HAAs). The LHSIA also requires the LHIN to negotiate Service Accountability Agreements (SAAs) between health service providers and the LHINs. As a result, hospitals now submit their Hospital Annual Planning Submission (HAPS) and the Hospital-SAA (H-SAA) to the LHINs for approval.

SECTION 2: THE CURRENT SITUATION

Introduction

The work of the Investigator and his team began in the midst of a period of deep disagreement between the SE LHIN and KGH as to the need for additional base funding to permit KGH to resolve growing service issues that the hospital had been addressing through planned deficit budgeting.

KGH saw itself as an efficient hospital – a perception supported by macro national and provincial indicators. The hospital attributed its operational problems to insufficient operational funding and believed it had done (and was doing) all it could without new funding. The SE LHIN and the MOHLTC acknowledged that the macro indicators painted a positive picture for KGH but could not understand how the operational problems worsened during a period when KGH had shown no growth in patient volume and had also received significant increases in government funding relative to other acute AHSCs.

The view of the LHIN was that the leadership of the hospital was not actively pursuing internal initiatives to help address the problems contributing to the growing financial pressures being faced by the hospital. The view of KGH was that they were efficient, that they needed more resources, and that they should be trusted as per their submissions to the LHIN. However, from the LHIN perspective, neither the submissions of the hospital or the subsequent draft Performance Improvement Plan (PIP) were effective in making the case for additional funding.

Consequently, the Investigator and his team were challenged with looking behind the differing perceptions. The goal of the Investigator's review was to dig below the surface to develop a clearer picture of some of the issues behind the submissions. By analyzing the performance data and soliciting input from key stakeholders, the Investigator and his team were interested in identifying possible solutions to help KGH move to a position where it can play a strong leadership role in building an integrated system of service delivery to better serve patients in the southeast.

KGH Financial Position

On February 27, 2008, the hospital projected a year-end (2007-08) operating deficit of approximately $13.5 M**,** more than double the operating deficit of $6M in 2006-07. At that time, the hospital also projected an additional $27.5M deficit for 2008-09. In April 2008, KGH expected to end 2007-08 with a $10.6M deficit.

In October 2007, KGH had reached the limit of its existing line of credit of $25M and was forced to obtain a temporary increase in the line to $40M. This increase was rapidly drawn on and in March of 2008 – had it not been for the support of the SE LHIN – the hospital would not have been able to meet its financial commitments to the staff (i.e., payroll) and suppliers. Currently, KGH remains in a very tenuous position with regard to meeting its obligations and is dependent upon the renewal of loans from the SE LHIN.

From 2003-04 to 2007-08 KGH received a 33.4% increase in its base funding from the MOHLTC – representing the second largest increase among the province's eight acute AHSCs. During this same period, patient volumes remained relatively flat. Assuming that KGHs base

funding is appropriate (a premise which KGH does not accept) relative to the other AHSCs, the hospital has been fairly funded.

Additional government revenue (supplemented by KGH deficit funding and the full utilization of the hospital's working capital line) combined with no significant growth in patient volumes should have resulted in greater operational stability. In fact, notwithstanding this substantial flow of revenue, the hospital experienced an increasing series of clinical service challenges during that period including:

- significant growth in the number of Alternative Level of Care[3] ("ALC") patients;
- high levels of rescheduled and postponed elective surgery;
- severely backed-up emergency facilities; and
- limited/restricted access to critical care beds.

In addition to these clinical challenges, the hospital was faced with growing staff morale problems impacting both retention and recruitment.

In the examination of the patient care and financial problems surrounding the hospital, it is important to understand that KGH did not inadvertently slip into its negative financial position. The decision to incur a deficit was made deliberately by the Board on the advice of Senior Management as a 'strategy' for responding to the hospital's clinical service problems.

KGH and its Relationship with the SE LHIN

In April 2007, the SE LHIN assumed responsibility and authority from the MOHLTC Regional Office for the KGH Accountability Agreement and the allocation of resources. Since that time, the relationship between the LHIN and KGH has become increasingly strained at the management level and ambiguous at the governance level.

Based on a review of correspondence between the LHIN and KGH Board Chairs and CEOs and interviews with the leadership of both organizations, it is apparent that the deterioration in the relationship has been precipitated by a number of factors including:

- a difference of understanding related to the circumstances leading to the signing of the 2007-08 HAA;
- the unresolved 2007-08 Performance Improvement Plan (PIP);

[3] ALC patients refers to those individuals occupying acute inpatient beds whom are awaiting placement in a more appropriate setting based on their individual care needs.

The Canadian Institute for Health Information's (CIHIs') Discharge Abstract Database (DAD) definition of ALC is: *"An ALC patient has finished the acute care phase of his/her treatment but remains in the acute care bed."*

- a perception within KGH that the LHIN does not understand the mandate and challenges of KGH as an academic health sciences centre;
- KGH belief that the LHIN expected them to balance the budget without cutting programs or services;
- a perception within the LHIN that the Board and Senior Management of KGH is unwilling to respect either the new mandate of the LHIN (as a legitimate replacement of the government) or the new accountability requirements;
- a perception by both Boards that the two organizations are unwilling to work constructively together at the Senior Management level to resolve the identified issues;
- public comments in the media directed to each other by the leadership of the LHIN and KGH;
- the initiative of the LHIN Board to request intervention by the Minister in absence of a local solution to the funding and performance issues at KGH.

KGH Culture: Embedded Beliefs

Over the years, KGH has developed a culture built on a number of strongly held beliefs that permeate much of the hospital's present communication and management practices.

"We are efficient and perhaps too efficient from a staffing perspective."

KGH believes it is an efficient hospital. Management points to macro national and provincial performance indicators that show low cost per case, high resource intensity weights, low nurse to patient ratio, actual costs lower than expected costs and a high number of ALC beds. These indicators are interpreted as sufficient evidence that the hospital needs additional funding to bring their services up to a level more in line with the other AHSCs.

"There is little that we can do to reduce ALC pressures due to lack of available facilities/services in the community."

The hospital has the second highest percentage of Alternate Level of Care (ALC) patients among its peers. The ALC issue is a bottleneck that must be addressed to ease the pressure on the unmet demand for acute care beds/services.

"We have been chronically under-funded."

The Senior Management has become fixated on the belief that the hospital is under-funded. Consequently, both the Senior Management and the Board have focused an inordinate amount of their energy and resources on advocacy efforts aimed at increasing the base funding of the hospital.

"KGH is being taken advantage of by other regional providers."

KGH recognizes its importance in providing secondary care for Kingston and nearby communities and accepts the responsibility to provide tertiary services to residents of the SE LHIN region and beyond. However, as a tertiary center for the LHIN they believe they are being challenged to cope with an unnecessary flow of patients with secondary conditions that are redirected from other hospitals within the region. This flow is perceived as contributing to current access pressures at KGH. This is a common complaint that KGH continues to raise with other hospitals within the region and has recently culminated in the hospital asking the LHIN to take action to address this concern.

"We have been disadvantaged by the protracted battles over the Health Services Restructuring Commission (HSRC) recommendations."

KGH believes it has been disadvantaged by the protracted battles with the government and Hotel Dieu Hospital (HDH) over the HRSC recommendations and by the delay in addressing the recommendation of a new Greenfield site for KGH. The cumulative decisions over many years to minimize repairs and maintenance (given the expectation of a new Greenfield premises) have resulted in the building up of significant requirements that could not await major capital renewal. This situation has put pressure on the hospital's operating budget at the expense of other pressing matters (i.e., new equipment, modernization of medical technology). It has also contributed to the hospital's negative working capital position.

The combination of all these perspectives has led KGH to conclude that: **"The hospital has done everything it can do and is a victim of a number of factors beyond its control."** These beliefs have taken on a life of their own at the expense of any commitment to assert leadership in assuming responsibility for control over the hospital's destiny.

SECTION 3: RESPONDING TO THE BELIEFS: THE EVIDENCE

This section addresses the "embedded beliefs" and compares and contrasts them with the findings of the Investigation team.

"We are efficient and perhaps too efficient from a staffing perspective."

KGH sees itself as the natural leader in acute care in the region and as a high quality performer among its peer hospitals. KGH believes that it is one of the most efficient teaching hospitals in terms of expected versus actual costs. This implies that the hospital has controlled its costs below what would be expected for their caseload. Additionally, KGH believes it has the second highest acuity in the country. If their acuity is high, their expected cost per case should be relatively high.

The finance and performance component of the investigation included a review of the hospital's finance and performance management indicators based on the gathering of data from various sources as well as meetings with key informants. Key data sources included:

- Data and reports produced by KGH
- Data and analysis assembled by the SE LHIN
- Data and information from the MOHLTC (including the HIT Tool, PDST database,[4] and Wait Times Website)
- Information retrieved from the CIHI Data Abstract Database (DAD)

The clinical analysis was performed by reviewing data from the CIHI database as well as MOHLTC databases identified above. In addition, meetings were held with staff of the SE LHIN and HayGroup consultants to determine their understanding of the clinical efficiencies and opportunities for KGH [see insert].

The Peer Review summarized the regional clinical picture in 2006 as follows:

- The SE LHIN demand for Inpatient admissions is relatively low compared to the province, given the existence of many complementary services in the SE LHIN.

The HayGroup further analyzed the clinical data and made the following observations:

- The average Resource Intensity Weight (RIW) of their normal (or typical) cases is relatively low compared to other teaching hospitals.
- KGH has a high percentage of the outlier cases, some of which are ALC. The average length of stay (ALOS) and average RIW of these outlier cases is extremely high. Therefore, it is the outliers that drive up overall acuity, not the normal cases.
- The SE LHIN population is not growing, although is experiencing some aging.

In consideration of the findings arising from the analysis undertaken by the Peer Review and Hay Group Consultants in 2006, the Investigator and his team undertook additional clinical analysis based on the 2006 year-end data. (The results of the analysis are summarized in the table below). The analysis shows that KGH's clinical performance has not improved, and not materially changed. Effectively KGH is in the same clinical situation today as

[4] Planning Decision and Support Tool

it was with the Peer Review report. Senior Management should have addressed these performance flaws and acted on them, particularly given the fact that they had been identified in earlier reviews.

Clinical Analysis Review

Performance Indicators	Investigator Team Analysis	Conclusions
Length of stay (LOS) ALC	▪ 19,441 ALC days in 2005/06) (an improvement from prior years). By definition, these are conservable days that should not be in an acute hospital.	There should be substantial opportunity to reduce the ALC beds but this will require both external assessment and closer coordination with other providers.
LOS Non-ALC	▪ 11,470 non-ALC conservable days, representing 8.1% of total non-ALC days. ▪ Both the raw days save-able and the percentage have risen in the last two years	Saving all 11,470 days is only theoretically possible. But, if one-half of those days were saved by reducing the LOS, then a reduction of 5,700 days would result in 17 beds being available to alleviate ER pressure or surgical case cancellations. At a LOS of 5 days (see Appendix – Table 7) and occupancy of 90%, this would equate to 1,100 more patients each year that could be admitted to hospital!
Total LOS	▪ At least 30,911 total conservable days	KGH's performance in LOS has not improved, and has slightly deteriorated over the last few years. Effectively, the hospital is in the same clinical situation today situation as with the peer review report in 2006.
Case acuity	▪ KGH has extremely high ALC days (see Appendix - Table 5). ▪ KGH average case weighting (RIW per case) is the second highest in the country. (Table 7). However, the normal, typical cases only have the 5th highest acuity in Ontario (which is basically average). This fact is inconsistent with the overall acuity being high. ▪ Typical cases account for 83% of the KGH patient caseload. It therefore appears that the high RIW is totally driven by 17% of KGH's patients – the outliers and ALC (most ALC are outliers, but not all – some are short LOS). Since ALC are supposed to be lower cost cases (i.e., cases that should not be in an acute facility) they can only be high acuity if the low weights are added up over a long period of time (i.e., a long LOS).	Case acuity is totally driven by long stay. Calculation of the RIW per day reveals that: 1. The average RIW (acuity) per day of normal cases is only at the average. 2. The average RIW (acuity) per day of outliers is actually below average

Operating Room (OR) Management	Management noted extremely high OR cancellations. This trend was attributed to a broad range of factors.	The Finance Department does not review any analysis of causal factors, nor is there evidence of discussion in the Senior Management minutes. This is considered a serious operational issue in light of the fact that cancellations rose to over 20% in December 2006 and have varied between 10% - 15% since. Management has reported that causal factors include lack of available beds, overbooking and the closure of ORs for renovations. An analysis of surgical cancellations implies that doctors are the largest reason for surgical cancellation; however, discussions with physicians and other staff suggest that data recording problems may be an issue. The Investigator and his team were not able to determine what (if any) forum within the hospital formally reviews surgical cancellations; however, Senior Management minutes do not report any analysis of this problem.
Cost per weighted case	Neither the Senior Management minutes nor the *Resources Committee* minutes reflect any evidence of specific clinical performance analysis and reporting.	KGH's high acuity leads to a conclusion that they are efficient. This is artificial. ALC cases are defined as lower cost cases that should not be in an acute setting, let alone a teaching setting. In fact, a hospital with high ALC should actually have a lower cost structure. Yet, their ALC cases are staying so long it leads to the appearance that they have a high acuity.

Based on the conclusions noted in the above table, it appears that the macro performance indicators have obscured some of the hospital's key micro performance issues. Had these issues been analyzed more carefully, they should have raised questions regarding the true efficiency of the hospital.

Another important issue to note is that management has contracted (assented to) a number of productivity and efficiency studies over the years. The two most recent included the EC Murphy Walsh report and LEAN. The EC Murphy Walsh study had 62% of staff completing detailed time studies as part of the review. Instead of engaging staff and using the results to initiate changes, management has been vocal in its criticism of the report. KGH defense is that the EC Murphy Walsh report might have influenced the LHIN to conclude that unrealistic savings were available. Even if one assumes that the hospital is correct on that point, it still does not justify the decision of the Senior Management to ignore other parts of the report particularly those related to staff morale and its impacts. Management also worked to dispute the recent Peer Review,

leaving a perception that they are not welcoming to external improvement suggestions at this time.

"There is little that we can do to reduce ALC pressures due to lack of available facilities/ services in the community."

The high LOS requires closer examination. The high number of ALC beds combined with the number of outliers suggests that there is much potential for improvement that will allow for the opening up of beds and improved access.

An external review [5] reported that KGH's ALC cases are valid.[6] However, a review of discharge behavior assessing how actively cases are managed revealed the following (see Table 3 and 4):

- 80.2% of discharges are to home (3rd highest teaching hospital)
- 7.2% of discharges have home care
- 2.7% of discharges are to LTC (6th teaching hospital)
- Waiting for LTC accounts for 56.6% of the ALC days while in hospital, while waiting for home care is only 5%

These discharge practices are inconsistent with the high number of ALC cases. This suggests that many of the patients listed as ALC might not be ALC patients. This implies that there is improvement to be gained by greater collaboration with the CCAC and LTC providers in the region. Interviews have indicated that despite the commitments made by members of the Senior Management the actual degree of coordination and cooperation from KGH with regard to discharge from ALC is very low, notwithstanding the importance of discharge to facilitate the successful utilization of beds at KGH.

"We have been chronically under-funded."

Senior Management believes that the principal answer to their problem is more resources and that without them, consequences are dire. Because of this, the strategies they employ and the way in which they present and interpret information are aimed entirely at justifying the need for more funding. The most notable example of this relates to management's recommendation to the Board to spend money which they did not have to meet what they believed were legitimate needs and then after the fact, seek additional funds from the LHIN to support them. Decisions with respect to the HAA/H-SAA, PIP and Balanced Budget further demonstrate how KGH has decided to 'manage' their financial situation.

[5] *Alternative Level of Care Report – Overview of Issues and Opportunities at Kingston General Hospital*, March 3, 2006. Karen R. Nelson, Chief of Social Work, The Ottawa Hospital.

[6] Ibid.

Hospital Accountability Agreement (HAA) & Performance Improvement Plan (PIP)

The failure of KGH, the MOHLTC and the SE LHIN to reach agreement provided the basis for the appointment of the Investigator. Among the first things the team had to consider were the various submissions for funding made by KGH and the LHIN responses to these.

As noted earlier, the KGH position was premised on a series of macro comparative indicators provided by CIHI and the OHA Hospital Report Card that ranked KGH in a positive light. These indicators were combined with demonstrable problems in the functioning of the hospital, particularly with respect to costs associated with the aging infrastructure and service delivery accessibility problems particularly within the areas of Surgery, Critical Care and Emergency. Much of the hospitals argument with regard to the access problems has focused on the issue of too many ALC patients and inadequate funding to support this caseload. The hospital interpreted the indicators as suggesting that the number of nurses was too low given the high intensity rating. Consequently, their case was to provide additional funding to substantially increase the complement of nurses. The ultimate argument was that failure to provide the additional funds requested would result in serious cutbacks in care to the point that KGH would revert to a community hospital and the medical school would not be viable and lose its accreditation.

Given that KGH was experiencing a chronic problem with staff morale (particularly among its nurses), increasing the staff complement was established as a key priority for responding to this issue. In these circumstances management recommended that the Board approve substantial increases in the budget to protect patient care (i.e., increasing staff complements). This became the principal rationale for deficit budgeting and for ignoring the demand for a balanced budget.

Despite these arguments, there were a number of issues of concern to the Ministry and later the SE LHIN as funder. During the period that the deficit was increasing, the volume of cases handled by the hospital was not growing. Patient care access problems were not improving, and staff morale problems were, if anything, worse. This raised the question as to whether money alone was the answer, and also heightened perceptions about whether the hospital was doing enough to address and resolve its problems.

These concerns might have been effectively addressed if KGH had provided a detailed business case to the SE LHIN demonstrating that they had taken action to be efficient in administrative matters, that they had a full understanding of what was driving their costs, and where new investment was needed so that an independent analyst could verify the reasonableness of the request. Instead, their best effort was to provide generalities regarding savings accompanied by the simplest of tables justifying their needs. It is also noteworthy that the hospital did not follow the template included in the HAPS and H-SAA sent to the hospitals by the LHIN. This template would have required a much more detailed case including documentation of their proposed budget financial recovery program in seven steps.

The Investigator and his team are unanimous in their view that the KGH submissions to the SE LHIN were inadequate and insufficient and that additional funding should not have been provided based on their submissions. This conclusion does not imply that KGH does not need additional funding. The strategy failed because the case was not made. If KGH had a good case it failed to make it.

What is important here is that there has been almost two years of dispute with no resolution. The fact that the case has not (to this point) been made, is especially important if one considers the possibility that there may indeed be a need for additional resources that has gone wanting because of the failure of the hospital to provide a quality submission. The failure to fund where the case has not been properly made should lie not with the funder but with the KGH for not addressing reasonable expectations.

Balanced Budget Plan

At the beginning of the investigation the message to the Chief Executive Officer of the KGH was that the Investigator and his team did not believe KGH had made its case. In the absence of a balanced budget plan at the commencement of the investigation process, the Investigator asked the CEO to prepare a balanced budget plan. The CEO responded to this request and prepared a new submission to the Board on the need for additional funding and the implications of balancing the budget in the absence of the additional funding identified. This plan was reviewed at a special in-camera meeting of the Board of Directors on April 24 and was submitted to the Investigator on April 29.

Predictably, given the current size of the deficit and the projected deficit, the reductions required to immediately balance the budget would be extremely damaging to service delivery at the hospital and to the medical school. The team accepts without reservation that immediate balancing would be extremely harmful given the expenditures to date and would not be a viable option. The problem with the submission is that it still failed to address in a comprehensive and convincing way the savings to date and the justification for additional money, nor did it provide the option of a phased in approach to balancing. The failure to provide detailed justification for new money remains the ongoing problem with all the KGH submissions.

"KGH is being taken advantage of by other regional providers."

Some individuals within KGH contend that the hospital has not been given sufficient recognition or respect from the other providers in the region, the SE LHIN and the MOHLTC. However, based on the views of some of the external partners in the region, the relationship between KGH and other providers in the region has been one of limited engagement.

KGH has participated for a number of years as the major sponsor of the Southeast Health Network. Through its participation in the Southeast Health Network and more recently under the auspices of the SE LHIN, KGH has participated with its regional partners in exploring numerous opportunities for inter-hospital collaboration including regional surgical coverage, referral of secondary care patients, inter-hospital transport and shared senior management. However, generally speaking, KGH has problems in its relationship with other providers. It is often seen as aloof and at times arrogant in its approach to its smaller colleagues. The one obvious exception to this is the Lennox and Addington Hospital (Napanee) where a very cooperative relationship exists between the two institutions. While it is a smaller hospital, the cooperation has proven beneficial to both hospitals and provides a clear example of the benefits that coordination can bring. Providence Care and the CCAC are constructive participants in the region and with the cooperation of KGH could be of more assistance in assisting with the ALC problem.

It is important to note that the other providers bear no apparent animosity to KGH. The attitude is rather one of frustration and lost opportunity. Perceptions on the relationships of KGH with external partners include:

- **The CEO and the Chair of the Board at the KGH are seen as taking positive positions in regional policy matters and planning initiatives but with minimal translation into action, particularly by those in KGH administration who have administrative carriage of the issues.**

- **The Chief of Staff at KGH has had a long and distinguished career at KGH and is noted for his hard work and dedication**. He is, however, seen by some as being difficult to deal with and is perceived as not being comfortable with joint undertakings that are not his idea or under his leadership.

- **There is a perception that the KGH culture is one that is hard to work with. The hospital operates somewhat as a silo within the region.** The ALC issue in particular requires coordination and cooperation with others in the region. Progress in addressing the ALC question has been very limited and there is a view that KGH wishes to address the issue "in its way" with little interest in the positions of other key partners.

- **The concern by KGH about the movement of secondary patients who could be handled back in their own hospitals is perceived by external providers to be out of proportion to the reality. That such a flow exists is not in dispute but the significance of the flow is questioned.** External hospitals believe that the flow is small and is to a large degree offset by patients from the Kingston area that go to their hospitals for faster service. Given the flat growth of activity at KGH it seems unlikely that there has been any new surge that has contributed meaningfully to the current back-ups at KGH.

- **Where KGH has failed to build good relationships the medical school has made considerable progress.** It is notable that the medical school has developed some strong relationships with other providers in its distributed medical education program.

"We have been disadvantaged by the protracted battles over the Health Services Restructuring Commission (HSRC) recommendations."

Capital is a significant problem for the hospital. The situation has been exacerbated by the hospital's decision to stop maintaining the buildings following the HSRC directives to relocate many of the services on a new Greenfield site. Consequently, current capital and maintenance funds are being consumed with old building problems. In addition, the nature of the configuration of the buildings and the extended age combined with the heritage status of some of the buildings provides for difficult operating circumstances.

The hospital has completed a facilities assessment to determine priorities. It also developed a capital budget request list and prioritized the requests based on risk.

In addition to the cash required for capital, spending on facilities maintenance causes an operating impact. Some capital projects increase depreciation expense thereafter. KGH is so far behind in its capital spending that new spending is new depreciation. There is not sufficient

"old" depreciation that ends. The details of their projected 5-year spend, and the impact is as follows:

Category	Total	KGH Share (not raised)	Depreciation
Redevelopment projects	$ 238.5 M	$ 14 M	$ 0.7 M
Other infrastructure – mostly facility problems	$ 77.8 M	$ 76 M	$ 4 M
Patient care equipment	$ 46.5 M	$ 46.5 M	$ 9 M
IT systems and administrative equipment	$ 19.8 M	$ 19.8 M	$ 4 M
TOTAL	**$ 382.6 M**	**$ 156.3 M**	**$ 17.7 M**

Senior Management has identified $77.8M of important infrastructure projects, of which the MOHLTC will partially fund $1.8M. This leaves KGH with the responsibility to fund the remaining $76M. KGH has identified $46M of the $76M as urgent, safety related building repairs. The hospital does not have the cash resources to fund this magnitude of projects, in addition to some equipment and IT replacement. They propose to fund $18M in the annual capital budget this year, assuming that operations are balanced.

Some of these projects will be classified as repair, and written off immediately, the remainder will be depreciated. Based on information from management, up to $2M of the $18M could be expensed, impacting operations. The remaining $16M will cause an increase in depreciation of $0.7M.

If the remaining $28M of the $46M is not addressed, the pressure will only increase due to newly identified projects in subsequent years. Therefore, funding a significant portion of these projects is urgent.

The project costs will also increase the operating deficit due to the increase in depreciation expense, or as a result of some projects being accounted for as maintenance expense. Consequently, there should be a minor adjustment to the hospitals base funding.

The recent creation of the University Hospitals Kingston Foundation[7] is also expected to impact the local share. Given that the hospital Foundations are now working together for a redevelopment campaign, management is expecting limited fundraising contribution to small projects, which is factored into the above numbers.

KGH does not have the financial resources to fund all its capital projects and requires an assessment and funding strategy for the critical needs. The Investigator and his team believe that

[7] The University Hospitals Kingston Foundation is the joint fundraising arm for Providence Care, Hotel Dieu Hospital and Kingston General Hospital. Created in 2005, the Foundation raises money for programs, equipment, education and research that benefit the 500,000 people in Kingston and South Eastern Ontario served by the three university hospitals.

the earlier the renovations and improvements are completed, the sooner more efficient operations and good working conditions can be restored at the hospital.

SECTION 4: HOSPITAL MANAGEMENT

Overall Findings

Leadership is all about inspiration and vision. Successful leadership teams are those that provide a compelling vision for an organization both for the people in it and the people who come to it. A vision is something that people can rally around, see themselves being part of and share in achieving. Leadership and management are not the same. While KGH refers to its Senior Management as the Executive Committee, this is not a leadership team. New leadership is required.

Based on a fairly extensive review of a wide variety of written materials, supplemented by discussions with members of Senior Management, other KGH staff and physicians, and representatives of other organizations, including the LHIN, the Investigator and his team have made the following observations about the KGH's leadership:

- **KGH's leadership approach is very top down. While there is a lot of talk about distributive leadership and participatory management, there is little evidence that this actually takes place.** Discussions with staff and physicians point to highly centralized decision-making with little opportunity for input. In addition, the rationale behind certain decisions is not always transparent (e.g., bed management). This results in feelings of disempowerment and as a consequence, many staff do not feel engaged as active members of the organization. They see themselves as simply being on the receiving end of various directives, edicts, strategies, policies, etc. They see things as being done to them as opposed to being done with them. While this might be a management strategy that can be employed during a very short-term crisis, this approach will not serve an organization well in the longer term since it creates an environment that fosters high levels of job dissatisfaction, poor staff morale, and ultimately, high levels of turnover and poor service quality. The linkage between staff satisfaction and service quality is clear: satisfied staff provide higher quality patient care! Dissatisfied staff run the risk of doing just the opposite.

- **There is very little evidence of any "out of the box" thinking among members of the Senior Management as it relates to dealing with their perceived problems**. The overarching problem has been defined as a lack of money coupled with a seemingly unfeeling and negatively biased system that "really does not understand the situation at KGH." Consequently, there is a lack of willingness to discuss or even explore other scenarios. The entire focus and culture has become one of circling the wagons and defending against outside forces. Not only does this foster the development of polarized relationships (them vs. us), but more importantly, the longer it goes on, the more ingrained it becomes in the organizational psyche. Everyone comes to believe that their view of the situation is true. Such would appear to be the case at KGH. The Senior Management has become so convinced that they are victims of under-funding that they have not encouraged an environment of constant improvement, or of looking hard at the recommendations of external consultants and providing more focused attention to better address service pressures in the hospital. In discussions with member of the Senior Management there was no acknowledge-ment that they had an obligation to live within their means. Quite the opposite. Not only is this fiscally irresponsible and lacking in judgment, but it places the organization, for which they are the leaders, in serious jeopardy.

- **There is an almost total focus by management on the issue of the lack of adequate funding with little appreciation for the impact that this focus has had on staff morale.** While staff morale has been notionally identified as an issue, Senior Management seems to lack any appreciation for the fact that they are in part responsible and accountable for it. Because of the strongly held belief that more resources will address most, if not all, of their morale problems, other causes of poor morale are not dealt with, discounted or in some instances, discredited. The result is that staff sees the Senior Management team as being unresponsive to their concerns. A case in point is the EC Murphy Walsh report. A significant number of staff participated in this review with the expectation that the results would be used to develop and implement strategies to improve quality of work-life. However, rather than taking the opportunity to use the findings in a positive way and explore opportunities for improvement, Senior Management has devoted considerable time and resources to discounting it and discrediting the researchers. The message to front line staff is clear: the leadership team is not prepared to do anything if it doesn't justify the need for more resources. More importantly, it serves to foster a sense of powerlessness; that nothing can be done to improve things without more resources. This situation has reinforced the cycle of increasingly poor morale.

- **Senior Management seems unable or unwilling to provide a positive vision for staff outside of a large injection of money**. This is a pervasive view and one that is inherently self defeating. Success becomes defined in terms of the ability to obtain more resources and when this does not happen (at least to the degree that KGH feels is appropriate) people see themselves as unsuccessful which in turn fosters poor morale. More importantly, however, it sends a clear message to staff and physicians that significant improvements can only be achieved with additional resources. If Senior Management is not able to provide a future vision and direction for staff and physicians outside of a construct that involves significant additional resources, then KGH will continue to face major roadblocks in improving its current state. In health care today, any hospital can make a case for more money to meet unmet demands. But the leaders are those that help create a future for patients, for staff and for their communities, that takes pride in what they are achieving, not what they cannot achieve. Senior Management has not been able to rise to this level and the organization is suffering for it.

- **There is widespread dissatisfaction with communication of hospital policies and priorities and a belief that some are kept informed and others are not.** Decision making processes are not understood and are often seen as arbitrary by what appears to be a very capable group of clinical and program managers. Many of the Program Managers and Medical Directors feel 'out of the loop" and believe that their full potential to perform effectively is compromised as a result. There is an enormous pool of talent and leadership among the Medical and Program Directors that is not being creatively utilized resulting in lost potential for the hospital.

- **Senior Management has had difficulties adjusting to and accepting the legitimate policy and funding leadership role of the LHIN.** While there is some rhetoric about working with the LHIN, it would appear to be more rhetoric than fact. The negative view of the LHIN is something that permeates throughout the organization and does not serve KGH well going forward. The working relationship between the Senior Management of the two organizations

The picture painted is one of a lack of effective leadership by Senior Management within KGH. Senior Management has failed to ensure the health and well being of the organization. While it may be argued that additional resources are required in the future, the strategy of spending now, with disregard for the fiscal health of the organization and the consequences therein, demonstrate a lack of management prudence that needs to be addressed.

Management Processes

A key focus of the Investigator's review was a desire to understand how key management processes work. Following is a summary of the key findings arising from this review:

Performance Monitoring

In March 2008, KGH released its Strategic Framework 2008-09 arising from extensive Board and Senior Management discussions to update earlier strategic priorities. The strategic framework document incorporates information on the hospital's five strategic priorities, key initiatives to achieve each of these priorities, some measures of performance associated with these priorities and management observations on results. The document is comprehensive and can serve as a useful performance report card for both governance and management. However, the Investigator and his team make the following observations:

- **Both Senior Management and the Board need to give careful consideration as to the appropriateness of certain measures and whether they are the 'best' indicators of performance.** For example, for Priority #2 *(Together we will provide an enhanced environment where staff are respected, valued, challenged and recognized as making a difference)* one of the measures is 'media relations index'. One questions whether this is a good measure of a quality work life environment. At the same time, there is no indicator of employee satisfaction included. So, one has to ask "Are they measuring the right thing?" Additionally, even though staffing has been identified as a long-standing problem, indicators for such important issues as vacancies and lost time are still in development.

- **Senior Management comments on current performance require substantial further work**. Some priorities have no management comments on performance (e.g., Priority #4 - *We will work with our partners in this region to provide an integrated, seamless patient-centred system.*) despite the fact that performance during some periods for key measures such as Criticall non-acceptance rate and surgical infections has been identified as not acceptable or at risk. For other priorities, statements such as "will bear close scrutiny" do not provide sufficient direction as to what is actually going to be done to address performance issues. Strategic Priority #5 is the subject of a separate discussion in Section 5 on Board Roles and Responsibilities.

In summary, the strategic framework and scorecard has the potential to serve as a useful tool for both governance and management. The key will be to make it a living document; something that is actively used to measure performance and to develop action plans to address performance

issues not just when they arise, but hopefully, to anticipate potential issues and deal with them proactively.

Budgets

- **Budgets appear to be finalized top down**. Departments develop their staffing needs and submit people hours (i.e. FTE's) to the Finance Department. Finance then calculates the rates and actual dollar budgets and distributes the results. The final reports then go out to the managers and VP's. As a result, it appears that the departments do not budget to a target, but more likely to a "need". This lack of understanding of the process was confirmed in interviews with some clinical leaders who expressed frustration over the lack of understanding at the operations level with respect to budgeting processes and cost drivers. It is possible that no one function really knows what they are budgeting, since it is sent back to them completed with rates, and total costs. Providing full salary rates and financial information in advance to departments for budgeting purposes would increase management's ability to make informed choices and increase engagement.

- Senior Management does meet to decide strategy and "investments" before the budget process is started. They decided to invest in nursing positions in an attempt to improve staff satisfaction and workload.

Financial Analysis & Reporting

- The Finance Department undertakes an analysis of monthly financial results. Questions go out to VP's to identify major variance items otherwise the Finance Department completes the analysis on their own. Although each VP and the programs are expected to do their own independent analysis, the Information and Analysis Department does the clinical and productivity analysis for the VP Programs. The results of this analysis are not reported back to the Finance Department.

- Finance does, however, prepare a monthly results package that is fairly comprehensive and includes a clear risk assessment and cash analysis. The monthly results are presented to Senior Management and the Resources Committee of the Board. The risks, including financial issues and cash issues are clearly outlined in the package, yet the minutes of both committees only reflect a comparison to budget. It would normally be expected that a hospital running a deficit and having debt limitations would have a focus on cash and debt. In addition, there is no evidence that the program-specific productivity analysis is included in this reporting.

Cash Management

- **KGH has debt, working capital and cash problems.** The Resources Committee has approved a number of capital projects which require a local share, and therefore cash. However, the minutes reflect little, if any, discussion regarding how the hospital will generate the cash required. The monthly results package does provide a cash forecast, however, the cash forecast presented to the Resources Committee last year ended in March 2008. The forecast represented a one-month forecast, but should have been done to reflect cash requirements for at least a year in advance.

- **Senior Management should be reviewing cash and the implication of decisions monthly.** In May 2008, management exceeded their line of credit. A new cash forecast for the first quarter of 2008-09 was drafted; however, the forecast provided to the Investigators represented only the first quarter of the fiscal year instead of the whole year. There is no evidence in the minutes of the Resources Committee regarding any review of cash forecast, or any requirement to forecast for a longer period, or to develop mitigating strategies**.**

Five-Year Analysis of Cost Pressures & Savings

- **Opportunities exist to better manage cost pressures.** Senior Management presented a chart to the Investigator and his team summarizing the key cost pressures and total savings generated over the past five years. A key item identified is that priority programs funding had increased $19M, while expenses had increased by $29M over the last five years, resulting in a $10M shortfall. This came as a surprise as most other hospitals have seen this program as highly profitable. The cost pressures were analyzed by the team, with particular focus on the priority program funding shortfall. Upon review management reported that there was a $3M error, over-stating the hospital's needs. Additionally, approximately $6M of the shortfall was caused by drug eluting stents, which the MOHLTC does not fund. [All cardiac centres in the province are expected to manage the cost of drug eluting stents against the funding for other cardiac procedures.] KGH has introduced drug eluting stents to the standard of other hospitals, without managing how to pay for them. No details were provided regarding the cost savings initiatives, other than referring the Investigator back to the PIP.

- **Additional cost pressures have been attributed to staff grid movement and inflation on supplies**. Most hospitals manage the staff grid movement by turnover and vacancies. Since KGH has significant pressure in both of these areas, the grid movement should be offset by hiring new staff at lower wages. Similarly, most hospital buying groups negotiate reductions in inflationary pressure on supplies.

Clinical Information Analysis & Reporting

- **While there is comprehensive work undertaken to develop reports, there is little evidence that Senior Management reviews productivity or develops a risk profile to ensure that key risks are reviewed.** The Information and Analysis Department has developed a very comprehensive database of clinical information that includes all KGH clinical data, four years of CIHI database, and up to 12 years of the market share of 40 regional hospitals. The department has also developed a significant number of comprehensive analytical clinical reports for the program managers to use. Program Directors are the key target for these reports which are published monthly or quarterly. However, based on the interviews it is not clear that clinical data is widely distributed and (if it is) whether it is used. It is reported that the Clinical Chiefs and the Program Directors have activity reviews; however, the Program Directors were not interviewed to determine how the information is used. The Information and Analysis department has also introduced concurrent coding.[8] The benefit of this activity should be to ensure patient treatment and

[8] Concurrent coding is when staff are present in the inpatient units and reviewing the case while the patient is there.

conditions are recorded properly, identify costs and potential discharges earlier. This is an active project.

Staffing Changes & Impact on Budget Deficit

Management has been transparent and up front about their recent strategy to increase nursing staffing and reduce the number of beds managed by each nurse. The analysis undertaken by the Investigator and his team did not include a review of nursing units; however, we did explore the following areas:

- Current staffing levels are reported to be significantly below average compared to other teaching hospitals. It may be reasonable however – given that the hospital's high acuity is driven by low acute patient days – that the hospitals costs and staffing should be below average.
- Management reported that each area was assessed on a case-by-case basis to determine which areas required more nursing. It would be impossible to evaluate this unless the same unit-by-unit study was performed.
- Staffing in the ICU has been increased to a 1:1 ratio. This means that there is one nurse on duty for every bed, 24 hours a day 7 days a week, representing a very acute service.

Academic & Clinical Leadership Perspectives on Management

Many of the observations drawn by the Investigator and his team were reinforced by the perspectives of academic and clinical leaders within the hospital.

KGH is fortunate to have a number of thoughtful and capable academic and clinical leaders at the management and operational level which bodes well for the future. Unfortunately, they are not operating in an environment that is clear to them although many describe a situation which they believe can be corrected if coordinated action takes place. While there is a strong belief in the need for more and immediate government funding, many are convinced that actions can be taken to improve the systems in the hospital. It was not surprising to find that physicians believe they can do a better job of managing things than management can. What was of concern was the lack of confidence by many that Senior Management could or would support them in meeting their challenges.

Extensive interviews with Medical Directors, Academic Directors and Program and Operational Directors at KGH revealed deep frustration with respect to a number of current management practices and uncertainty as to how these can be resolved. These included:

- **Bed management in the hospital is a matter of widespread dissatisfaction, and is viewed as a bottleneck that could be addressed (at least in part) by a more efficient management system.** There is no clearly articulated process for administration of the bed management policy and many believe the bed management decisions are largely ad hoc. There is a widespread belief that the Chief of Staff micro manages the bed allocation and that the lack of clarity in bed allocation and management substantially contributes to patient flow problems as well as to nursing dissatisfaction. In particular, there is a strong held belief that the bed management policy is not working effectively and adding to the problems of a number of departments including Emergency, surgery, and to a lesser degree the ICU.

- **Little real understanding at the operations level of budgeting and cost drivers and concerns over the lack of use of high quality clinical data (developed by the hospital and SEAMO) that could be used to inform planning and decision planning**. There is a general sense of frustration that many of the immediate access and system management issues at the hospital are not well managed and that these are contributing to the staff morale problems. There is, however, a clear desire among many physicians and program leads to have a better understanding of the costs of their operations so as to maximize their ability to more effectively plan and deliver their services.

- **Concerns about leadership within the hospital**. Most have no sense of the contribution of the CEO and while there is recognition of the valuable contribution the Chief of Staff has made in his long history with the hospital, many believe that his style is no longer consistent with contemporary hospital management practice. Some believe that the decision making process is too closely held by the Vice President, Clinical and Chief Nursing Officer and the Chief of Staff with very little meaningful consultation, delegation or even transparency around decisions. There is a sharp division between those who have confidence in the Vice President, Clinical and Chief Nursing Officer and the Chief of Staff and those who do not.

- **Concern that the LHIN doesn't understand the nature of AHSCs and their unique missions that lead to higher costs.** Important factors that need to be recognized include:

  - Costs associated with biomedical research,
  - Direct and indirect investments associated with the provision of graduate medical education,
  - Unmeasured differences in case mix between teaching and non-teaching hospitals,
  - Actual and measurable differences in the case mix of teaching hospitals,
  - Impact of early adoption of high technology, and
  - A necessity to maintain standby capacity for highly specialized patient care.[9]

[9] HayGroup. (March 2005). *The cost impact of the academic missions of teaching hospitals – a review of the literature.*

- **Support for program management**. The change to a program management structure was generally perceived as a good thing and there is considerable support for more teamwork. There is a strong concern, however, that the advantages of program management are not being fully realized as a result of a lack of transparency in addressing differences that develop between programs, unclear policy and process for setting priorities, administrative silos and little leadership with regard to problem solving. For some, there is a belief that the more independent a program can be from the day to day administration of the hospital the more successful they are likely to be.

Concluding Observations

The key messages arising from the analysis undertaken by the Investigator and his team are as follows:

- KGH is at roughly the same level of clinical performance as it was in 2006.
- The length of stay (LOS) for the average patient is increasing but the level of acuity is not.
- KGH has artificially high acuity indicators because the long LOS creates a false impression of high acuity.
- Artificially high acuity leads to the impression that KGH is efficient; however, given that most of the cases are ALC (which cost considerably less than an acute stay) the hospital should actually have a lower cost structure.
- KGH can be more efficient. Looking at the details, behind their indicators suggests that there is considerable room to improve performance that would free sufficient beds to address a number of their patient care access problems.
- Senior Management should review LOS and surgical cancellations as a standing agenda item.
- 80.2% of the inpatient cases are discharged to home. Only 2.7% are discharged to long term care and a further 7.2% sent home with home care. These discharge practices are inconsistent with the high number of ALC cases. This suggests that many of the patients listed as ALC might not be actual ALC patients.
- There should be an external review of ALC clinical case management to identify opportunities to reduce the impact of ALC pressures on the hospital.
- KGH has serious problems with maintenance and capital repair. These problems require high priority attention from the Ministry.

SECTION 5: HOSPITAL GOVERNANCE

Background

The governance review focused primarily on the governance policies, decisions and processes of the Board of Directors in relation to those matters which precipitated the investigation and in consideration of new expectations related to governance practices. While the governance review did not include a comprehensive audit of the current KGH governance structures and processes, it did address priority opportunities for governance renewal that emerged from the review of matters pertaining to the investigation.

The process for review included interviews with all members of the Board of Directors and one former Director, several meetings with the KGH Board Chair and CEO, meetings with staff of the SE LHIN and LHIN Board Chair, and the KGH legal counsel. In addition, members of the Team reviewed extensive documentation and attended one Board meeting and a meeting of the Resources Committee. The following provides a summary of the key findings and conclusions arising from the governance review:

Board Accountability

With the increasing focus on the accountability of Boards of Directors in both the private and not-for-profit sectors in recent years and the passage of the CFMA in 2004, it is now considered best practice for hospital Boards to explicitly define in either Board policy or the hospital by-law their understanding of their accountabilities to multiple stakeholders including: patients and communities served, the MOHLTC, and Local Health Integration Networks (as of June 2007).

Despite the Board's intent to update its by-laws to align with the new legislation, the 2007 amendments to the KGH by-law are silent on the accountability of the Board of Directors. Furthermore, the focus in the *Principles of Governance* (Section 4.11) is solely on the relationship of the Board to its community rather than a balance of its relationship to its community and its funders.

Section 4.11(b) specifies that *"The Board serves the community in carrying out its responsibilities."* Arising from the CFMA, which places an onus on hospital Boards for accountability to government and now the LHIN as funder, the KGH Board of Directors, like many other Boards across the province, are being challenged to balance their new accountabilities with their very strong belief in their fundamental accountability to meet the health care needs of their patients and community. This challenge is reflected in the minutes of the March 2007 Board meeting which state that *"the Board has a responsibility to patients served by the hospital and then an obligation to the government who provides a certain portion of the services."* The tension between these accountabilities permeates both the culture and decision-making of the Board of Directors and is fuelled by what was referred to by one Director as *"an ideological predisposition of the CEO and Senior Management to do the right thing in regard to the delivery of care rather than the responsible thing"* of also managing within budget.

The Investigator and his team accept the importance of the hospital meeting its accountability to its patients. However, the KGH Board of Directors has not given sufficient attention to the need to balance its accountability for services to its patients and community with its accountability for the stewardship of the public funds which are

required to provide these services. This prevailing attitude among many of the Directors on their accountabilities as a Board provides an important context for the specific decisions which the Board has made in the past two years related to the KGH budget, resource allocation and clinical programs. However, it is important to note that a growing number of elected Directors who are focused on the increased accountability for financial management have quite recently become more vocal within the Board about the accountability for public funds.

Board Roles & Responsibilities

Section 4.08 of the by-law defines three roles for the Board of Directors: policy formulation, decision-making and oversight. Review of documentation indicates that the KGH Board has established a limited number of Board policies to guide its decision-making and oversight. These policies, which are contained in the hospitals "Administrative Policy Manual", are largely related to signing authority, conflict of interest and Board meeting procedures.

The Board has, however, focused significant time and energy since 2006 on putting in place governance processes to support its roles in decision-making and oversight. Most notable among these are the six 'Challenge questions' which were introduced in March 2007 "*to assist Board members…to add value to the decision-making process at KGH…and to allow the Board to measure or judge how well the decision was made.*" These questions were to "*assi*st *Board members in fulfilling their oversight/fiduciary responsibilities as a Board member*" and were to be addressed in both the briefing notes by Senior Management and the deliberations of Board Standing Committees.

Board minutes during this period demonstrate a genuine concern within the Board to ensure that recommendations by Senior Management and Board committees include consideration of options, are linked to key strategic documents and that Board Standing Committee members focus for the Board the key issues which need to be considered by the Board. However, it is not apparent from the minutes of specific Board decisions that the 'challenge questions' have to date had the intended result in improving the rigor of the Board's decision-making and oversight of the hospital as established in the by-law.

Despite an understanding of its responsibilities in section 4.09 of the by-law, a review of the Board's involvement and effectiveness in relation to the matters under investigation would suggest that the Board has not effectively fulfilled several of its responsibilities as outlined below.

Establishing Strategic Priorities

As a result of the strategic planning retreat in January 2008, at the February 2008 Board Meeting, the Board of Directors approved five strategic priorities as follows:

- We will work to ensure that our patients have access to safe, quality care in the right place at the right time
- Together we will provide an enhanced environment where staff are respected, valued, challenged and recognized as making a difference
- We will provide an environment that values and fosters learning and innovation

- We will work with our partners in this region to provide an integrated seamless patient-centred system.
- We will seek sufficient resources to maintain a balanced and sustainable budget, without compromising patient services, academic obligations and research capacity.

The final strategic priority, which ties the achievement of a balanced and sustainable budget to an increase in resources (i.e., funding), appears to be at odds with Section 4.11 (b) and (d) of the principles of Governance in the by-law, which state that "The Board shall ensure that the Corporation provides the best possible health care within the resources that are made available to it; and "The Board shall constantly seek resources to meet the needs of the community served and shall ensure that the Corporation operates within its resources and monitors their efficient and effective use.

The majority of the Board of Directors aligned their 'qualified' approach to balancing the budget with their position on their primary accountability to patients. A minority of Board Directors took the position that balancing the budget was the priority; however, they were not successful in making this case to their colleagues. **Recognizing the critical state of the hospital deficit at the time these priorities were established in early 2008, it is difficult to understand how the Board could have established this strategic priority with such a qualified approach to achieving a balanced budget.**

Oversight of Chief Executive Officer (CEO) and Chief of Staff (COS) Performance

The processes established by the KGH Board of Directors for establishing CEO and COS performance objectives and for evaluating their performance are comprehensive and consume considerable Board time during the course of the year. However, there is serious question as to the effectiveness of the process in either ensuring CEO and COS accountability to the Board for defined performance goals and objectives or in ensuring improvement in the actual performance of the CEO and COS where the need for improvement has been identified.

It is apparent from the interviews with members of the Board that there is a divergence of perspectives among Directors on the performance of the CEO. Concerns identified by numerous Directors related to achievement of Board-approved goals, strategic leadership and advice to the Board, recurring and unresolved issues over several years and lack of visibility and clear direction to the organization. A minority of Directors, however, expressed a high level of satisfaction with the performance of the CEO.

A 360 degree review of the performance of the CEO was conducted by the Board Chair in March 2008 based on the CEO goals and objective for 2007-08 as approved by the Board. The results of the review were shared on a confidential basis with the Investigator and his team and were consistent with our findings. Despite the concerns expressed by Directors both to the Board Chair and to the Investigator and his team, the outcome of the 360 review was that the CEO was seen to have met expectations.

While the Board has endeavored to establish a process for CEO performance management that is aligned with best practice, the Board has been challenged to establish concrete performance measures and to utilize the results of this process to strengthen CEO performance. Our review of documentation related to CEO goals and evaluation as well as

the interview findings strongly suggest that the Board is at best divided on the performance of the CEO and is increasingly concerned and lacking confidence. This is an untenable and unsustainable situation at this time of unprecedented need for strategic and operational leadership by the CEO to address the financial crisis, human resource and patient care issues within the hospital.

While there appears to be a higher level of confidence and support for the COS, based on a review of documentation as well as interviews with the Board and within the organization, it appears that an acceleration of the search process for the future COS would be desirable.

Ensuring Financial Viability of KGH

Hospital Accountability Agreement (HAA) & Performance Improvement Plan (PIP)

The KGH Board of Directors has been publicly criticized by the SE LHIN for having signed the *2007- 08 HAA* knowing that they could not balance the budget. This issue, more than any other matter discussed in the Director interviews, demonstrates the intense struggle which the KGH Board experienced between its perception of its accountability to its patients and community and its accountability to balance the hospital budget under the *Commitment to the Future of Medicare Act*.

As noted in the discussion of the HAA and PIP in Section 2, in the summer of 2007 the SE LHIN required KGH to prepare a PIP in which the hospital was expected to identify strategies to balance the budget by March 31, 2008 to comply with the signed 2007-08 accountability agreement. However, the approach used by KGH management and supported by the Board in two successive drafts of the PIP identified that additional resources were required by the hospital to address chronic funding issues and *"factors beyond our control"*. The PIP was subsequently rejected by the LHIN on several grounds including a reliance on additional revenue, and request for additional funding to address *"factors beyond the hospital's control"*

In February 2008, despite the requirement of the LHIN that the hospital file a balanced Hospital Annual Planning Submission for 2009-10, the Board approved the recommendation of management to submit a plan of *"strategies to create a sustainable hospital"* which identified $36 million in additional annual operating resources required from new funding or cost reductions. In April 2008, in response to the balanced budget plan prepared by the CEO at the request of the Investigator, the Investigator and his team concluded that the submission failed to identify a systematic and phased approach to financial recovery and achievement of a balanced budget.

With respect to the *2007-08 HAA*, the Investigator and his team accepts that the Board believed it was acting in good faith when it signed the Agreement. However, since that time, if it were fulfilling its responsibility for financial stewardship of the hospital, the Board would have insisted that management prepare a balanced budget plan including a systematic, detailed and phased approach to the reductions required consistent with maintaining quality care and meeting its academic obligations. This plan would have not only provided the evidence to support a phased approach to balancing the budget over time but would have potentially satisfied the Board of Directors of the LHIN that the hospital required additional resources and was acting in good faith.

Resources Committee

The first line of oversight in addressing financial accountability and viability should have been the Resources Committee of the Board. The findings arising from a review of the minutes of this committee and the year-end report reveal that:

- While financial results are presented each meeting, with risks and financial issues, there are few references in the minutes to any specific discussion or debate about alternative analysis, productivity or the cash impact of the deficit.

- Capital projects appear to receive approval without a thorough discussion regarding the impact on cash and operations. The minutes do not reflect any discussion of cash forecasts. Therefore, there is no evidence that management discusses the implication of decisions and identifies the challenges in advance. Particularly concerning is that the cash forecast provided with the monthly results package is relatively short-term. The forecast provided with the February financial results only forecast to March 2008.

- The Committee always supports projects if patient safety or staff satisfaction issues are raised.

- The Committee has approved an annual budget plan and two PIP (performance improvement plans) submissions to the SE LHIN that were justifying an increase in expenditures and very focused on justifying this need. We see only one discussion focused on budget reduction, and no direct request of management to develop alternate plans.

The lack of a detailed review of the implications of decisions combined with the absence of longer term forecasts leave significant exposure to KGH. Evidence of this shortcoming was that management had to make an urgent decision to exceed the approval policy by drawing on debt above the approved bank line of credit. A normal routine of discussing long-term cash forecast with the Resource Committee would have identified this event in advance.

The Investigator and his team have concluded that in order to support the Board to meet its responsibility to ensure financial viability of KGH, the Resources Committee needs to improve its oversight, by reviewing long-term cash forecasts and demanding increased clinical analysis and impact analysis of decisions.

It is important to note that the Audit Committee did advise the Board of its serious concern about financial risk arising from both the deficit and cash flow situation. While its warnings in October 2007 did precipitate a focused review of Director liability, it did not appear to spur the Board to take definitive corrective action in relation to the rapidly escalating credit line and deficit.

Oversight of Organizational Performance

The majority of the Board of Directors believes that the Board has not been effective in establishing expectations with Senior Management for improved efficiency or other aspects of performance improvement. Where clear expectations have been established, there is a perceived resistance by management on the grounds that *"the hospital is the most efficient teaching hospital,"* and *"everything that can be done has been done."*

There is almost unanimous concern among Directors related to the excessive gap in human resources leadership within the organization, most notably with respect to the longstanding serious state of staff morale and chronic sick leave. In recent months, it appears that these issues have received increased attention by the Resources Committee and the Board of Directors with several directors implying that the Board has significantly increased the pressure on Senior Management to demonstrate leadership and bring forward very specific solutions.

The Board has not been sufficiently challenging to Senior Management in its oversight of performance within KGH. The Board has been too ready to accept Senior Managements' assurances of having maximized efficiencies, which they had not substantiated (see Section 3) and there has been a recurring pattern of acceptance of management explanations for sub-standard performance in relation to sick time and staff morale without sufficient challenge to management to identify solutions to these problems. It is encouraging, however, to see a growing tenacity arising from increasing frustration and recent action demonstrating that the Board is starting to "drill down" much more diligently than in the past. Going forward it will be essential for the Board to not only ask questions of management but also hold management accountable for specific plans to address performance variances with clear timelines and deliverables.

Ensuring Effective Communication (The 2007 Advocacy Strategy)

Arising from the experience of the Hospital Accountability Agreement in March 2007 and consistent with the Board's increasing concern about access to care, in June 2007, the Board unanimously decided to:"*support in principle the creation of a Government Relations/ Advocacy Task Group to identify and undertake and advocacy strategy between now and the 2007 October 10 election to obtain needed funding and support from the provincial government."* The Terms of Reference for the Government Relations/ Advocacy Task Group identified its role as follows: *"to identify and undertake an advocacy strategy to secure the financial and other support required to allow KGH to be a leading academic hospital today and into the future."* The advocacy campaign was launched in June 2007 to inform the public of the hospital's situation and continued throughout the provincial election campaign.

While the Board was clearly motivated by its concern to ensure continued access to high quality patient care, the public advocacy campaign was ill-conceived in two respects. First, there is no evidence in the minutes or other documentation that the Board exercised appropriate due diligence to ensure that the information that they were providing to the public was based on solid evidence of KGH performance. Secondly, while the advocacy campaign informed the community that the hospital was experiencing serious problems, it further jeopardized the credibility of the Board and the hospital with their principal funders – the Ministry of Health and Long-Term Care and the LHIN, who were still expecting a genuine business case to justify the

expectations of the hospital. The absence of such a case suggested that advocacy was being used to avoid serious attention by the Board and Senior Management to escalating financial and performance issues.

Despite the LHIN's specific request in September 2007 that the hospital discontinue the advocacy campaign, a review of hospital documentation confirms that the campaign continued throughout the election including representatives from the hospital actively utilizing all-candidates meetings to convey its message. It is not apparent from the documentation that any alternative to an advocacy strategy was considered by the Board.

Despite their positive motivation to inform the community, the Board was at best naïve in believing that the timing of the advocacy campaign in relation to the election would not incur the criticism and further alienation from government and the LHIN.

Building an Effective Working Relationship with the South East LHIN

The deterioration of the relationship between the hospital and the LHIN (as outlined in Section 2) is an issue of significant concern to both the KGH and LHIN Boards.

From the perspective of the LHIN Board, the KGH Board is reluctant to accept its new mandate and authority. There is a widely held view that the KGH Board does not have a good grasp of the hospital's finances and have not shown the necessary governance leadership by challenging management to develop a plan to address the deficit and balance the budget. Despite repeated requests by the LHIN Board to the KGH Board for a plan to address the deficit, the LHIN Board believe that the KGH Board is clinging to the mindset that the deficit will be covered as in the past and that "they have done all they can."

From the perspective of the KGH Board, the LHIN Board has not demonstrated sufficient understanding of the responsibilities of KGH as an academic health sciences centre (AHSC). Concern has also been expressed at the inability of the LHIN and KGH Senior Management teams to establish an effective working relationship and that public communication by the LHIN management to the media has been unnecessarily confrontational despite the apparent understandings and cordial communication between the two Boards.

It is interesting to note that while the relationship between the two organizations at the Board and Senior Management is strained, the LHIN Board Chair and KGH Board Chair are both optimistic about their working relationship at the regional level in providing joint leadership to a new Committee of Hospital and CCAC Board Chairs to engage in governance level discussion of LHIN-wide health system improvement and integration opportunities. While this committee is in early stages of development, it is seen by the LHIN Board and KGH Board as a very significant opportunity to strengthen governance understanding and leadership of health system improvements within the Southeast LHIN.

While the LHIN may feel - with some justification – that its role is not respected by KGH, the LHIN must recognize that KGH has AHSC issues that need to be understood in assessing the hospital's needs. There are unique relationships with the university and more broadly with the AHSC system throughout the province that would benefit from some recognition and more importantly, from discussion between the SE LHIN and KGH as well as with other LHINs and AHSCs. At the same time, KGH needs to abandon its defensive position and can only be well

served by devoting more time and attention to ways in which they can work more collaboratively with the LHIN.

Despite the obvious expressions of frustration and disappointment in the deterioration of the relationship between the two organizations, the conclusion of the Investigator and his team is that there is a sense of urgency and commitment within both the LHIN Board and KGH Board to restoring an effective working relationship at the governance and operational levels. However, this will require significant investment of effort on the part of both parties including very candid discussion of the issues between them and the development of very clear ground rules for the relationship going forward. It will require the Board and Senior Management of the LHIN to recognize that it is not possible for KGH to balance the budget immediately without cutting programs and services and to support KGH through a prudent and responsible recovery process. Equally, it will require the Board and Senior Management of KGH to recognize their responsibility to submit a phased and systematic approach to financial recovery while maintaining its patient care and academic obligations.

Governance Structure & Process

The KGH Board of Directors has spent considerable time revising its governance structures and processes to ensure that they are aligned with best practices. This work has included:

- significant revision of the administrative by-law in 2007
- reducing the number of elected Directors
- streamlining of Board Standing Committees
- restructuring of the Board agenda format
- introduction of "challenge" questions to enhance the level of rigor in the analysis and discussion of management and Standing Committee recommendations to the Board
- a comprehensive process for the evaluation of the performance of the CEO and Chief of Staff including a 360 review in 2008 of the CEO performance
- annual self-assessment of the performance of the Board and individual Directors and a follow-up meeting of each Director with the Board Chair
- extensive use of Board retreats, special education sessions and special Board meetings to address major issues
- more systematic approach to Director recruitment and selection to achieve a skills based Board
- attendance by Directors at governance education programs offered by the OHA and other organizations.

While the KGH Board of Directors is a very dedicated and hard-working Board, interview findings and review of documentation indicate that further attention to governance renewal is required to maximize the effective functioning of the Board. Priorities for governance renewal are to:

- Revise the title and responsibilities of the Board of Governors (the members of the Corporation) to clearly differentiate its roles and responsibilities from those of the Board of Directors of the hospital;

- Redefine the scope of the Board Chair's position and distribute some of the Chair's current responsibilities among the Board of Directors;
- Revise the Principles of Governance to include a clear statement of Board Accountabilities;
- Align the statement of responsibilities of the Board of Directors with the new expectations under the *Local Health System Integration Act* and define the relationship between the Board of Directors and the Board of Directors of the SE LHIN;
- Establish Board policies that are aligned with the responsibilities of the Board of Directors;
- Support the Board of Directors on appropriate levels of engagement to strengthen their oversight of hospital performance;
- Complete the process initiated by the Board in 2008 to ensure that the size and composition of the Board is aligned with best practice, minimizes the potential for conflict of interest and reflects the regional role of KGH;
- Clarify the governance relationship between the KGH Board of Directors, Queen's University and the medical school;
- Renew the process for nomination of Directors to achieve greater transparency,
- Review the current membership of the Board of Directors and appoint Directors as required to fill vacancies, ensuring that the Board reflects a diversity of regional perspectives and appropriate skills and expertise;
- Review the scope of responsibilities and size of the Board Standing Committees and the processes related to in-camera matters.
- Significantly reduce and focus the documentation provided to the Board of Directors and Board Standing Committees; and
- Reduce the demand on Director's time commitment to the hospital.

Board Leadership

The KGH Board Chair has very strong support from the Board of Directors who are most appreciative of her very heavy commitment of time and effort over the past two years on behalf of the Board and the hospital. This has included not only fulfilling the normal responsibilities of Chair but also an unprecedented level of involvement in day-to-day operational matters arising from the escalating financial and clinical pressures confronting the hospital. In addition, the Chair has assumed increasing responsibilities to represent the Board in a variety of regional governance forums with the Board Chairs of the LHIN and other hospitals and agencies within the LHIN.

While recognizing the obvious dedication of the Board Chair and the extremely enthusiastic endorsement which she has received from her Board colleagues, based on the review of the Governance structure and the Board Chair's documentation of the responsibilities and time commitment of this position, as presently constituted, it can only be filled by an individual who

is retired or not otherwise employed. The Investigator and his team believe that the scope of the Chair's position needs to be significantly redefined as it currently unrealistic and an inappropriate limitation on succession to the Chair.

The term of the current Board chair is completed in June 2008. **At this time of transition in Board leadership and arising from our overall findings on the governance of KGH, the Investigator and his team believe that the Board would benefit from a new Chair who will be seen as an agent of change and will provide leadership to a new era for the KGH Board.**

Concluding Observations

The decisions of the KGH Board of Directors have contributed significantly to the current situation which precipitated this Investigation. The Board has, in a genuine desire to advance the interests of patients, lost its focus on its equal responsibility to effectively oversee management and to ensure financial viability of the organization. Based on the review of the specific decisions related to strategic priorities, CEO performance, and financial viability, the Board of Directors does not appear to have exercised sufficient diligence or optimal judgment. The Board of Directors has also tended to demonstrate more "hindsight" than "foresight" in relation to signing the Hospital Accountability Agreement, challenging management on organizational performance and implementing the advocacy strategy.

Having said this, the KGH Board of Directors, like many other Boards at this time of significant change in the Ontario health care system, is itself in transition. It is clear from the Director interviews and Board actions in recent months that while the current Board has made mistakes in judgment, an increasing number of Directors understand and accept the need for change in their oversight and decision-making and are committed to renewal. The Investigator and his team have concluded that the majority of the Board of Directors have learned from their experience and should be given the opportunity to demonstrate this commitment provided that a full governance renewal process is undertaken. Going forward, it will be essential for the Board to not only place greater emphasis on exercising its due diligence in asking questions of management but also hold management accountable for specific plans to address variances from expected performance in all aspects of the hospital's operation with clear time lines and deliverables.

SECTION 6: KGH AND EXTERNAL RELATIONSHIPS

KGH and the Hotel Dieu Hospital

The relationship between the Hotel Dieu Hospital (HDH) and KGH is long and checkered. In recent years the relationship has improved as evidenced by a high degree of integration between the two hospitals, particularly at the physician level. After many years of acrimony, the two CEOs now have a positive relationship and have co-operated in achieving a number of program and administrative initiatives. The relatively recent decision to establish the University Hospitals Kingston Foundation is a major step forward.

The mandate of the Investigator and his team has not included the relationship between KGH and HDH at any level. However, the investigation confirmed that the reality is that the two organizations are functionally interdependent and increasingly operating as a single organization. Highlights arising from our review with respect to the HDH/KGH relationship are as follows:

- **The ongoing rationalization of programs between the two sites, while positive, certainly impacts on the operational budgets of both hospitals and the longer term financial impact on both requires closer examination**. Thought should be given to looking at the combined budgets of both hospitals while accommodating the ongoing independence of the HDH Board.

- **At least one-third of KGH Directors identified the need to aggressively pursue the integration of KGH with HDH at the governance and operational levels.** This belief arises from the significant evolution of the relationship between the two hospitals in the last five years. As a result of the integration of the medical staff, clinical programs and ambulatory and inpatient services, there is a strong view among many of the Directors that KGH and HDH are now effectively operating as 'a single organization on two sites.'

- **Greater coordination in the use of facilities and in the administration of both institutions could provide increased acute care to the region and maximize opportunities for both hospitals to realize their potential. The hospitals should continue to work to integrate their management and operations to provide a progressive model of integration that seamlessly serves patients in south eastern Ontario**. The decision to move ambulatory/day surgery to HDH seems to be working well and both are looking at moving more ambulatory/short stay surgery to this site to address some of the surgical facilities problems at KGH. This realignment is likely to impact the operations budgets of both and the dynamics of their broader operations.

The conclusion of the Investigator and his team is that the enhancement and formalization of the interdependence between HDH and KGH is absolutely critical to the future viability of patient care, education, research. It is also critical for ensuring the financial viability of HDH and KGH and stabilizing tertiary centre services for the population in the SE LHIN.

KGH and the South Eastern Ontario Academic Medical Organization (SEAMO)

The South Eastern Ontario Academic Medical Organization ("SEAMO") was the pioneer in alternate payment plans for physicians working in an AHSC in Ontario when it was established in 1994. One of the initial driving forces behind the creation of SEAMO was the desire to

provide academic stability for the Queen's medical school. With respect to that objective it has been a considerable success.

At the time of its creation, SEAMO was also seen as a potential future model to free academic physicians from the perceived constraints of the fee-for-service system. The creation of SEAMO was followed a few years later with the establishment of an Alternate Funding Plan (AFP) for the other AHSCs in Ontario. SEAMO remains separate and distinct from the new plan.

Unfortunately, SEAMO was not the subject of a meaningful outside study as to its effectiveness as an alternative to fee-for-service payment. This failure to properly study the differences in impact of both funding approaches on accountability has left a void that permits advocates of each approach to draw their own conclusions. There is a cottage industry of opinion on the merits of SEAMO from an accountability perspective. The issues around SEAMO and accountability have been further complicated by the introduction of shadow billing in the 2005 Agreement which further confuses measuring the original objectives of SEAMO and may further complicate the work incentives that impact performance.

SEAMO has been beneficial to maintaining a strong academic presence at KGH. A comprehensive study of the SEAMO experience as an AFP should be beneficial to further strengthening the performance of SEAMO while informing the province's approach to AHSC funding. Importantly, from the perspective of KGH, it is difficult to determine to what degree SEAMO impacts either positively or negatively on the efficiency and overall performance of the hospital.

Fundamental to provincial AHSC AFP was the establishment of the three parties central to the success of an AHSC, the hospital, the university and the physicians. Called the Signatories Committee, a name borrowed from SEAMO, the Committee is a committee of equals with equal representation from the hospital, the university and the physicians. This Committee negotiates the accountabilities among the parties. As the AFP funding was to recognize teaching, research and clinical responsibilities, this Committee is the forum for sorting out the accountabilities through negotiation among the three parties. SEAMO is governed differently.

The Dean of the medical school is also the CEO of SEAMO. While this was seen as appropriate at the time of the creation of SEAMO, it should be revisited in the context of the three-way accountability which has been established in other AHSCs in Ontario. While there has never been any suggestion of anything untoward, it is awkward for the Dean who in addition to his appointment as Dean of the Faculty, is also charged with the complex and challenging roles as a Board member of KGH, and as CEO of SEAMO. The result of this situation is that the Signatories concept at SEAMO combines the leadership at SEAMO on behalf of the physicians and the leadership representing the University in the same person. Consequently one individual provides leadership for two organizations at the table leaving the hospital automatically at a potential disadvantage in negotiations.

It would seem appropriate that SEAMO, as the physician funding mechanism, ought to adopt the process for Signatories Committee as redefined by the provincial AHSC AFP now in place at other AHSCs. In this scenario the Dean would serve as a member of the Signatories Committee representing and negotiating the academic expectations of the medical school. Given the commitment in SEAMO and the provincial AHSC AFP to academic medicine, this should pose

no risk to the medical school. The CEO of SEAMO, selected by the physicians, would represent the physicians, and the hospital would continue to have its own representative to ensure that the clinical requirements of the hospital were met.

KGH and Queens' University

Concern regarding the governance relationship between KGH and Queen's University was a recurring theme in interviews with at least half of the KGH Directors. The specific issues of concern relate to the dynamics within the Board arising from the ex-officio University position and a perceived disproportionate impact of the Medical School on Board and hospital decisions.

The affiliation agreement between Queen's University and KGH and the KGH By-law provide for an ex-officio position on the KGH Board of Directors for "the Principal of Queen's University (or delegate)." The ex-officio position is occupied by the Dean of Health Sciences, who also has interlocking relationships with KGH as the CEO of SEAMO as noted above.

The Conflict of Interest provisions in Section 4.06 of the KGH by-law contain an unusual clause which is intended to address these interlocking responsibilities as follows:

> *"A Governor of the Hospital may have interests with stakeholders of the Hospital which may appear to be a conflict of interest. The Board recognizes that where the perceived conflicts related to non-profit stakeholders/partners that share common goals with the Hospital that the benefits of having such members on the Board outweigh the potential difficulties relating to the perceived or actual conflict of interest. The benefits include:*
>
> *(a) If the operational reality of the inter-relationship that the Hospital has with key stakeholders/partners that is critical to the hospital achieving its mission and vision, and*
>
> *(b) Increased capacity of the Board because it leads to fuller and more informed deliberation on issues that have cross-organizational implications.*
>
> *For reasons noted above, notwithstanding provisions to the contrary contained in [The Conflict of Interest clause of this by-law] where a member has an actual or perceived conflict of interest relating to a not-for-profit partner or stakeholder, the Board member shall be entitled to be present at and take part in the deliberations with respect to the proposed matter, contract or transaction but shall not be entitled to vote."*

As a result of the numerous positions which the Dean as ex-officio representative of Queen's University holds within the University, KGH, HDH and SEAMO, he acknowledges and regularly declares his various conflicts of interest at the beginning of the Board of Directors or Board Standing Committee meetings. However, he regularly represents the interests of his various "stakeholders" to the KGH Board, resulting in confusion as to whether he is acting in the best interests of external parties or of KGH. This confusion, combined with the responsibility which the Board feels as a result of the interdependency between the hospital and the medical school and the position of Queen's within Kingston, is seen to some to have a disproportionate influence on the deliberations and decisions of the Board of Directors.

The Investigator and his team recognize the complexity and fundamental interdependency of the relationship between KGH and Queen's University. However, we believe that there is considerable confusion in the understanding of accountability, authority and fiduciary

duty of the Queen's ex-officio Director position on the KGH Board. While recognizing that an ex-officio position for the Dean on the Board of Directors is a consistent practice in Ontario's AHSC's, the unique, overlapping relationships between KGH and Queen's would benefit from a review to ensure that the accountabilities are clear and well understood by all members of the Board.

SECTION 7: CONCLUSIONS & RECOMMENDATIONS

There are compelling reasons to believe that KGH has considerable potential to excel as an Academic Health Sciences Centre and provide high quality patient care to the entire SE LHIN region. This can not be accomplished without a strong vision for the future; a vision that does not currently exist. The hospital needs to rebuild its mandate on a fresh new vision as a tertiary, academic centre that can meet the opportunities and leadership challenges needed to achieve regional integration in partnership with other health care providers. The best interests of a hospital and the community it serves have not been advanced by adopting the old tactics of demanding additional funds or running-up deficits with the belief that they will eventually be bailed out. The best interest is to be aware of broader system expectations and to take seriously the new accountability requirements arising from the legislation in order to advance the hospital strategy on a very focused and businesslike basis.

The Board of Directors, while endeavoring to implement and demonstrate best practices in governance, has not kept pace with changing expectations in the new era of accountability expected of publicly funded institutions. In particular, the Board has fallen short of its responsibilities to ensure thorough financial stewardship and to constantly test the substance behind management positions. This weakness – combined with a Senior Management that has not kept pace with the need to respond effectively and creatively to the pressures that surround a large AHSC – has compounded the financial and other pressures facing the hospital.

Senior Management has lost focus on the changes expected of hospital management. The hospital has relied on the macro performance indicators to establish that it is efficient relative to most other comparator hospitals. Looking behind the macro data suggests, however, that there are areas where Senior Management could and should have taken action to bring about meaningful improvement. While it may be argued that additional resources are required in the future, the strategy of spending now, with disregard for the fiscal health of the organization and the consequences therein, demonstrate a lack of management prudence that needs to be addressed.

The belief that deficit budgeting is an appropriate practice to meet patients care needs is well intended but shortsighted. There are many programs that can be better delivered when a hospital has maintained the financial discipline that permits it to exercise discretion in providing additional services in the best interest of a patient. When a hospital has exhausted its financial flexibility, as is now the case with KGH, there is no opportunity to introduce a new or enhanced treatment that might benefit the patient. This kind of flexibility is particularly important in an academic health science centre which must serve as a centre of innovation.

This does not suggest that KGH is without genuine problems or that all of the problems can be resolved without additional funding from the MOHLTC and the LHIN. KGH has had to apply more operational funding to maintenance and repair than is reasonable. The major capital redevelopment project is urgently needed and should be given every priority by the hospital, the MOHLTC and the LHIN to ensure that it moves ahead with dispatch.

KGH may have a good case for additional operating funds. However, the question of how much additional funds are required is far from clear. The failure of KGH to make its case on operational funding and the lack of solid evidence on a number of issues arising from this review

makes it impossible to answer the question of how much more money should be added to the current base budget of the hospital. Until the new KGH management has prepared its recovery plan and submitted its Performance Improvement Plan, the MOHLTC should support the LHIN in providing ongoing bridge funding so that KGH can meet its obligations to patients, suppliers and staff.

The sum of these conclusions and recommendations is that KGH Board needs a period of renewal and KGH Senior Management needs a strong and fresh start if it is to meet the reasonable expectations of the communities it serves, the LHIN, and other partners – including the medical school and the other health care providers in the region.

If there is a sad reality in the conclusions, it is the lost time and opportunity to better serve patients and the running up of a substantial debt which will limit the flexibility of the hospital as these matters are addressed and corrected.

The Investigator and his team make the following recommendations:

Governance

Recommendation 1: The Lieutenant-Governor–in-Council should immediately appoint a Supervisor for KGH under the *Public Hospitals Act*. The Supervisor would:

- Temporarily assume the responsibilities of the KGH Board of Directors. During this period, the current Board of Directors will remain in place and serve in an advisory capacity to the Supervisor. Upon completion of the Supervisor's mandate, the Board of Directors will reassume their full governance authority.
- Lead the process for the selection of a new Chair of the KGH Board of Directors.
- Appoint a temporary CEO for KGH (pending selection of a permanent CEO) to begin the implementation of the changes which are necessary to support more effective and efficient operations.
- Appoint, in consultation with new Board Chair and the Board of Directors, a permanent CEO who brings previous experience as a CEO of an academic health science centre with a track record of strong leadership, team building and system orientation.
- Oversee the governance renewal process of the KGH Board of Directors.

The Supervisor would step down on the completion of the governance renewal process and the appointment of the permanent CEO.

Recommendation 2: As an immediate priority in governance renewal, the Supervisor should establish a Nominations Committee to assist the Supervisor in selecting a new Board Chair. The Nominations Committee should be comprised of:

- the Supervisor (as Chair);
- at least two community leaders (appointed by the Supervisor);
- one member appointed by the KGH Board of Directors;

- the current Chair of the KGH Board of Governors Nominating Committee.

Recommendation 3: Following the appointment of the new Board Chair by the Supervisor, a governance renewal program should be implemented to assist the Board in fulfilling its accountabilities and strengthening its governance structures and processes to ensure improved performance in the future. Priorities for governance renewal are to:

- Revise the title and responsibilities of the Board of Governors (the members of the Corporation) to clearly differentiate its roles and responsibilities from those of the Board of Directors of the hospital;
- Redefine the scope of the Board Chair's position and distribute some of the Chair's current responsibilities among the Board of Directors;
- Revise the Principles of Governance to include a clear statement of Board Accountabilities;
- Align the statement of responsibilities of the Board of Directors with the new expectations under the *Local Health System Integration Act* and define the relationship between the Board of Directors and the Board of Directors of the SE LHIN;
- Establish Board policies that are aligned with the responsibilities of the Board of Directors;
- Support the Board of Directors on appropriate levels of engagement to strengthen their oversight of hospital performance;
- Complete the process initiated by the Board in 2008 to ensure that the size and composition of the Board is aligned with best practice, minimizes the potential for conflict of interest and reflects the regional role of KGH;
- Clarify the governance relationship between the KGH Board of Directors, Queen's University and the medical school;
- Renew the process for nomination of Directors to achieve greater transparency;
- Review the current membership of the Board of Directors and appoint Directors as required to fill vacancies, ensuring that the Board reflects a diversity of regional perspectives and appropriate skills and expertise;
- Review the scope of responsibilities and size of the Board Standing Committees and the processes related to in-camera matters.
- Significantly reduce and focus the documentation provided to the Board of Directors and Board Standing Committees; and
- Reduce the demand on Directors' time commitment to the hospital.

Recommendation 4: Following the completion of the governance renewal process and recruitment of a permanent CEO, the new Board Chair and CEO should lead the Board of Directors in developing a new vision for KGH that provides focus and opportunity for the future.

Management

Analysis & Reporting

Recommendation 5: The CEO initiate a review of all performance indicators and make greater use of internal performance analysis to ensure that the hospital can maintain the highest performance standards in serving the public. This work should include:

- An immediate external review of length of stay with particular attention to the large number of outliers.
- An external review of ALC patients in cooperation with Providence Care and the CCAC to assess admission and discharge practices and the large number of outliers. This review should involve the LHIN and be coordinated with the provincial initiative on ALC management.
- An external review of the bed and operating room management systems and implement adjustments based on best practice experience at other peer hospitals.
- Involvement of program leadership in a comprehensive review of hospital policies to ensure greater clarity and their effective engagement in the functioning of the hospital.

Recommendation 6: The CEO initiate a review of all reporting practices to ensure that an accurate portrayal of KGH performance is provided to provincial and federal agencies charged with performance reporting. This work should include implementation of a full case costing system.

Leadership & Human Resources

Recommendation 7: The CEO build an effective, accountable leadership team that:

- demonstrates fiscal accountability in serving the community,
- establishes targets and monitors hospital productivity and performance, and
- effectively engages program leaders in the functioning of the hospital and encourages teamwork and creativity at the program management level.

Recommendation 8: The CEO engage in a comprehensive review of the staff morale problem particularly with regard to the retention of nurses and develop an immediate action plan for responding to these issues.

Funding

Recommendation 9: The CEO develops a recovery plan to achieve a balanced budget for approval by the Board as the basis for the development of the Performance Improvement Plan for submission to the SE LHIN.

Recommendation 10: Pending the submission of the Performance Improvement Plan including the hospital's need for additional resources, the SE LHIN (supported by the MOHLTC) should continue to provide bridge funding to KGH to allow it to meet its obligations to suppliers and staff.

Recommendation 11: On the completion of the Performance Improvement Plan, and its approval by the SE LHIN, the MOHLTC should flow additional funds to the LHIN to address any shortfall in KGH base funding.

Recommendation 12: The MOHLTC should provide the SE LHIN with an additional $5M to add to KGH's base funding immediately to address the impact on the operating budget related to ongoing maintenance costs and to cover the costs associated with carrying out the reviews and their implementation.

Recommendation 13: The MOHLTC should provide KGH with $15M in one-time funding to assist the hospital in addressing own funds urgent facilities repairs.

Recommendation 14: The MOHLTC should place high priority on the KGH capital renewal project to minimize the amount of future stop-gap expenditures required to maintain aging and deteriorating buildings.

External Relationships

Recommendation 15: KGH and HDH should continue to work to integrate their management and operations to provide a progressive model of integration that seamlessly serves patients in Southeastern Ontario.

Recommendation 16: The MOHLTC provide resources to support an independent study of SEAMO to determine the most effective performance accountability structure.

Recommendation 17: SEAMO should adopt the same signatories' process in place in the other AHSC AFPs.

APPENDIX