

Hospital Board Governance

Background

Almost all public hospitals in Ontario are incorporated under the *Corporations Act* and governed by a board of directors. In the 2007/08 fiscal year, there were over 150 hospital corporations in the province. The *Corporations Act* sets out requirements for the hospitals' boards of directors, such as the minimum number of directors and minimum frequency of meetings.

The *Public Hospitals Act* and its regulations provide the framework within which hospitals operate. The *Public Hospitals Act* also sets out requirements regarding the composition and responsibilities of boards, including responsibilities for the quality of patient care. Under the *Ministry of Health and Long-Term Care Act*, the duties and functions of the Minister of Health and Long-Term Care (Minister) include governing the care, treatment, services, and facilities provided by hospitals. The Minister is also responsible for administering and enforcing the *Public Hospitals Act* and its regulations.

Boards can play a vital role by providing the leadership necessary to ensure that hospitals offer the best patient care possible while functioning efficiently, effectively, and economically. Ineffective boards can detrimentally affect patient care and contribute to inefficiencies. Research in the

United States on governance has found a direct link between hospital board practices that focus on quality and higher performance by the hospital, both clinically and financially.

In 2007/08, the total operating costs of hospitals were about \$20 billion, of which the Ministry of Health and Long-Term Care (Ministry) funded about 85%. The additional 15% came from such sources as charges for semi-private and private accommodations, payments from the Workplace Safety and Insurance Board, parking fees, and donations. Each hospital board determines how its funds are spent to best meet the needs of patients in its area.

Until last year, hospitals were accountable to the Ministry, which funded them. That changed on April 1, 2007, when, under the *Local Health System Integration Act*, new Local Health Integration Networks (LHINs) assumed responsibility for prioritizing, planning, and funding certain health-care services, including hospitals. The stated purpose of the *Local Health System Integration Act* is to “provide for an integrated health-care system to improve the health of Ontarians through better access to high-quality health services, co-ordinated health care in local health systems and across the province, and effective and efficient management of the health system at the local level by LHINs.” Rather than reporting to the Ministry, hospitals

now report on most matters to one of 14 LHINs across the province. The LHINs are accountable to the Ministry.

Ontario is one of the few provinces in Canada in which hospitals still have their own individual boards of directors. Most other provinces eliminated them when they introduced decentralized models, such as regional health boards, for the delivery of health-care services.

Objective and Scope

Our objective was to review the board-governance practices and oversight processes of Ontario hospitals, and compare them to current best practices in governance.

With the assistance of an independent survey firm, we sent surveys to all board members of 20 Ontario hospitals to obtain their feedback on board-governance and oversight practices at their hospitals and issues facing their boards. About half of them responded, with at least several members responding from each of the 20 hospital boards. The 20 hospitals all provided acute-care patient services; varied in size; and represented all 14 LHINs. The surveyed hospitals are shown in Figure 1.

We interviewed staff from the Ministry and experts in Ontario hospital governance, including individuals appointed as supervisors under the *Public Hospitals Act*. We reviewed relevant documents, including peer review reports on hospitals that had or were budgeting deficits, and literature on governance, including publications from the Ontario Hospital Association, Ontario Securities Commission, Canadian Institute of Chartered Accountants, Conference Board of Canada, Institute of Public Administration of Canada, and Canadian Comprehensive Auditing Foundation. We also reviewed information from other jurisdictions on best practices in governance.

We reviewed the results of a 2007 survey on governance the Ontario Hospital Association (OHA)

conducted. It asked for one response from each hospital in the province and reported an 80% response rate. In addition, we inquired about the OHA's initiatives to strengthen hospital governance in Ontario. We also reviewed the results of a 2007 governance survey of all Greater Toronto Area (GTA) hospitals, conducted as a result of the appointment of a hospital supervisor at one GTA hospital.

We developed criteria to guide our survey and interviews, based on recognized good-governance practices that should be in place. We discussed these criteria with senior management at the Ministry, who agreed to them.

We did not rely on the Ministry's internal audit service team to reduce the extent of our work because it had not recently conducted any audit work on hospital board governance.

Summary

Many of the hospitals we surveyed have adopted a variety of good-governance practices. These practices include an orientation program for new board members and a written code of conduct and confidentiality guidelines. However, many board members who responded to our survey indicated that hospital governance could be improved by clarifying the roles of hospital boards, the Local Health Integration Networks (LHINs), and the Ministry of Health and Long-Term Care (Ministry). As well, many board members identified areas where they felt hospital governance practices could be strengthened. Some of these areas, as well as observations arising from our research and other work, are summarized as follows:

- Almost 70% of board members responding to our survey indicated that information-technology skills were underrepresented on their board, and almost 50% identified legal skills as being underrepresented.
- Ex-officio board members—persons appointed by virtue of their position within the hospital

Figure 1: Hospitals Surveyed

Prepared by the Office of the Auditor General of Ontario



or another organization, such as medical and community groups, volunteers, hospital foundations, and municipalities—may be placed in the challenging position of representing specific interests which might, at times, be in conflict with the hospital's and community's best interests. A survey of hospital boards in the Greater Toronto Area noted that the average board had six ex-officio members, with one board having 12 such members out of a total of 25.

- More than 55% of hospitals have bylaws permitting individuals to pay a small fee or meet other criteria to become community “shareholder” members, which entitles them to elect the board members of the hospital. There is a risk that a hospital's priorities can be significantly influenced if enough board members are elected who have a specific agenda or represent a specific interest group.
- Almost all board chairs responding to our survey indicated that their board had an orientation program in place for new directors to help ensure that they initially understood their roles and responsibilities, and about 75% indicated that there was also a continuing education program in place.
- Only slightly more than half of responding board members indicated that the information they received on their hospital's progress toward the achievement of its risk-management objectives and goals was “very useful,” with most other members stating that it was just “moderately” or “somewhat useful.”
- Over 90% of the chairs responding to our survey indicated that, in accordance with best practices in governance, the most recent evaluation of their CEO compared actual performance to expectations. Furthermore, almost all the responding board members

indicated that evaluating hospital management's performance was an important part of their role. However, only 63% of members “strongly agreed” that they were involved in evaluating their CEO's performance.

- Various Ministry-funded reports have recommended that certain good-governance practices, such as facilitating competency-based recruitment and setting term limits for directors, be addressed in legislation. This may warrant review when future amendments to the *Public Hospitals Act* are being considered.
- Hospital boards, peer reviews, and ministry inspections, investigations, and supervisor appointments have identified and/or recommended many best practices for hospital governance. However, no formal process has been established to share these practices among hospital boards.

We wish to thank the board members who completed our survey for their input, as well as the experts in hospital governance who met with us.

OVERALL MINISTRY RESPONSE

The Ministry supports the Auditor General's review of governance practices and agrees with the Auditor General on the importance of good hospital governance. However, as noted in the Auditor General's report, hospitals are autonomous corporations under the *Public Hospitals Act* and responsible for the quality of care provided by their institutions, as well as their governance structures. Nevertheless, noting the importance of good hospital-governance practices and the role of the Ministry in appointing inspectors and supervisors when governance issues arise, the Ministry will work with its partners to foster good-governance practices.

Detailed Observations

BEST PRACTICES IN HOSPITAL GOVERNANCE

The *Public Hospitals Act* (Act) and one of its regulations outline some specific powers of hospital boards, including the power to:

- appoint physicians—and revoke or suspend those appointments;
- monitor activities within the hospital for compliance with the Act; and
- ensure that appropriate admitting procedures are in place for patients.

The Ontario Hospital Association (OHA) provides further guidance to hospital boards through educational sessions and reference materials on their duties, including:

- ensuring quality of care for patients;
- participating in the development of a hospital strategic plan;
- selecting and overseeing senior management;
- reporting to members and stakeholders, including the Ministry; and
- approving financial statements.

In the last five years, there has been increased interest in ensuring that hospital boards follow good-governance practices. During this period, the Ministry funded several reports, including one commissioned by the OHA in 2004—*Hospital Governance and Accountability in Ontario*—that assessed hospital governance across the province and identified best practices. In addition, the OHA has implemented training and certification programs to promote the consistent practice of good governance. Accreditation Canada, an organization that conducts external reviews of hospitals in Canada based on its performance standards, also released governance standards that it planned to use starting in 2008 to evaluate hospitals seeking accreditation. Over the last decade, many other organizations have also researched and reported on

the effectiveness of governing boards, with some specifically focused on hospital governance.

Based on our research from a variety of sources, we have summarized several key best practices for the effective operation of a hospital board and categorized them within six areas, as outlined in Figure 2.

Board Composition

Best practices in governance indicate that effective hospital boards are composed of individuals who:

- have the appropriate levels of ability, commitment, and independence to fulfill their responsibilities;
- collectively, have the diversity and depth of knowledge and competencies to carry out the board's oversight responsibilities; and
- are selected through a systematic, fair, and transparent nomination process.

All of the hospitals that we surveyed indicated that they had a board-recruitment or nominating committee to make recommendations for the appointment of new directors.

Hospitals are complex organizations. For this reason, there is a wide array of competencies that a board should collectively possess in order to effectively carry out its mandate. These competencies include:

- clinical/medical;
- business management;
- finance/accounting;
- legal;
- construction and project management;
- risk management;
- human resources; and
- information technology.

Tools that a recruitment or nominating committee uses to identify and assess potential candidates include skills matrices and candidate interviews. A skills matrix is a table that compares the current competencies the board collectively possesses to the key competencies required over the next three to five years, based on the hospital's strategic plan.

Figure 2: Selected Best Practices for Hospital Board Governance

Prepared by the Office of the Auditor General of Ontario

board composition	<ul style="list-style-type: none"> • Board is composed of people who, individually, have the ability and commitment to fulfill their responsibilities and who, collectively, have the breadth of knowledge and competencies to carry out the board's responsibilities • Board members are selected through a nominating process that is systematic, fair, and transparent • Board appointments are made to minimize all conflicts of interest
roles and responsibilities	<ul style="list-style-type: none"> • Board roles and responsibilities are clearly outlined in a written charter or bylaws • An orientation program is in place for new members covering such topics as their roles and responsibilities in achieving board objectives, as well as conflict-of-interest policies • An ongoing training program is in place covering topics such as emerging governance issues and practices, as well as more detailed information on specific hospital programs
involvement in strategic decisions and risk management	<ul style="list-style-type: none"> • Board members act to ensure that the organization's objectives are met through strategic decisions, including: <ul style="list-style-type: none"> • overseeing the development of a multi-year strategic plan • monitoring progress on the implementation of the strategic plan • approving capital and operating budgets consistent with the strategic plan • understanding risks inherent in hospital operations and overseeing the development of a risk-management plan
access to relevant information for decision-making	<ul style="list-style-type: none"> • Board members are provided with relevant and understandable information to enable them to effectively oversee hospital operations • Information is disseminated in advance of board meetings to allow members sufficient time to review it prior to meetings
committees	<ul style="list-style-type: none"> • Board establishes committees to support it in fulfilling its responsibilities relating to such key areas as quality, finance and audit, and human resources
performance evaluation	<ul style="list-style-type: none"> • Processes are in place for the annual evaluation of the performance of individual directors, and of the board as a whole, against the performance expectations outlined in the board's charter or bylaws • Board annually assesses the CEO's performance against job description and related performance expectations approved by the board

Gaps noted in key areas become recruitment priorities. A 2007 OHA survey on hospital governance found that over 85% of responding hospitals used a skills matrix and over 80% interviewed selected candidates when recruiting board members.

As well, respondents to our survey generally felt that their boards were well represented in most of the competency areas listed above. However, almost 70% of respondents indicated that information-technology skills were underrepresented on their board, while 50% identified legal skills as being underrepresented.

The number of members on a hospital board must be balanced between the need for the required competencies and the need for the board to be a manageable size for productive discussion and decision-making. Experts in the area of hospital governance differ in opinion regarding the optimal number of board members. However, optimal size is generally said to range between 13 and 20 members. The Ministry does not track the number of members per hospital board. However, the hospitals in our survey averaged about 18 members per board—from a low of nine members to a

high of 24. As would be expected, larger hospitals in the Greater Toronto Area (GTA) appear to have larger boards: a 2007 survey of GTA hospitals noted that these boards averaged about 22 members, with a range from 16 to 30. By comparison, hospitals in smaller communities may have smaller boards owing in part to the fact that there are fewer people in the local community who are available to serve on the board. While larger boards can more readily have members covering all the core competency areas, smaller boards can often function more effectively.

Ex-officio Board Members

The OHA's *Hospital Governance and Accountability in Ontario* noted that board members have the "duty to act loyally and avoid conflicts between the director's personal interests and the interests of the corporation." We noted that some directors, referred to as "ex-officio" members, are appointed by virtue of their position within the hospital and other organizations, such as a hospital foundation, volunteer group, municipality, or religious organization. Such appointments may be the result of provincial legislative requirements or hospital bylaws. For the most part, these members have the same voting rights as other directors.

The *Public Hospitals Act* (Act) requires that the following people be appointed as ex-officio members of hospital boards:

- chief of staff or chair of the medical advisory committee;
- president of the medical staff; and
- in certain hospitals, vice-president of medical staff.

However, a 1992 review of the Act recommended changes so that "no person appointed to or employed by a hospital can serve as a member of that hospital's board of directors." The concern was that ex-officio members who are medical staff, for example, could find it difficult to balance the goal of advancing the medical services delivered by the hospital with the need for fiscal responsibility.

Hospital boards need access to medical advice and other clinical information, yet that advice could come from a separate medical advisory committee available to the board, or through the appointment of qualified individuals from outside organizations.

In addition to legislated ex-officio positions, hospital bylaws often require certain ex-officio appointments—municipal councillors, for example, or representatives of religious or educational institutions, foundations, or volunteer organizations. These bylaws are generally established and approved by individual hospital boards on the basis of guidance—from the Ontario Hospital Association and the Ontario Medical Association—that was most recently revised in 2003. However, the more recent OHA report *Hospital Governance and Accountability in Ontario* noted that the "representative" appointment of board members based on specific interests is "inconsistent with recognized best practices" because it can create a real or perceived conflict of interest. For example, municipal councillors may have difficulty balancing their responsibilities to a hospital board with their duty to represent the people who elected them when faced with decisions such as locating certain clinical services outside of their constituency. Ten percent of the respondents to our survey indicated that one of their top three roles as a board member was to represent specific interests, including medical and community groups, municipalities, volunteers, and the hospital's foundation. Interestingly, some board members responding to our survey noted their board had recently conducted a governance review that resulted in the reduction of the number of ex-officio members to only those required under the Act.

At the time of our work, the Ministry did not have any information on the number of or different types of ex-officio directors currently serving on hospital boards. However, results of a 2007 OHA survey indicated that about half of all boards have representatives from both their hospital's foundation and volunteer association. Almost 40% had municipal representatives. Furthermore, a survey

of hospital boards in the GTA noted that they had an average of six ex-officio members out of an average 22 member board—with one board having 12 ex-officio directors out of a total of 25.

Community “Shareholder” Members

A number of reports commissioned by the Ministry have emphasized the need for hospital boards to obtain community input. Some hospital boards do this by allowing for community “shareholder” members (also known as community corporate members), usually individuals from the general public. These individuals generally pay a modest annual fee to the hospital or its foundation, or must meet criteria such as living near the hospital and showing support for the hospital’s objectives. As community “shareholder” members, they function much as do the shareholders of a commercial corporation—that is, under the *Corporations Act*, they can elect all the members of a hospital’s board of directors except those ex-officio directors appointed through provincial legislation or hospital bylaws.

In certain circumstances, however, community “shareholder” members may impede the board’s decision-making ability. For example, reports commissioned by the Ministry indicated that the ability of hospital boards to make difficult decisions may be hindered if directors elected by community “shareholder” members:

- have a specific agenda;
- lack the necessary knowledge, skills, and experience; or
- become involved in disputes with the community “shareholder” members, which may impact the director’s continuing membership on the board.

The OHA’s report, *Hospital Governance and Accountability in Ontario*, noted the importance of aligning community “shareholder” membership with the effective functioning of the hospital board to “preclude the potential for inappropriate members or, worse, a hijacking” of the board’s agenda. This underscores the risk that a hospital

can be “taken over” by a particular group with an agenda to the detriment of other stakeholders. A 2007 hospital peer review commissioned by the Ministry indicated that, at one hospital, it was “evident that board members are subjected to influence by selected members of the community including those that are politically active. The board must ensure that processes are in place to balance localized advocacy groups and are not aligned with only one of the many community-based coalitions.”

Literature on best practices suggests that a community advisory committee can provide hospital boards with community input without the need for community “shareholder” members. Nevertheless, the results of a 2007 OHA survey indicated that more than 55% of hospital boards have bylaws permitting community “shareholder” members, who have the right to elect members of the board.

The Ministry indicated that it has no information about any systemic issues that might have arisen as a result of the existence of community “shareholder” members. Similarly, the Ministry has no information on the effectiveness of community “shareholder” membership in conveying community views to boards.

The *Local Health System Integration Act* also requires the LHINs, as well as hospitals, to obtain community input. It states that one of the objectives of the LHINs is to “plan, fund and integrate the local health system to achieve the purpose of the Act, including [engaging] the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation.” While hospitals will continue to require community input in the future, particularly in the area of service delivery, there may be an opportunity for them to obtain some of this input through their LHINs.

Board Roles and Responsibilities

Best practices in governance indicate that directors have a responsibility to understand their duties and

obligations as board members, including board-governance processes and hospital operations. The roles and responsibilities of directors should be clearly communicated to and understood by all directors. As well, these roles and responsibilities should be outlined to all new members of a board in an initial orientation program and through continuing education throughout their term.

The roles and responsibilities of directors are normally documented in each hospital's bylaws. These bylaws are unique to each hospital and generally outline the responsibility of the board as a whole, the duties and responsibilities of individual directors, the code of conduct, and the conflict-of-interest and confidentiality guidelines. All of the board chairs responding to our survey stated that their boards had written conflict-of-interest and confidentiality guidelines; 88% indicated that their boards had written codes of conduct. As well, 94% of the responding board chairs stated that their board had an orientation program in place for new directors. However, 25% indicated that there was no continuing education program.

Functioning of the Board

Among a board's most important responsibilities is to oversee the development of, approve, and monitor the hospital's strategic plan and risk-management plan. To fulfill these and other responsibilities well, boards require information covering a significant number of different topics. Therefore, to facilitate in-depth discussions and analysis of this information and other duties, such as meeting with the hospital's auditors, most boards establish committees to focus on specific areas, such as quality, human resources, and finance.

Involvement in Strategic Decisions and Risk Management

Hospitals should have a multi-year strategic plan. The strategic plan should include the hospital's vision, mission, and values; strategic direction and

related goals and objectives; implementation timetable; and performance indicators that measure the hospital's progress in meeting its strategic plan. The board should oversee the development of and approve the strategic plan. In addition, the strategic plan should be reviewed annually and formally updated every three to five years or when there is a significant change in the hospital's operating environment.

All of the board chairs responding to our survey indicated that their strategic plan had been updated and approved within the past five years, with 75% indicating that it had been updated and approved within the past two years. Furthermore, 44% of the responding board members ranked approving and monitoring the hospital's strategic plan as one of their top three roles as a director: only "acting in the best interests of the hospital" and "ensuring quality patient care" ranked higher in importance. As well, almost all of the board members noted that they received information on the status of their hospital's progress in achieving its strategic plan once a year or more frequently.

Building on the approved strategic plan, the board should also oversee the hospital's development of a risk-management plan. The risk-management plan should identify and assess the significant risks that the hospital faces, and outline management's strategies for minimizing the identified risks. Best practices in governance indicate that the board should approve the risk-management plan and regularly monitor the hospital's risk-management activities. Almost all of the members responding to our survey stated that monitoring risk-management activities was either a "moderately" or "very important" part of their role. (Figure 3 illustrates a number of the challenges or risks currently facing hospital boards, as noted by board members in their responses to our survey.) However, over 30% noted that they received information once a year or even less often on their hospital's progress toward the achievement of its risk-management objectives and goals. Furthermore, only 58% indicated that the information

Figure 3: Selected Challenges Facing Hospital Boards

Source of data: Board Member Responses to Survey by the Office of the Auditor General of Ontario

financial constraints	Funding issues consume a significant amount of time of many hospital boards because they impact staffing levels and the patient-care services the hospital can offer
shortage of medical professionals	Inability to recruit medical and other professional staff also affects patient-care services
improved relations with the LHINs	There is a need for an improved relationship between some hospitals and their LHINs. For example, hospital boards would like better communication with their LHINs regarding funding and patient services
shortage of beds	Shortages of in-patient beds occur primarily because patients no longer requiring hospital care remain in hospital beds until appropriate alternative accommodation, such as in long-term-care homes, becomes available
infrastructure challenges	Some board members highlighted the need for expanded or renovated facilities to meet patient needs
changing patient population	The needs of a growing and/or aging patient population require significant ongoing board monitoring and adjustment of hospital-service levels
public perceptions	Hospitals experience difficulties in gaining community acceptance for proposed major changes to hospital activities

they received was “very useful”—most other board members stated that it was only “moderately” or “somewhat” useful. Responding to a survey question asking members to cite examples of best practices to share with other boards, one member highlighted the importance of focusing risk management on quality and safety matters as a key part of the board’s focus on quality of care.

Access to Relevant Information for Decision-making

Hospital senior management provide board members with much of the information they use for decision-making. This information should be concise and understandable because too much information or data is as serious a problem as too little. As well, the information must be relevant to the decisions required and the alternatives the board members need to consider.

In addition to information on the hospital’s progress in achieving its strategic plan, our survey indicated that board members generally received information in a number of areas on a regular basis, including:

- patient and staff safety;

- patient wait times;
- number of emergency department visits;
- number of beds occupied by individuals awaiting an alternative level of care, such as in a nursing home; and
- financial information, such as the hospital’s budget versus actual expenditures.

Overall, the majority of board members responding to our survey found that the information provided to them for their meetings was useful. As well, a number of board members commented that their boards had established a standard package format for information, including key indicators of the hospital’s performance that are tied to the hospital’s strategic plan. This enabled board members to more easily review the information. However, a few members noted that some of the information they received, such as financial reports, was too lengthy to review effectively. Furthermore, despite the fact that the majority of board members found the information they received “useful,” only 60% of respondents to our survey “strongly agreed” that they did not “rubber-stamp” decisions reached by hospital management and senior medical staff. An additional 35% “somewhat agreed” that they did not rubber-stamp decisions.

When asked to suggest improvements, board members responding to our survey noted a few common areas. While many board members stated that they could track their hospital's performance over time, they would also like to be able to compare its performance to that of other comparable hospitals—of a similar size and providing similar services—within their LHIN and province-wide. As well, a number of board members indicated that they would like additional information regarding quality of patient care and patient and staff safety.

To enable members to become familiar with the information and actively participate in related board discussions, board members should receive necessary information in time to review it before their meetings. Overall, 72% of responding members “strongly agreed” that they received information in enough time to prepare for board meetings; an additional 22% “somewhat agreed.” A few members commented that their boards had required management to send information for the board meetings to members a specific period of time in advance of meetings so that members had sufficient time to review it.

Committees

Hospital boards generally establish a number of committees to focus on specific areas. These committees meet separately and report back to the board with summaries of issues and related recommendations. Typical hospital board committees include:

- executive;
- finance and audit;
- quality;
- human resource;
- information technology;
- community liaison;
- board recruitment/nominating; and
- governance.

In addition, the *Public Hospitals Act* requires all hospitals to have a Medical Advisory Committee,

comprised of hospital physicians, which reports to the board.

In general, board members responding to our survey indicated that most of their committees were either “good” or “excellent” at fulfilling their duties and keeping their board informed of their activities. However, 32% of board members indicated that their information technology committee was either “fair” or “poor” at fulfilling its duties, and 24% said it was “fair” or “poor” at keeping the board informed of its activities. In addition, 16% said their community liaison committee was “fair” or “poor” at fulfilling its duties, with 14% also saying it was “fair” or “poor” in keeping the board up to date. Some respondents mentioned as best practices that their entire board meets as a committee on certain important issues; that committee members have specific experience related to the committee's area of responsibility; and that the board regularly reviews the committee structure to ensure that important issues are assessed in depth and to avoid duplication among committees.

Performance Evaluation

A board's overall performance, as well as the performance of each board member, should be evaluated annually. These evaluations are generally conducted by board members completing questionnaires about the board's processes and performance, and their own involvement with and contribution to the work of the board. The main purpose of these evaluations is to identify ways to improve the board's efficiency and effectiveness.

The 2007 OHA survey noted that about 85% of hospital boards evaluate their own performance. However, the 2007 governance survey of GTA hospitals, conducted as a result of the appointment of a supervisor at one GTA hospital, found that just under half of the GTA hospitals had such a process. Only 58% of members responding to our survey “strongly agreed” that their board had a reasonable process for evaluating its performance. Furthermore, 25% of the responding chairs noted that their

board does not evaluate the performance of each board member. In fact, the GTA hospital survey noted that 82% of boards did not have an evaluation process for individual board members.

Best practices in governance also recommend that a board annually assess its CEO's performance against established expectations. Over 90% of the chairs responding to our survey indicated that their CEO's most recent evaluation compared actual performance with expectations. Furthermore, almost all the board members responding to our survey indicated that evaluating hospital management's performance was an important part of their role. However, only 63% of members "strongly agreed" that they were involved in evaluating their CEO's performance.

Other Governance Practices Noted

In our survey, we asked board members to indicate any key practices used by their board that they felt would be useful to share with other boards to assist them in better carrying out their responsibilities. Figure 4 contains a number of the practices put forward that we felt were worth highlighting.

RECOMMENDATION 1

The Ministry of Health and Long-Term Care should work with its stakeholders, including the Local Health Integration Networks (LHINs), to help ensure that hospital boards are following good-governance practices, such as:

- recruiting board members with the required competencies and avoiding any conflicts of interest by, for instance, minimizing the number of non-legislated ex-officio board members;
- establishing effective processes for obtaining, when needed, community input that represents the views of the people the hospital serves; and
- requiring that management provide concise, understandable, and relevant information

for decision-making, including periodic information on what progress the hospital is making in achieving its strategic and risk-management plans.

As well, the Ministry should work with its stakeholders to develop a process for sharing best practices in governance among hospital boards province-wide.

MINISTRY RESPONSE

The Ministry supports this recommendation and will work with appropriate stakeholders, such as the Ontario Hospital Association (OHA) and others, to implement good-governance practices. Currently, the OHA has an established role and expertise in hospital good governance. The OHA provides information on this area to hospitals and regularly conducts workshops and publishes reports. The Ministry will continue to work with the OHA to disseminate governance best practices to Ontario's hospitals.

OVERSIGHT OF HOSPITAL BOARDS

Public Hospitals Act

The *Public Hospitals Act* (Act) was enacted in 1931. In 1992, a steering committee reviewed it at the request of the Minister of Health (as the Ministry was then known). The review recommended that the Act be rewritten rather than revised because of the significant changes in health care and the increased complexity of hospital management and operations that had occurred over 60 years. The committee specifically recommended that new legislation clearly define the responsibilities and accountabilities of hospital boards and the Ministry. The government subsequently made a few amendments to the Act, which, with related regulations, addressed such issues as liability protection and consistency of terminology between the Act and other legislation. However, the government has

Figure 4: Suggested Best Governance Practices from Hospital Board Survey

Source of data: Board Member Responses to Survey by the Office of the Auditor General of Ontario

board composition	<ul style="list-style-type: none"> • Advertise board vacancies and interview potential board members based on skill sets required by the board • Use the board-member selection process to screen out individuals from single- or special-interest groups who wish to be board members
roles and responsibilities	<ul style="list-style-type: none"> • Hold 30-minute board education sessions before scheduled board meetings to keep members up to date on various subjects, including hospital activities • Have board members visit various hospital program areas to ensure that they understand their hospital's various operational areas
involvement in strategic decisions and risk management	<ul style="list-style-type: none"> • Use a clear, concise performance "scorecard" that visually compares the hospital's performance to its strategic plan • Use a reporting system with pre-established indicators to regularly measure key aspects of the hospital's activities • Use trend information to identify areas of potential problems related to hospital activities • Encourage open and candid discussions, where all board members have an opportunity to speak • Hold in-camera board meetings without hospital management present • Use a precise work plan to ensure that the board focuses on key issues • Place key issues requiring decisions near the top of the meeting agenda to ensure that they are discussed
access to relevant information for decision-making	<ul style="list-style-type: none"> • Receive key reports a week in advance of board meetings so that members have time to prepare
committees	<ul style="list-style-type: none"> • Designate one day a month for major committees to meet, thereby ensuring that specific issues are addressed on a timely basis
performance evaluation	<ul style="list-style-type: none"> • Perform an annual board self-evaluation survey, give results to the board members, and act on the suggestions
oversight	<ul style="list-style-type: none"> • Have the LHIN regularly address the board, including an update on its plans and a discussion of any issues • Have the Ministry address the board annually, including an update on its plans • Increase the development and use of regional information-technology and procurement services to increase information sharing and reduce duplication and costs • Create a set of performance measures that all stakeholders agree with
other	<ul style="list-style-type: none"> • Co-operate with other health-care boards and share useful practices

not made most of the steering committee's recommended changes. Independent reports on hospital governance funded by the Ministry over the last five years have again recommended amendments to the Act in a number of areas, including many of the ones noted in the 1992 review. These include, for example, setting term limits for directors and

facilitating competency-based recruitment. The Local Health System Integration Act has resulted in further changes to responsibilities for the management of health-care delivery in Ontario. However, both it and the *Public Hospitals Act* contain only a few sections addressing good-governance practices.

Local Health Integration Networks (LHINs)

As previously mentioned, as of April 1, 2007, the LHINs assumed responsibility for prioritizing, planning, and funding certain health-care services, as well as integrating the services of hospitals, long-term-care homes, mental health and addiction agencies, and other health-service providers. Hospitals retained their own boards and now report to the LHINs regarding most of their activities. The LHINs report to the Ministry.

Ontario is one of the few provinces in Canada in which hospitals still have their own individual boards—most other provinces eliminated them when they introduced decentralized organizations, such as regional health boards, for the delivery of health-care services. In May 2008, Alberta announced that it was eliminating its nine regional health authority boards, and replacing them with a single health-services board. There are different benefits to each of these approaches. For example, one benefit of having a board of directors at the hospital level is more direct oversight of the hospital's activities. One benefit of a regional board, without individual hospital boards, is the ability to more fully co-ordinate within the region the delivery of all health-care services, including those of hospitals. One single centralized board may be better suited to promote consistency of care and best practices across the province.

In the 2007/08 fiscal year, the LHINs became responsible for the accountability agreements that the Ministry had in place with the hospitals. Furthermore, as of 2008/09, the LHINs became responsible for negotiating the accountability agreements directly with the hospitals. These agreements generally outline both the hospital's and the LHIN's obligations. More specifically, the agreements include hospital service-level requirements—that is, specified targets to be met in key areas, such as patient access, quality of care, and safety. The agreements also include the hospital's funding and information to be reported to the LHIN quarterly and annually. As of August

2008, approximately 80% of hospitals had signed agreements with their LHINs for the 2008/09 and 2009/10 fiscal years.

With respect to ensuring that the required quarterly information is reported to their LHINs, 55% of board members responding to our survey indicated that they spent “limited” time or “no time at all” ensuring this was done. Furthermore, when asked about specific indicators required to be reported under the 2007/08 agreement, 22% said that they reviewed patient wait times only once a year or less often; 40% said they reviewed patient readmission rates versus expected readmission rates only once a year or less often; and 35% said they reviewed the number of full-time nurses once a year or less often.

Although hospitals now report directly to their LHINs on most matters, many board members responding to our survey stated that clarifying the relationship between their hospital, their LHIN, and the Ministry was one of their main challenges. We heard similar comments from LHIN officials and other hospital-governance experts. As one board member said of his or her LHIN, “It is a foggy relationship at best.” Board members also indicated that there was a need to improve communications with the LHINs, including receiving more timely responses to requests and information to allow them to understand what hospital activities the LHINs monitor. In addition, board members would like more information about their LHIN's strategic plan so that they can align their hospital's strategic direction with it, where appropriate.

External Reviews

When a hospital is facing operational and financial difficulties, the board works with its LHIN to formulate a recovery plan. Depending on the extent of the difficulties, hospitals may also be subject to a peer review, or the appointment of an inspector, investigator, or supervisor. While LHINs can initiate a peer review, they can only recommend that an inspector, investigator, or supervisor be appointed:

the authority to appoint these individuals remains with the Minister under the *Public Hospitals Act*.

Peer Reviews

In 2004, the Ministry established a requirement that all hospitals budgeting a deficit submit a plan for eliminating the deficit by the 2005/06 fiscal year. In conjunction with this, the Ministry introduced a hospital peer review process whereby executives and physicians from hospitals with balanced budgets may be asked to review the operations of hospitals projecting deficits. The purpose of these reviews was to make recommendations that would assist the hospitals in eliminating their deficits. The Ministry co-ordinated these reviews until they became the responsibility of the LHNs in April 2007. The specific operational areas reviewed are determined by the peer reviewer, the hospital, and the Ministry (prior to April 2007) or the LHIN. These areas could include a review of the hospital's organizational structure and administrative processes, including its budget and fiscal accountability processes and hospital board governance, as well as areas for possible savings and other sources of revenue.

An April 2006 ministry evaluation of the hospital peer review process noted that some peer reviews were not conducted as soon as they should have been, allowing financial problems to worsen before intervention occurred. The evaluation also noted that governance and related decision-making processes should be considered in all peer reviews because "when a hospital is off the rails, it all rolls up to the board."

Although a budget deficit may trigger a peer review, not all hospitals in a deficit position have been subject to a peer review. For example, according to their audited financial statements, 90 hospitals reported a deficit in the 2007/08 fiscal year; 50 of these hospitals also experienced a deficit in 2006/07. However, from 2004/05 through 2007/08, only 17 peer reviews were conducted in total. The Ministry informed us that hospitals

experiencing relatively small deficits were not subject to a peer review and that, in the case of a few hospitals, the Ministry initiated its own investigation or appointed a supervisor.

We reviewed a sample of peer reviews and noted various issues that occurred at more than one hospital. These included capital projects commencing without proper planning and hospitals not adequately analyzing the impact of new clinical programs on their operations. The peer reviews also noted specific governance issues, such as board members not having the needed competencies. One recent peer review recommended that the hospital board adopt a code of conduct and establish a system for senior management to provide strategic information to the board.

While some of the peer review reports are publicly available to hospitals wishing to review them, the Ministry has no process in place to share with other hospitals the issues and associated recommendations arising from the peer reviews to assist them in proactively identifying such potential issues at an early stage.

Inspectors, Investigators, and Supervisors

Under the *Public Hospitals Act*, the Minister may appoint a hospital inspector, investigator or supervisor.

An inspector has the authority to enter a hospital to determine whether the provisions of the *Public Hospitals Act* and regulations are being complied with. Inspections were initiated by the Ministry's regional offices until these offices closed at the end of the 2006/07 fiscal year. The Ministry told us that, because of the closure of these offices, it has no information readily available on the inspections that were performed up to that time. As well, no inspections have been performed since 2006/07.

A hospital investigator or supervisor may be appointed where it is considered in the public interest to do so, such as when there are concerns about the quality of the hospital management and administration, the quality of patient care, or the

availability of financial resources for the delivery of health-care services. An investigator makes recommendations for corrective action to the hospital's board and senior management, and also reports these recommendations to the Minister and the LHIN. A supervisor's powers, on the other hand, include the right to exercise all of the powers of the hospital's board and senior management, or, if the board is permitted to continue functioning, to require that any act of the board be approved by the supervisor. Supervisors report their findings and recommendations to the Minister. Between October 2006 and July 2008, the Ministry appointed investigators at three hospitals and supervisors at nine hospitals.

As with peer reviews, the Ministry indicated that there is no formal process for sharing the issues and associated recommendations arising from investigator or supervisor appointments. Such information could assist other hospitals in preventing similar situations from arising. However, the Ministry indicated that some of the investigator and supervisor reports are publicly available to hospital boards wishing to review them.

RECOMMENDATION 2

The Ministry of Health and Long-Term Care should:

- as recommended in various Ministry-initiated reviews, consider incorporating good-governance practices, including those that would facilitate competency-based recruitment and set term limits for directors, into future changes to legislation or other requirements;
- clarify the respective roles and responsibilities of hospitals, Local Health Integration Networks (LHINs), and the Ministry;

- encourage the LHINs to ensure that key information is shared between LHINs and hospitals to assist hospital boards in working effectively with the LHINs; and
- in conjunction with the LHINs, develop a process to summarize and share key issues and recommendations arising from external reviews—such as those from peer reviews, investigations, and supervisor appointments—to assist hospital boards in recognizing and proactively addressing similar issues at their hospitals.

MINISTRY RESPONSE

The Ministry will follow up as appropriate on this recommendation. Currently, there are many programs and processes related to this recommendation in place. For example, the *Local Health System Integration Act, 2006* provides direction to stakeholders on the roles of the Ministry, LHINs, and service providers. The Ministry-LHIN Accountability Agreements provide further direction about the parties' obligations. As well, the LHINs produce long-term strategic plans as part of their accountability framework. The LHINs have released their first Integrated Health Service Plans for the three-year period starting in April 2007. These plans and other information are posted on each LHIN's website and are readily accessible to hospital boards.

With respect to sharing issues and recommendations from external reviews, the Ministry meets monthly with the LHINs, at which time issues related to external reviews are discussed.

The Ministry will continue to work with the LHINs and other stakeholders to clarify governance-related issues.