The Solutions Group

Focused Organizational Analysis

of

Guelph General Hospital

FINAL REPORT

Submitted To:
Ministry of Health and Long-Term Care
Toronto, Ontario

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August 26, 2002

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1.0 Introduction

The Ministry of Health and Long-Term Care (the Ministry) requested a focused review of the capital redevelopment project at Guelph General Hospital (GGH). The objectives of this review were to:

- Describe and evaluate the planning and decision-making processes of the board and senior executive levels as they pertain to the capital redevelopment project, program enhancements and hospital finances, including references to policy setting and information flow and to the roles, structures and relationships among board, CEO, executive and planning teams.
- Assess the financing of the capital redevelopment project and its sustainability, including references to previous and committed expenditures, projected costs and their assumptions, (both one-time and ongoing), MOHLTC approvals and sources of funding.
- Assess the decisions that considered the impact of the capital redevelopment project and capital purchases on hospital operations and finances, both operating and working funds, short term and longer term.
- Evaluate the decisions on which program enhancements were based, specifically related to the capital redevelopment project and their potential impact on hospital operations and finances, both operating and working funds, short term and longer term.
- Assess the financial management processes of the hospital, including cash management, financial reporting and those related to the capital redevelopment project.
- Make any appropriate recommendations for action.
- Identify the lessons learned from the GGH experience that can be applied to other similar projects currently under way in Ontario.

The review process took place over a three week period. The review included:

- An extensive review of documentation, including:
  - The functional program.
  - Designs drawings.
  - Selected purchase orders.
  - Correspondence between architects, contractors and the hospital.
  - Correspondence between the hospital and the Ministry.
  - Board minutes from 1997 to 2002.
  - Executive Committee minutes.
  - Board Construction Committee minutes.
  - Senior management team meeting minutes.

- Interviews with board members, the executive team, the construction project manager, architects, contractors and Ministry representatives.

We appreciate the time and effort given by all parties to assist us in our investigation. This draft report summarizes the findings and conclusions of the focused review.

2.0 Context – Key Decision Points in the Capital Redevelopment Project

The capital redevelopment project for GGH evolved over 10 years, beginning with the 1991 recommendations for a new role for GGH and culminating in the official opening of the renovated facility in the summer of 2001. In order to guide the review and focus on issues in decision-making, a high-level summary of key dates is presented here. This chronicle of activities is not intended to be a detailed summary of events, but rather a summary of key events in the planning and construction process.

Year	Event/Activity
1991	• Blundell Report is released, recommending that all acute care services be located at GGH, including the transfer of acute care programs from St. Joseph's Hospital. • The Ministry supports this new role for GGH.
1992	• Minister approves redevelopment and expansion of GGH current site.
1994	• A functional program is developed for GGH. Two key issues with the program: - No solid data-driven decisions (e.g. population projections, workload projections) that leads to the need for major change orders during construction - The program is developed assuming new facilities will be built, despite knowing that the project would combine new construction and redevelopment of existing space • The functional program is approved by the Ministry in November 1994
1995	• GGH raises the issue of one-time costs to capital division in February 1995. Ministry staff suggest deferring that discussion but also indicate that operating costs should not be addressed through the capital division.
1996	• Project manager is hired • Operational problems identified in working drawings • No evidence Ministry is advised of problems that will lead to some major changes during construction
1997	• Ministry confirms funding and approves contract award to PCL. • Construction begins. • Staging impacts on ongoing operations now begin to be clear • No evidence that operational cost impacts are developed or communicated to Ministry
1999	• Letter to Ministry in February 1999 with submission of one-time costs to capital division. In March a letter is received that this should be addressed through operations division. • Although HSRC directives are not made for GGH, HSRC population projections are used, suggesting more beds are required • Leads to first major change order to be submitted to Ministry: proposal is to convert 7th floor formerly planned administrative space to inpatient beds and leave admin services where they are (at 73 Delhi Street) with a plan to renovate that space – no consideration of the appropriateness of that space is made at this time • Verbal (November 9, 1999) and written (November 19, 1999) approval for the change including 73 Delhi Street is provided by Ministry staff and construction begins – formal written approval by Minister not received until June 2000

2000	• Government policy changes drive next major series of change orders: more birthing rooms required to accommodate 60-hour minimum stay and space allocation for ER visits is increased • Verbal approval for changes is received, construction begins and formal written approval by Minister is received in January 2001
March 2001	• Hospital is advised that renovation of 73 Delhi Street is impractical, and discussion of three-storey addition over Emergency begins. (The concept of a three storey addition has been previously discussed in 1988 and in 1999 but for other purposes.) • Ministry not notified at this time • Project manager insists that heavy construction cannot be under way once Emergency space is occupied in mid-August – any solution must accomplish the completion of heavy construction before the opening of the new Emergency space • General contractor is asked about feasibility of timing
April 2001	• PCL indicates a fast-track solution is possible and a proposal is requested • The Board is informed that there is an issue about 73 Delhi Street and that a proposal will be brought to the May meeting for their consideration.
May 2001	• May 7 – proposal is received from PCL with proviso that it must be signed immediately if timing constraint is to be addressed • May 8 – contract is signed • May 8 – Executive Committee of the Board is polled for support – a teleconference is held but no minutes are kept – best recollection of participants is that contract was signed before this meeting but was contingent on Executive Committee approval. No discussion of Public Hospitals Act or legal implications of signing contract without Ministry approval • May 14 - Ministry is informed that another major change order is needed • May 29 – Executive Committee reports to regular Board meeting that a proposal for the three storey addition has been developed to replace the original plan for renovations of 73 Delhi Street. Board is informed that there is no Ministry approval. No indication to Board that this is other than a proposal and that a contract has been signed. Board endorses Executive Committee decision, but is not informed that they will be in violation of the Public Hospitals Act by doing so. • May 29 – information on change order request provided to Ministry
June 2001	• June 5 – Meeting held with Ministry to discuss the change order – Ministry has a number of questions/concerns – the most significant is regarding public traffic flow through a patient care area • June 19 – telephone call from Ministry to CEO and project manager that the proposal cannot be supported • No evidence of meetings held, but decision to proceed is made between Board Chair (also Building Committee chair), project manager and CEO. • June 25 – actual construction begins • Ministry is not informed that construction is under way.
July 2001	• July 10 – formal written notice is received from Ministry staff that change order will not be approved at this time • No communication to Ministry of ongoing construction

August 2001	• August 10-15 (estimate) – Emergency opens • August 26 – photographs indicate that three storey addition is well under way – steel beams up but no brick work is evident • August 27 – telephone call from Ministry staff to CEO requesting status of three storey addition and CEO confirms that construction is under way
Sept. 2001	• Ministry writes GGH Board Chair advising Ministry will not participate in funding three storey addition and will be arranging for review of governance and financial management of the capital redevelopment project

This time frame is important, and will be addressed in the discussion of how decisions were made, who was involved, and what could have been done differently.

3.0 Capital Planning and Construction Process

The Ministry of Health publishes a Capital Planning Manual which is a guide to the planning process. The version referenced for this review was dated November 1996. It states: *Depending on the scope and size of a project, the ministry's capital planning process may consist of as many as five stages:*

Stage 1: Proposal
Stage 2: Functional Program
Stage 3: Preliminary Design Development
Stage 4: Contract Documentation Development
Stage 5: Implementation

This chapter presents a review of these stages at GGH.

3.1 Proposal: Master Program and Master Plan

The Ministry Planning Manual states*:*

"For hospital based capital projects with program or service delivery impacts the hospital may need to submit a master program/master plan. The need for these documents should be discussed with the hospital's prime ministry contact before formally submitting the Capital Project Request Form."

Given the very extensive change in the role and programs to be operated at GGH, a master program and master plan would have been expected as a pre-requirement to functional planning, especially since the previous planning documents were clearly out of date and not consistent with the new role of GGH.

A master program/plan was not prepared as the starting point for GGH planning following the Blundell Report. A master plan had been completed in 1985, but for a very different future for GGH. If a master plan and program had been prepared following the significant role change for GGH, the functional program might have been more appropriate as it could have identified which areas would be built new and which would be provided in renovated space. As it was, the functional program was written as if all space would be in new facilities, creating some unrealistic expectations for users.

3.2 Functional Program

The functional program prepared for GGH by Spectrum appears to have met the general criteria laid out in the Ministry Planning Manual. However, a number of weaknesses in the program would have an impact of future construction impact on future construction:

- The functional program was written as if it were a new hospital being built, despite the fact that both GGH and the Ministry knew that redevelopment on the same site inevitably meant renovating some spaces within the existing walls, which always results in compromises. Because the functional program assumed all new construction, no mention is made of which departments would be located in new vs. renovated space or that a number of moves and related one-time costs would be incurred. Had this been defined at this stage, it may have prevented some of the changes that occurred during construction. Further, the hospital would have been able to identify an estimated capital and operating cost impact for the Ministry.

- The level of operational analysis is weak. For example, no discussion of the impact of case carts and surgical workload in the CSR section was found. This contributed to the undersizing of the CSR that together with other factors created the need for change orders and the related domino effect during construction.

- The level of analysis regarding population projections and future bed requirements was also weak. Had it been more robust, the need for the additional beds (other than the beds for obstetrics, which were a result of a policy change) might have been foreseen, again avoiding some of the change orders required later.

- As noted by the Ministry in their comments back to GGH, it included room layouts that were not required, and some were also in violation of the building code. The Ministry pointed this out in their letter of approval to proceed to block schematics, which also indicated a number of issues to be addressed in subsequent design stages. The room layouts were provided by a US based architectural consultant working with Spectrum. The usual practice in Canada is for the architects contracted to design the new facility (in this case, Parkin) to provide detailed room layouts as part of their normal design services.

The Functional Program prepared for GGH appears on the surface to have met Ministry guidelines for content. No professional standards are required for functional programmers and this art and science is specific to health care facilities. The Ministry indicated that they had concerns about the quality of work performed by some functional programmers, but hospitals hire these resources directly. The hospitals and the Ministry would likely benefit from a more comprehensive definition of qualifications required for functional programmers and a database that included track records.

Criteria to consider for functional programmers include:

- Range of expertise appropriate to the particular project.

- Experience and track record.
- Size and scope of project.
- Use of appropriate workload indicators for each functional area.
- Use of a recognized method for projecting population growth.
- A database that includes workload, staffing, space relationships and equipment, together with a post occupancy evaluation by department.

3.3 Preliminary Design Development

The Planning Manual outlines the roles of prime and sub consultants, selection criteria, fee levels, and contents of block schematics and sketch plans.

It appears that for the most part the GGH project was consistent with Ministry policies and appropriate documentation was provided. Normal practice in Ontario is to charge 8 % of the construction cost for new construction and 10 % for renovation work (as it is more complicated). GGH negotiated a blended rate for the total project of 8.9753 %, and after discussion this was approved by the Ministry.

The Planning Manual states that the Ministry may share the cost of retaining a project manager. This is included in the Planning Manual Stage 3 – preliminary design development and may qualify for cost sharing. The need for a project manager is typically discussed at the project kick-off meeting with the Ministry

The size, scope and complexity of the GGH project clearly required a project manager and this was indeed funded within the capital budget. However, the project manager was not engaged until the working drawings were nearing completion. The hospital had limited resources internally, (both skills and time), to ensure that all future operational issues were being addressed during working drawing preparation. The requirement for a very complex phasing with multiple moves and interim solutions might have been better managed if the project manager were engaged earlier in the planning process. Furthermore, the role of the project manager was only to manage the current construction project in the main hospital building and did not include 73 Delhi Street, despite the fact that it was intended to retain and upgrade that building, albeit for different uses at the start of the main redevelopment project.

GGH was very dependent on the project manager for his advice on operational matters as well as for construction management (which is the purpose of this role). The project manager provided advice about operational issues, and GGH deferred to his advice and recommendations for all aspects of the construction project, including things that were beyond construction (for example, the operational impact of the phases of construction, Ministry policies and processes and Ministry relations).

3.4 Contract Document Development

A number of stages are required in the development of contract documents:

- Working drawings and specifications.
- An elemental cost breakdown from an independent cost consultant.
- Cost variance (if any).
- Space variance (if any).
- Prequalification (optional).
- Public Tenders.

These requirements are clearly defined in the Planning Manual and appear to have been followed by all parties in the identified stages. The Planning Manual notes the requirement of the use of a stipulated price tender with pre-qualified bidders in a public tendering process. This is undoubtedly the best approach for cost containment, and was the process used at GGH. The Ministry does not permit design/build approaches as an alternative to stipulated price. Design/build was not used in GGH until the three storey addition was planned.

3.5 Implementation

The Ministry Planning Manual states:

"Submission of change orders to the Ministry is not required unless compensation is being requested or the change order has an impact on the function of the space in question. The Ministry does not fund change orders unless these are the result of:

- *Unforeseeable circumstances (as defined in the Planning Manual as circumstances that could not have been foreseen with the best due diligence)*
- *Changes in regulatory requirements*
- *100% ministry funded projects."*

In addition to numerous change orders that were a normal part of the construction process and were not reported to the Ministry, three significant change orders were experienced in this project.

- The first change order resulted from revised bed projections provided to GGH by the Health Services Restructuring Commission as a part of the rural and northern network review. This resulted in additional beds that had to be factored in to the existing design structure, and resulted in a number of changes

commonly known as the "seventh floor changes". Because these changes were essentially Ministry-driven (through the HSRC suggestions for rural and northern networks), Ministry staff provided verbal (November 9, 1999) and written (November 19, 1999) support for the change order seven months before it was formally approved by the Minister. Formal approval, which according to the Ministry Planning Manual is required before construction can proceed, was actually received after the additional beds were built and in operation.

- The second change order resulted from a change in Ministry policy regarding the post partum minimum lengths of stay from 36 to 60 hours and changes in Ministry standards for emergency department space. This required additional birthing rooms, and again, as a Ministry-driven change, approval was expected. It was during discussion of the second change order that GGH requested and was granted an additional capital grant to renovate 73 Delhi Street for ongoing use for non-clinical purposes. The formal written approval in this case was also received after construction was well under way.

- The third change order resulted when GGH received advice from their architects, in the absence of Ministry approval, that the renovation of 73 Delhi Street would not be prudent because of major air-handling and other concerns. This change required the redirection of Ministry funds ($1,041,173) from two approved projects (73 Delhi Street and the Environmental Services component), as well as support from the Foundation for this construction. GGH reports that they assumed that this project made sense and would receive the support of the Ministry. However, Ministry policy (and the Public Hospitals Act) stipulates that funds must be used for the purposes approved.

In the first two groups of change orders approved by the Ministry the process outlined appears to have been followed. However, in one circumstance, only verbal approval was provided prior to construction. Formal Minister approval often took several months, with the result that the changes were in fact already complete by the time written confirmation of the approval and the associated grants was received.

In the case of the third major change order, GGH believed that this process would be the same as for previous change orders. However, four things were different about the process that was followed:

- This change was driven by a decision not to renovate 73 Delhi Street, which had been Ministry approved and for which capital funds had been provided during a previous change order. This change is considered an unforeseen event that could have been foreseen, which the Ministry clearly specifies are changes that it will not fund. GGH was unaware of or did not appreciate this difference.

- Although the Ministry was involved from the beginning in discussions around the first two change orders, they were not at all aware of the changes proposed for the three storey addition until after the contract was signed with the contractor to proceed with construction and the project was well under way.

- The Hospital clearly knew that this was a different process, because they went to the Foundation to receive funds to support the construction, clearly recognizing that there would be issues with the approval of this change order.

- The Ministry concerns raised about the proposed changes once they were aware of them were never addressed by the Hospital. In particular, the issue of public traffic in patient care areas was not seen as an important issue and was not addressed in the construction.

The Ministry also questions the conclusion that 73 Delhi Street could not be used for administrative space.

3.6 Project Manager

The Ministry Planning Manual describes the project manager as an individual hired by, and representing the interests of, the health care facility during the design, construction and commissioning of a capital project.

The role of the project manager designed by GGH included five key functions:

- Complete the project on time and on budget.
- Facilitate communications between owner, architect and contractor.
- Review/monitor project budget.
- Review project accounting to ensure architect invoices are certified and forward for authorization for payment to appropriate executive. Provide regular written reports to executive in charge.
- Report to executive in charge, including regular written reports..

GGH considered itself very fortunate to have an enthusiastic, aggressive and knowledgeable project manager. They attribute much of the success of their project to their project manager. The project manager worked with a number of user committees throughout the construction project.

Each of the GGH project manager responsibilities is briefly discussed below.

3.6.1 Complete project on time and on budget

Although GGH reports that the project was completed on budget and on time, both budget and timing changed during the course of the project. Significant funds were raised at the community level and this allowed the Ministry's contribution to be contained. However, given the extent of renovations and interim moves, they did come very close to schedules and enhanced budget for the construction under very trying circumstances.

The project manager worked very aggressively to keep the project on time and on budget.

3.6.2 Facilitate communications between owner, architect and contractor

Varying points of view exist on how this was managed at GGH. The contractor indicated that communication was excellent. The architects believed they were left out of a number of key decisions concerning changes to the building and were often told "just do it" even though there were implications for building systems or other spaces. The project manager and board chair indicated relationships with the architects were strained after the arrival of the project manager who identified the need for changes but the architects resisted without additional fees. The architects say they were not certain of the budget.

3.6.3 Review project budget

The project manager was very aggressive in the management of the budget and took this part of his role very seriously. At the time the project manager started in late 1996, the project was already considered to be over budget, (based on the cost consultant's estimate), and there was a lot of discussion about the real budget, what could be changed in the contract, etc. Both during tendering phase and construction the budget appears to have received a lot of attention and also created a lot of tension between architect and owner, particularly where less expensive finishes, windows, etc. were selected by the project manager to save money that may have long term consequences for operations. Working with a fixed price contract (i.e. not design/build) undoubtedly contributed to this. Savings in the capital budget, therefore, may well have been short-sighted in that they did not consider operating cost implications of savings achieved. For example, wheel guards were removed from the contract, and yet wall damage has already occurred and now wheel guards are being installed.

3.6.4 Review project accounting ensuring invoices certified by architects and forward for authorization for payment

The project manager authorized all requests for payment (based on the certificate of completion signed by the architect). However, the role of the architect and senior management in the approval process is unclear. Requests for payment to the Ministry were signed by the project manger only, with a copy going to the CEO, CFO and the Manager of Finance. The CFO did not play any 'control' role in the financial management of the capital project. This likely occurred because the previous CFO became the CEO during the latter stages of planning and the hospital was without a CFO for a period of time when the manager of finance authorized payments. The process continued after the new CFO was recruited.

3.6.5 Report to executive in charge

The project manager reported to the CEO. Real reporting, however, appeared to be to the Board Chair, who also chaired the Building Committee (also called the CPMT). This reporting relationship was inappropriate. The Board Chair placed himself in conflict by getting close to the day-to-day activities of the construction project, therefore failing to separate this from the board's oversight role.

The project manager was given extensive power to change design details developed by architects/engineers because he had the full support of the Board Chair. With these two individuals being involved in such decisions, the long term operational impacts for the hospital may not have been fully considered. An example is the decision to remove wheel guards from the contract (as noted previously).

Regular written reports from the project manager were in the form of the minutes of the Construction Project Management Team (CPMT). These minutes appeared to have been kept on a regular basis and appeared reasonably comprehensive.

3.7 Construction Project Management Team

The Construction Project Management Team actually evolved from the Building Committee of the Board. It was chaired during the entire construction period by the board chair. This Committee reviewed all change orders with financial or functional implications. Although the Committee had a broader membership, the Committee Chair, (also Board Chair), CEO and project manager worked very closely together in the overall management of the project.

3.8 Relationships and understandings between architect and hospital

The role of the architect in a construction project includes assuming the legal responsibility for administration of the contract and completion of the building. In many cases, the architect will report periodically to the Board. At GGH, the architect reported to the Board during design but not through construction. Once construction began, reporting to the board was through the CPMT Chair. There was no direct independent report to the whole board. On a day to day basis the architects reported to the project manager.

This reporting relationship created some tensions between the architect and GGH. The project manager made numerous changes to the design details, some, but not all of which were intended to contain costs, and if the architects did not accept direction from the project manager they would be ordered to do it by the Board Chair.

3.9 Relationships and understandings between contractor and hospital

The relationship between the contractor and GGH was generally quite positive. One issue that could have been better planned was the very tight move schedules (two weeks to vacate areas scheduled for renovation). These timetables may have been better managed if more thorough planning on staging had been completed earlier in the process. As a result, these moves placed tremendous strain on operating departments. However, the relationship between the contractor and the hospital was not at all problematic in the completion of the construction project.

3.10 Relationships and understandings between Board, CEO and project manager

The relationships between the CEO and project manager were reported to be very positive. However, while on paper the project manager reported to the CEO, it appears that he had a more direct reporting relationship to the Board Chair who also chaired the CPMT. This was an inappropriate reporting relationship that will be addressed in the chapter on governance.

3.11 Management of change orders

Change orders are an inevitable part of the construction process. However, the hospital objective should be to minimize these since they can be quite costly. In general, renovations are more likely to generate unforeseeable change orders due to the need to tie in to existing systems, all of which may not be known in detail at the design stage.

Examples would be the need to deal with soil contamination. The current process outlined in the Ministry's Capital Planning Manual appears to work well for these as long as they can be made within the approved budget.

Change orders as seen at GGH were more unusual. For the most part, the sketch plan should freeze the design—at least the floor layouts—which simply do not change for any reason after construction starts. It would be expected that the functional programmer and the hospital, together with the architect and with advice from the Ministry, would have thoroughly investigated the workload and space requirements, including bed numbers, prior to finalizing sketch plans. Although changes in policy such as the 60 hour post partum policy are rare during a construction project, the impact in this case was substantial.

The process for change orders typically includes these steps:

- Architect issues "contemplated change order" along with the drawings/specifications to contractor after discussion with project manager.
- Contractor provides price.
- If no additional cost, project manger can authorize.
- If additional cost reviewed by CPMT.
- An additional step for Ministry approval is required if added Ministry funding is required. To facilitate a timely response, such approval will always be verbal initially, followed by written approval from the Minister.
- If authorized, architect issues change order.

This process is appropriate and appears to have been followed with the exception of the last major change order with respect to the three storey addition. Also, in the case of other major change orders, formal written Ministry approval came after completion of much of the work involved. Although the last change order was clearly different than the previous two major changes, GGH made some assumptions that the approval process would proceed as the other two had:

- The distinction that this change request was Hospital-driven and "unforeseen" as opposed to "unforeseeable" was not appreciated.

- The distinction that Ministry requests for further information or clarification were signals that this change order would ultimately be approved once questions had been answered, even though no verbal or informal approval or signal from the Ministry had been received, was also not appreciated.

Although the Hospital reports that they were moving forward in good faith, (after having made the commitment without Ministry approval), and with an expectation that this change order would be approved just as previous change orders had, signals exist that GGH recognized this change order was different. For example, no effort was made to address the concerns the Ministry had about traffic flow through patient care areas, probably because a contract had been signed without even informal approval and GGH knew that they would have issues but anticipated that they would "seek forgiveness and then carry on". Evidence exists that the Ministry recognized the need for a timely response, and that efforts were made to accommodate the needs of GGH.

3.12 Ministry involvement in construction phases

The Ministry's involvement in a hospital construction project typically involves the review and approval of all key stages of the planning and construction process. Once construction begins, it includes:

- Approval of requests for payment.
- Review of change orders if additional funding is required or a change in function will result.
- Approval of scope changes when driven by Ministry policy.

The process of support and approval for major capital projects has changed significantly in recent years, particularly since the introduction of the HRIT process for implementing HSRC capital development directives. The Ministry now has extremely limited capacity to review plans and changes in capital projects. Very limited planning resources exist in the Capital Division of the Ministry, and the relationship/communication between the capital and operating divisions is not as tightly coordinated or synchronized as it might be (although it has improved in recent years). As a result, when a hospital experiences operational cost difficulties during construction, no provision exists in capital budgets to fund these costs, and the Operations Division does not recognize them. As a result, a hospital may spend down working capital until costs can be justified, reviewed, approved and recovered.

In addition, the resources of the Ministry do not allow for any on-site monitoring of construction as it is in progress. The Planning Manual does, however, make provision for the use of an independent construction monitor.

3.13 Lessons Learned

The planning and construction lessons learned at GGH can provide insight to the Ministry that could have valuable benefit in other similar projects currently under way in Ontario. The experience of GGH has led to a number of subjects for discussion with the

Ministry with regard to the possibility for new processes to support the planning and construction processes at hospital sites. They include:

3.13.1 Master planning/programming

The Planning Manual indicates that major role changes "*may require*" a revised master program/master plan. A master program addresses program changes that require additional space and resources and changes in workload that make the facility's current services and space inadequate. The master plan contains a site plan and line drawings showing major building elements and identifies obsolete buildings to be demolished or renovated. Application of this requirement would have been very meaningful for GGH:

- The 1985 master plan that existed was based on a very different plan for the hospital.
- The plan was more than five years old when the Blundell Report was released and had not ever been updated.
- The building planning did not identify that renovation of 73 Delhi was not appropriate.

Only by identifying general phasing plans and the entire " big picture " of the hospital site will it be possible to anticipate the operational impacts and related costs of a redevelopment project. This requires a master plan that reflects the role and future expansion plans of the hospital. The Ministry staff report that this is now done.

Recommendation

We recommend that:

(1) The Ministry ensure that all major capital projects have a current master plan that includes the entire site, and that the functional program is developed to reflect the master plan and the extent to which it is new versus redevelopment.

3.13.2 Redevelopment vs. new planning

Renovation projects are extremely taxing for everyone. A hospital contemplating redevelopment needs to work closely with the Ministry to carefully evaluate both capital and operating implications of green versus brown site development before proceeding with a redevelopment project. This was not done at GGH by either party. The current practice is that hospitals provide Net Present Value analysis for the various options, in particular greenfield vs. brownfield development.

3.13.3 Functional programming

The functional program is the most significant planning document that defines in detail the workload volumes, staffing, major operating systems, major equipment, space and interdepartmental and intradepartmental relationships to be developed in the design of a new or renovated facility. Once design has begun, any changes required in the program descriptions may lead to increases in architectural fees. More importantly, however, if errors in the functional program are not detected until construction is underway, costly change orders may result.

GGH identified flaws in the plan after the project manager was engaged, but the design had progressed so fare that additional fees would have been incurred for redesign.

Given the lack of industry standards for functional programs and functional program consultants, the Planning Manual should be enhanced to provide more specific guidance to the planning process to help hospitals and to reduce the opportunity for errors or omissions in the functional program.

The dependence on good functional programming consultants places the Ministry and a hospital at risk if the consultants do not provide comprehensive advice and a solidly developed functional program that will be used by architects to move to working drawings. No standards are currently in place to ensure that hospitals engage consultants who are qualified to provide high quality services during functional program preparation. Since most hospital executives do not have experience with facilities planning, they rely on their functional program consultants to identify the operational and capital impacts of their project. If this is not well done, change orders may be excessive, costly and even risky.

Criteria to guide the selection of functional programming consultants and a template for ensuring that all programming aspects are addressed can reduce the risk of serious errors and provide the Ministry and hospitals with greater assurance that the program is solid. For example:

- A database of space by department with appropriate workload measures would assist in the review of functional programs. A database does not currently exist, and the Ministry relies on staff with varying levels of operational and planning experience and expertise to communicate questions to the hospital through the hospital consultant. An information system is currently under development that will assist with this endeavour.

- Although potential operating cost impacts should be considered obvious by people involved in planning projects, without an expectation that this consideration is included in submissions to the Ministry, they will not

happen consistently or comprehensively. This expectation will force discussions and considerations that are currently not always happening at an early stage in the planning process.

Recommendations

We recommend that:

(2) The Ministry and the hospital industry jointly develop criteria or guiding principles to guide the selection of functional program consultants.

(3) The Ministry provide a mechanism for hospitals and Ministry staff to have the information and the tools to effectively review functional programs, including the development of a database of processes, staffing patterns, workload and space allocations that is accessible to Ministry staff, hospitals and consultants.

(4) The Ministry work with the representatives from the hospital industry to develop a process for functional program submissions that include detailed operating cost analyses that include one time costs as well as ongoing operating costs, particularly for redevelopment projects.

3.13.4 Planning Manual

The Ministry Planning Manual is very detailed about procedures in the latter stages of the planning process (e.g. sketch plans through construction), but is very general about the pre-planning stages (role study through functional program) where key decisions are made about both space and operational planning. Additional information about what factors are to be considered in determining the requirements for each department or service, including workload and operating systems, would be helpful

Recommendations

We recommend that:

(5) The Ministry work with the hospital industry to expand the description of requirements for functional programs in the Capital Planning Manual.

(6) The Ministry conduct a post occupancy evaluation of all major capital projects and include the results in a proposed database.

3.13.5 Capital and Operating Division planning processes

Although the Capital and Operating divisions of the Ministry now appear to be working together, we understand this was not always the case. This had serious implications for funding operations during and after construction. Turnover of regional office staff and reduced resources in capital planning likely contributed to this. In addition, it was not clear to the hospital who approved what. For example, approval to construct nuclear medicine did not mean approval to operate it.

A major gap in the planning process at GGH was the lack of integration between operating and capital approvals and the lack of clear communication related to these. This led to working capital problems in the hospital and contributed the hospital's view that the Ministry was not coordinated between its capital and operating divisions. These issues helped to erode relationships between GGH and the Ministry.

Recommendation

We recommend that:

(7) The Ministry ensure that a mechanism exists for the capital and operating branches of the Ministry to collaborate effectively with each other during major capital project planning and construction so that capital and operating cost approval processes are synchronized.

3.13.5 Change orders

Submission of change orders to the Ministry is not required unless compensation is being requested or the change order has an impact on the function of the space in question. The Ministry does not fund change orders unless these are the result of:

- Unforeseeable circumstances
- Changes in regulatory requirements
- 100 per cent ministry –funded projects.

The interpretation of this change by GGH was that they were not asking for additional dollars in the case of 73 Delhi Street. However, they were planning to reallocate funds that had been approved for other things, and clearly the function

of the space was changing. However, GGH believed their proposal was within the spirit of previous approvals. The Planning Manual does not identify sanctions for non-compliance with this process. Clarification of Ministry policy is required.

Recommendation

We recommend that:

(8) The Ministry include a clear description of change order procedures during the project kick-off meeting with a hospital.

3.13.6 Resourcing capital projects

The planning division now has very limited resources**.** If the stated Ministry approval processes are to be followed, appropriate resources are essential to respond to change requests on a timely basis in order to permit construction to continue without costly delay claims. In the case of the first two bundled change orders, the Ministry provided verbal and written approval to proceed with changes prior to receiving formal written approval. This process will likely continue, given the Ministry capital planning cycle. The Ministry needs to explore ways to provide support for unforeseeable circumstances in a timely manner. The current process of verbal approvals before formal approval is given could be seen as a mixed message, yet it would be totally impractical given the situation for the hospital not to have proceeded. In the case of the third change order, the Ministry appreciated the need for a timely response and indeed provided feedback within three weeks of the submission of the change order request—more quickly than might normally be the case.

3.13.7 Funding a project manager and other advisors

The Ministry Planning Manual introduces the topic of a project manager in Stage 3 of the Capital Planning Manual – Preliminary Design Development. The current practice is that a discussion of a project manager and clerk of the works is discussed at the kick-off meeting after the Minister's approval for the capital project. Since most hospitals (in particular, smaller hospitals), do not have expertise internally, and since many key planning and operational decisions are made at the functional program and master planning stages, earlier introduction of the project manager role may provide expertise that would assist in advising the hospital at an earlier stage in the planning and construction process.

The Ministry is responsible for spending very large sums of taxpayers' money in partnership with the governing hospital boards. Accountability is from the architect who signs the certificate of completion to the hospital, whose executive in charge in turn approves it for payment to the Ministry, who processes the

payment. Although the Planning Manual makes provision for engaging a construction monitor, this is not routinely done. The project manager's role is to advise the hospital, and this works as long as the interests of the Ministry and the hospital are aligned. However, when these interests come into conflict, as was the case in Guelph, the Ministry had to rely on informal mechanisms to learn that the Public Hospitals Act had been violated.

A mechanism is needed to monitor capital projects. This does not mean site inspections. Various means, such as quarterly reports for the board, reports from hospital operations staff or other mechanisms should be considered. It should build on the accountability of the board to ensure that a project complies with the approved tender documents and construction contract. It should also include the identification of risk factors that may lead to a project going off the rails. A type of variance reporting might be effective to achieve this objective.

Recommendation

We recommend that:

(9) The Ministry develop a mechanism to monitor major capital projects during construction.

3.13.8 Communications between Ministry and a hospital involved in a major capital project

Communication difficulties occur when all parties do not have the same understanding of outcomes of discussions, especially if there is a time delay between the discussion and the documentation of decisions made or actions proposed. This requires that both parties be diligent in documentation of discussions, and that no assumptions are made in even the most informal discussions.

The best practice for both parties is to keep a record of all discussions, and to ensure that the responsible people are kept informed of discussions, decisions, and issues.

The Ministry needs to take advantage of the lessons learned from this review. In the spirit of accountability relationships between the Ministry and hospitals, the Ministry should provide information learned from this review that will signal difficulties in the course of major capital projects at other hospitals around the province, particularly for hospitals in the planning stages or early construction phases of their projects. The Ministry should also develop a process to ensure ongoing compliance with approvals provided by the Ministry. The Ministry

should also communicate to these hospitals that if problems can be detected and reported based on these lessons learned, early intervention will be viewed as a positive, proactive problem solving process for both sides.

Finally, the Ministry should also consider some sort of contingency planning for situations such as those that arose at GGH. A planning and construction process occurs over many years. Government policy can change many times, as we saw at GGH. With the increasing demands for technology, new advances in surgical techniques, increased use of primary care and improved clinical utilization management as examples, the opportunities for policy revision or replacement are vast. The final construction issue at GGH (the three storey addition) aside, some of the other change orders that GGH experienced, and the resulting impact of changes that had to be made mid-construction, deserve consideration. These issues cannot be planned for by either party, but should be addressed as required in a spirit of cooperation and flexibility.

Recommendations

We recommend that:

(10) The Ministry ensure timely written communications of all key discussions and decisions and ensure that approvals explicitly identify what is and what is not approved.
(11) The Board and Senior Management improve the documentation of discussions with the Ministry, particularly with respect to assumptions, major commitments and/or outstanding issues.
(12) The Ministry copy a hospital's board chair in all key communications with the CEO.
(13) The Ministry undertake to provide all hospitals undergoing major construction projects with information learned in this review, with an expectation that any signs of difficulty in those projects be communicated to the Ministry as soon as possible.
(14) The Ministry consider a process of contingency planning for major capital projects that recognizes the need for flexibility in adherence to decisions made early in the planning process.

4.0 Governance Decision-Making Processes

Hospital boards in Ontario are entrusted with a significant and costly component of the health care of the population. A continuous challenge for many boards is to focus on facilitating and monitoring the activities of the hospital rather than controlling day-to-day activities. Without some distance from day-to-day operations, the board will be challenged to maintain a future-focused and objective perspective of the issues it faces and the responsibilities with which it has been entrusted.

This chapter focuses on the governance decision-making processes of the GGH Board of Commissioners as they relate to the capital redevelopment project.

4.1 Board Composition

The current composition of the GGH Board of Commissioners was set out in 1963 (revised in 1971) in the Guelph Hospital Act. The Board of Commissioners was (and is) charged with the management and operation of GGH. Members include:

- One City of Guelph councillor
- Two representatives appointed by the County of Wellington
- One representative appointed by Guelph City Council who is a resident of the County of Halton.
- Eight residents of Guelph appointed by City Council
- Up to four term appointments from the Board.

In addition, the Board has five ex officio members:

- Chief of Staff
- President of Medical Staff
- Vice President of Medical Staff
- CEO
- Representative of Volunteer Association (recently removed as an ex officio member).

The make-up of a board will set the stage for strong or weak governance. Board composition includes the recruitment and selection of new board members, reappointment of members to additional terms, the length of a member's term, and the removal of non-performing board members.

4.1.1 Member profiling

The determination of what the profile of board membership should look like is complex. It depends on the role of the board, its particular responsibilities, and any initiatives or challenges that it will be facing over a period of time. One particular challenge is to determine the importance of a balance of community representation and business expertise. Although such a balance is important, membership should also include general qualifications that include:

- Willingness to serve.
- Ability to meet time commitment.
- Willingness to participate in board orientation and continuing development.
- Objectivity.
- Integrity and the absence of serious conflicts.
- Values consistent with the hospital.

In addition, board members should be selected with specific qualifications in mind, including (but not limited to):

- Business experience and qualifications that can contribute to decision-making (e.g. legal, accounting, finance, construction, development, human resources, communications, etc.).
- Socioeconomic status, race and ethnicity balance that is representative of the communities served.
- Political connections.

When a member's term is ending and members are up for re-appointment, careful consideration should be given to:

- The performance of members whose term is ending, and whether that performance warrants serving another term.

- The vacancies that will need to be filled and the skills and talents that will be required to keep the overall make-up of the board representative and balanced.

The GGH Board has little or no input to the selection of people for appointments to the Board. Appointments are either ex officio or are made by the Guelph City Council and the County of Wellington. In the past year, the Governance

Committee has been able to have some input to the advertisement for member recruitment that appears in the local paper and has been able to submit a list of criteria for member selection. However, this has not been a change in process. Rather, the current city council representative has been willing to receive such input. The Board is therefore at significant risk for having the best complement of talent and expertise.

A board should never be influenced by external constituencies with respect to its work. Many hospital boards in Ontario and elsewhere are reducing or eliminating political appointments to ensure that the board is not unduly influenced in the increasingly difficult decisions that it must make to serve the interests of all stakeholders of the hospital. Further, a board must have the ability to recruit members who will, together, provide for a membership that has all of the necessary qualities and expertise to allow the board to function effectively.

A major review of the composition and structure of the GGH board is required. It has not been reviewed since 1971. Many things about hospital governance have changed since that time. This review is both warranted and required.

Recommendation

We recommend that:

(15) The GGH Board approach the City of Guelph to undertake a review of the Guelph Hospital Act, with a view to changing the method for selecting board appointments and providing a significant role for input for the sitting Board, particularly with respect to required qualifications for new Board appointments.

4.1.1 Member terms and reappointments

Members are currently appointed to four year terms and can serve a total of three terms (12 years) on the Board. Although most Board members are within the limits of their appointments, at least one member has served on the Board for 14 years.

The purpose of the length of a term and the number of terms to be served by board members has a purpose. The length of a term should be long enough to provide a board member with the opportunity to become familiar with the major board responsibilities and functions and to make a contribution. If a board member is not performing at an acceptable level by the end of the term, performance accomplishments or failures should be factored in to consideration of a term renewal.

The planned turnover of board members provides an opportunity for a board to renew itself and to ensure that the community has an opportunity to have a variety of talents and perspectives to contribute to the organization's continuous improvement and development. This is not a reflection on members who have served a number of terms, but rather ensures that other members of the community with similar qualifications are provided with an opportunity to serve.

The Board's by-laws state the number of terms a board member will serve. These by-laws should be followed.

Recommendation

We recommend that:

(16) The GGH Board review its by-laws with respect to member terms and ensures that all members are in compliance with these terms.

4.2 Board Structure

Board structure includes the size of the board, the number and type of committees of the board, and committee reporting relationships

4.2.1 Size of the Board

The board currently has 12 designated members (as noted previously) appointed based on constituency representation and five ex officio members. The terms of one third of the appointed members come up for renewal every year.

The by-laws also have provision for up to four term appointments. These appointments can be made by the Board, are for one year, and provide for augmenting the Board's composition to include specific experience or expertise that may be missing in the appointed members. The Board currently has one term member.

A number of invited guests regularly participate in Board meetings, including the Vice Presidents of the Hospital. The Chair of the Board is elected at the first meeting of the board following the Annual General Meeting. The term is one year.

Although current standards for board size suggest that the board should be much smaller than its 18 members, the GGH Board has fewer members than many Ontario hospital boards. Because of the prevalence of a number of ex officio members, establishing a board size that is much fewer than 12-13 members is difficult.

Recommendations

We recommend that:

(17) The GGH Board recommend that the review of the Guelph Hospital Act consider a reduction in appointed members to nine and minimizing the number of elected officials included in Board membership.

(18) The GGH Board Governance Committee continue its work to develop a profile of board membership that will address the governance accountabilities of the Board.

4.2.2 Committees

Committees of the board serve a critically important function. They do help the board conduct its business. They do not augment the functions of staff.

With an effective and functioning committee structure in place, the full board can focus on policy decisions, while the committees deal with a study of details and the preparation of recommendations for the board's consideration. Committees also serve as an excellent training ground for future board members.

The work of board committees should be carefully crafted and monitored by the full board. Each year, specific objectives and goals for committee work should be laid out and the committees should be directed to report to the board on their progress towards those goals and objectives.

The standing committee structure at GGH is limited to a Fiscal Advisory Committee and an Executive Committee.

The Executive Committee has never met until recently. Meetings have been held in the past year. The content of these meetings has not been consistent with the mandate of the Executive Committee as laid out in the by-laws. However, the new Board Chair is attempting to have the Committee meet more regularly and to be more consistent with the by-laws.

The GGH Board has developed a very effective process for reviewing its additional committee requirements every year, and establishes committees to focus on specific goals and objectives for the year. Although committees typically include traditional quality, fiscal and human resources oversight functions, the naming of committee changes every year.

The Board established a Governance Committee last year to address some specific governance related concerns, and this committee has been very active in developing stronger governance processes.

Most Board committees provide regular monthly reports to the Board, although the level of detail reported varies significantly. The Building Committee (which no longer exists but was in place during construction) provided verbal reports at most meetings of the Board, although the level of detail provided was limited in most reports. The clarification of the authority and accountability of committees is needed to ensure that the committee is serving its role and that the Board maintains appropriate oversight responsibility. Committees should assist in the work of the Board – but they should not assume the authority of the Board. The expectation for reporting (level of detail, decisions made, etc.) should be laid out in the terms of reference of each committee.

Recommendation

We recommend that:

(19) The GGH Board review its committee structure and the process for establishing committees to ensure that a clear mandate is set for each committee, that the mandate is followed, and that regular reporting of committee work is made to the Board.

4.1.3 Leadership succession

The role and performance of a board chair is critical to the success of the board. The selection of a board chair will determine the tone and function of the board for the term served. Most board chairs are elected for a two year term. That contributes to the stability of the board and a mentoring process for future board leaders. Most boards also have a progression plan to the chair position, although it does not have to be strictly followed.

The GGH Board Chair is elected for a one year term, which is generally expected to be renewed for two additional years. No Vice Chair position exists, so the determination of Board Chair is not prescribed. A Chair-elect is named approximately one year before the end of the current Chair's term.

Recommendation

We recommend that:

(20) The GGH Board establish a process for Board Chair selection that assures that a Board Chair serves more than a one year term.

4.3 Board Roles and Responsibilities

A board's performance is enhanced when a clear and shared agreement of how it will execute its fiduciary responsibilities is laid out and supported by every member of the board. This requires a clear explanation of the responsibilities and roles that the board assumes in carrying out its functions and an agreement by all board members that they understand and accept those roles and responsibilities.

In order to carry out these roles and responsibilities, the board must:

- Understand its stakeholders and the responsibilities it has to those stakeholders.
- Define a framework of behaviour (values) within which it will operate as it carries out its function.

4.3.1 Stakeholders

The sole purpose of a board is to represent and look after the interests of stakeholders. Everything the board does, every decision that is made, should be viewed from the perspective of all stakeholders. The challenge for public hospitals is that many stakeholders' interests must be managed. They include external stakeholders (e.g. suppliers, patients) and internal stakeholders, (e.g. employees, volunteers). A board must be very cognizant of its most important stakeholders, while recognizing that expectations come from many constituencies. The key stakeholders of a Canadian public hospital include:

- The Hospital Corporation (or in the case of GGH, the City of Guelph).
- The Ministry of Health as the agent of government that allocates funds and determines legislation, regulations and policy.
- The medical staff who practice in the hospital and generate the patients that are the business of the hospital.
- The community that makes up the hospital's catchment area.
- The patients served.

At GGH, Board members did not consistently identify all of these groups as stakeholders. All members identified the community (and the city council) as a key stakeholder. However, a number did not appreciate the Ministry as a stakeholder, or physicians as stakeholders. The importance of understanding the government (through the Ministry) as a stakeholder cannot be underestimated.

4.3.2 Key board roles

A board has three key roles:

- **Policy formulation** — Policy formulation is one of the most critical components of a board's function. If policies are carefully crafted and comprehensive, and reasonable interpretation of those policies will ensure that the board's work is accomplished. GGH is not a policy-driven Board. Although some policies exist, they do not provide the foundation for delegation of authority and decision-making to committees or to the CEO. This is a common challenge for hospital boards.

- **Decision making** — Decisions made by a board should be limited to only those decisions that cannot be delegated and should be grounded in policy. With a sound policy structure, a Board does not have to make many decisions. The GGH Board is not an active decision-making Board. Some of its decisions are made at the committee level, which is appropriate if the ultimate reporting and accountability is at the Board level. However, this Board appears to delegate its authority without policies to support that delegation, and has no monitoring process to follow and monitor committee decisions.

- **Oversight** — With effective policies in place and decision-making limited to those things that require the objective and fiduciary consideration of the governing body, the board can focus its attention on monitoring the key activities of the organization. The oversight role of the board is critical to its ability to fulfill its fiduciary responsibility while maintaining an objective distance from operations. In the capital redevelopment project, the Board almost completely abdicated its responsibility to the Board Chair in his role as the Chair of the Building Committee/CPMT. Even other members of the Building Committee/CPMT deferred to the Board Chair because of his experience with other major construction projects (primarily a multi-unit housing facility in the city).

  We have already noted that this committee was clearly an operations committee, directly involved in the day-to-day decisions of the construction project. As a result, the Board had no oversight/monitoring function for the capital redevelopment project almost from the beginning. This abdication of responsibility is a serious gap in the responsibility that the Board has to ensure

that appropriate decisions are made and that it can effectively report its activity to the Ministry.

Recommendation

We recommend that:

(21) The GGH Board continue its efforts to develop the knowledge of the Board with respect to its accountabilities, specifically with respect to policy development, oversight responsibilities, and its relationship with and responsibilities to the Ministry of Health and Long-Term Care.

4.4 The issue of Board responsibility for the capital redevelopment project

Special comment is needed with respect to the capital redevelopment project. One of the key drivers of this review was the lack of governance oversight for the capital project. This was a major factor in the events of last year.

The Board Chair had a responsibility to monitor the activities of the construction project management team to ensure they fulfilled to best interests of the stakeholders of GGH. The CEO, as the executive in charge, had a responsibility to guide the activities of construction and to ensure that the Board was regularly informed. Both of these individuals got very involved in the day to day activities of the construction project, to the extent that:

- They made decisions that contravened standard practices.
- They took risks without informing the Board, administration or Ministry.
- They did not give the Board the information it needed to make an informed decision.
- They were directly involved in day-to-day activities and lost the perspective of oversight.

All of the people involved acted in what they believed to be the best interests of the hospital and the community. They believed that they were making the best use of public funds. However, they acted without regard to their fiduciary responsibilities, and without regard to the responsibilities of their positions.

Ultimately, the Board is responsible for what happened. Although they believed they were deferring to experts, they essentially abdicated their responsibility to govern this situation. Although it is easy to appreciate how this happened, the Board must realize

that this was a serious breach of their duty to the province. If this Board defers a project and responsibility of the magnitude of the redevelopment project, it could be a concern that this happens with other responsibilities as well.

No board should ever let this happen. The GGH Board must now appreciate, with all of the facts in hand, that they should have asked tougher questions and provided stronger direction to the issue of the three storey addition.

Given that this was not done, the Board has put the Ministry in an untenable position. The resolution of this issue will not happen easily or quickly. Without a serious review of governance practices, delegation processes and fiduciary responsibilities, a tense and untrusting relationship with the Ministry will likely continue.

Recommendations

We recommend that:

(22) The GGH Board undertake a thorough debriefing of the sequence of events leading to the May 29, 2001 Board meeting with a view to understanding how governance processes were breached and how they can learn from this experience.

(23) The GGH Board engage a specialist in governance to coach them in governance issues and ensure the Board is aligned in its understanding of its roles, responsibilities and accountabilities.

4.5 Relationship with CEO

A board delegates much of its authority to be executed by the CEO. Relationships with the CEO are therefore critical:

- The board's expectations of the CEO must be clearly articulated in writing.
- The CEO should ensure that the board is fully informed about all activities of the hospital; in particular with respect to financial issues and quality of care.
- The CEO should have annual performance goals and receive a performance appraisal from the board that is used as the basis of any compensation adjustments.

The GGH board has full confidence in its CEO. They have provided positive performance reviews, and speak of the CEO with great respect. The CEO, however, has not provided all of the information that he should to the Board in keeping the Board informed about hospital activity. For example, he failed the Board in 2001 by not making it clear that the decisions that were being made with respect to the three-storey addition were in violation of the Public Hospitals Act. Regardless of any advice or

counsel from the Board Chair at the time, the CEO should have stepped back from the decision made by the Executive Committee and the Board and ensured that members had a complete understanding of the implications of the decision being made.

A concern about the current situation is that the CEO has been strongly influenced and directed by the former Board Chair. The Board Chair's role is not to direct the CEO.

5.0 Financial Management Processes

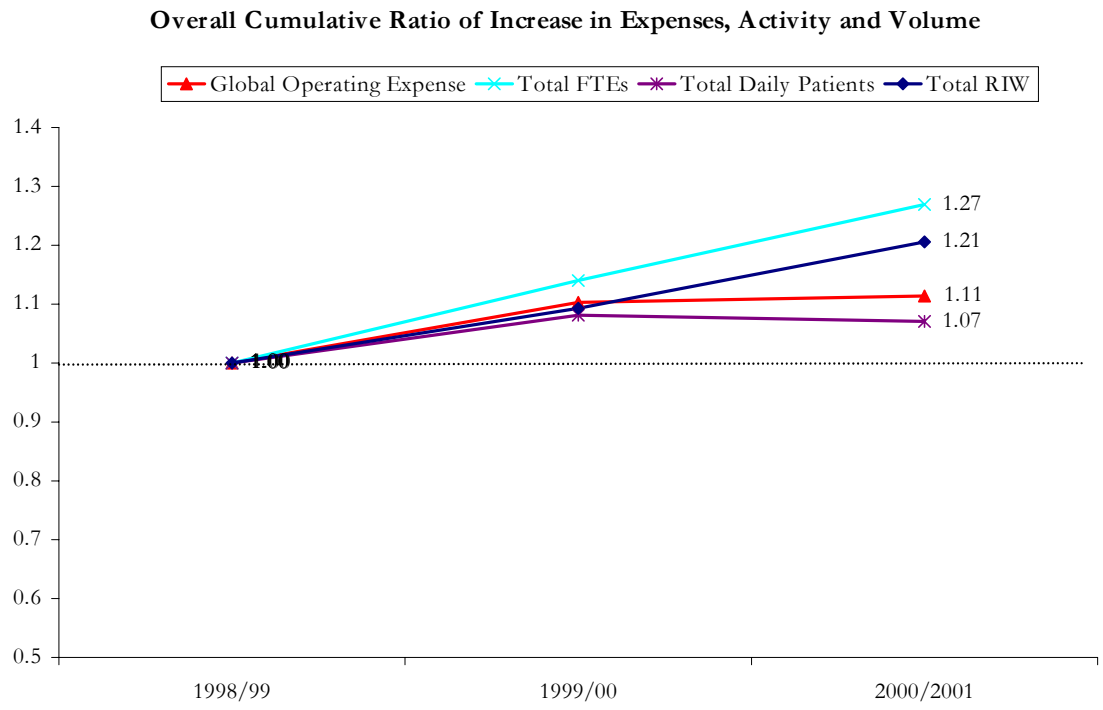
The review of financial management included a review of:

- Overall trends in expenses and activity.
- Operational funding.
- Working capital.
- Business planning/PCOP/Budgeting.
- Capital financing.

5.1 Overall trends

Trends in expenses and activity were reviewed for the past three years. Exhibit 1 presents the overall cumulative ratio of the increase in expenses, activity and volume for 1998/99 through 2000/01.

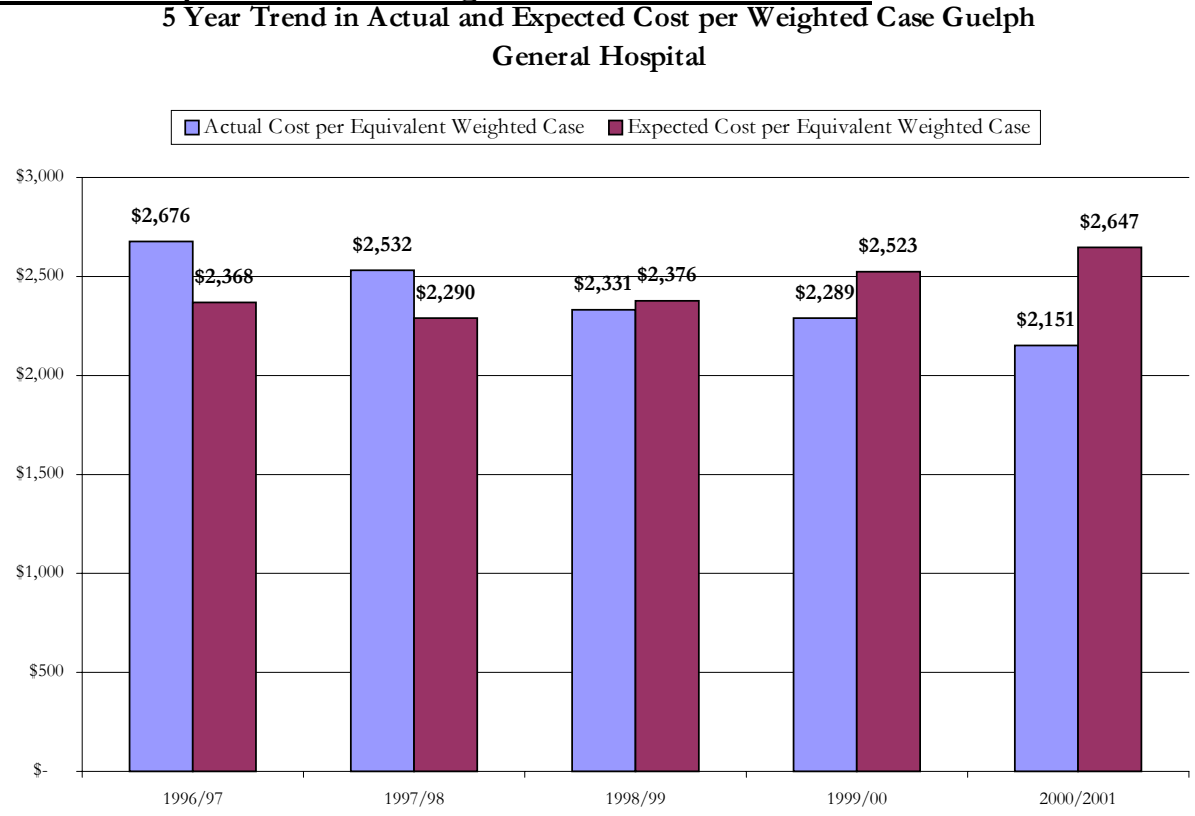
Exhibit 1
Cumulative Ratio of Increases in Expenses, Activity and Volume



This table shows that although the RIW increased, overall expenses did not grow at the same rate.

Exhibit 2 presents a five-year trend in actual and expected cost per weighted case.

Exhibit 2
Actual and Expected Cost Per Weighted Case 1996/97 to 2000/01



Between 1996/97 and 2000/01, an 11% increase was experienced in weighted cases, with a corresponding increase in acute care expenses of 4.7%. The net effect on actual cost per weighted case was a decrease of 6%.

An estimate for 2001/02, (for which final data are not yet available), suggests that expenses will have increased by 28% and weighted cases will have increased by 17%. GGH expects to have an actual cost per weighted case that is close to or below its expected cost per weighted case in 2001/02..

5.2 Operational funding

The nature of the operational funding challenges faced by GGH and the Ministry are not adequately described with a review of annual financial statements. Such statements represent the financial picture of an organization at a point in time. This picture can be distorted with:

- The granting of "one-time" funding at the end of a fiscal year.
- The accounting treatment of "transition" or "one-time" costs and revenue.
- The provision of cash advances to deal with cash flow issues during a year.

During the course of the Capital Redevelopment Project, GGH experienced operating funding pressures. The Ministry and GGH worked together to resolve these challenges. All of the methods described above were employed in the process. With the most recent funding announcement (June 2002), operational funding issues have been substantially resolved.

The path followed to arrive at the 2002/03 funding announcement has been difficult. Considerable efforts have been expended by all parties to develop program transfer budgets that fairly represent the requirements of the hospital and recognize the funding constraints under which the Ministry operates.

The current level of operational funding deals with most of the operational funding issues that GGH has had. In the covering letter sent with the recent funding announcement, the Ministry stated clearly that they now consider the PCOP process to be closed. Like every other hospital in the province, negotiations around program and service expansions in select areas are ongoing. Recommendations in this area therefore focus on lessons learned. These include:

- The Program Funding Transfer Methodologies developed for GGH preceded the more formal methodology subsequently developed for HSRC mandated moves. GGH worked with the Ministry and external consultants to develop an approach that was designed to meet the needs of all parties (PCOP). This approach was based on existing program transfer approaches and was influenced by the methodologies adopted by HSRC.

- The approach followed by GGH was based on their understanding of directions given by Ministry staff. As a result, misunderstandings developed between GGH and the Ministry. Some of the assumptions used in the process were never formally documented or confirmed with the Ministry.

- With any negotiations around operational funding hospitals need to understand the process followed at the Ministry. The expectations of the Board failed to recognize the timelines and process required by the Ministry. Appropriate understanding of the process by all parties would have helped to ensure realistic expectations were set.

- With the 2002/03 funding announcements, it is worth noting the GGH and Ministry generated PCOP come close to the same total projected costs. The approach followed by the two parties may have had significant differences. The end result, however, is similar. This highlights the need to communicate and clearly define and document any assumptions made in the process.

All parties need to work with a common set of assumptions and principles in the financial and costing components of any PCOP. This should include:

- Agreement on what costs are going to be included in any analysis.
- A clear methodology for developing unit costs.
- A definition of unit cost efficiency expectations.
- A review of funding constraints, including limits of funding available from the hospital transferring programs.

These issues need to be resolved at the start of any process. PCOPs cannot simply be based on the operating costs at the receiving site. As a result, unit costs may have to be reduced in order to meet available funding envelopes.

Recommendations

We recommend that:

(24) The Ministry develop documented definitions and procedures for PCOPs that are reviewed and agreed by all parties before the plans are developed.

(25) The GGH Board and Senior Management undertake an educational program to understand the process followed by the Ministry when evaluating capital projects and approving operating fund allocations.

(26) The Ministry Regional Team and GGH Senior Management meet to discuss the misunderstandings and assumptions that have led to the current tensions between both parties, and to develop an improved process of communications and collaboration for the future.

The ability of GGH to maintain its unit cost efficiency levels throughout the Capital Redevelopment Project were discussed previously. This level of performance is not

typical for hospitals undergoing change of the magnitude experienced at GGH. A number of practices employed by GGH can be highlighted for any other hospital dealing with major restructuring:

- Departmental budgets were not simply combined as programs and services merged. New budgets were established for all departments and cost centres as part of the PCOP process.

- The new budgets established were not based on existing departmental cost-structures. A group of comparator hospitals was established and budgets were based on setting key performance indicators at the twenty-fifth percentile mark for the group.

- In essence, a zero-based budget approach was adopted and each department was challenged to operate in the top quartile of the comparator group.

For GGH, the misunderstandings between the hospital and the Ministry, and the resulting tensions that developed, could have been avoided through improved communication and better understanding of each other's perspective. Management of operating funds is efficient and effective at GGH. The only issues here are related to communication and understanding.

Recommendation

We recommend that:

(27) The Ministry consider the GGH approach to developing an operating budget as a template for hospitals in similar situations.

5.3 Working capital

Working capital has been a continuing problem for GGH throughout the capital redevelopment project. Exhibit 3 shows the status of working capital over the past seven years.

Exhibit 3

Working Capital Performance

Guelph General Hospital
Working Capital - Continuity Schedule
A:\[g1.xls]WorkingCap

03-Jul-02

	1995/96	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	
Current Assets								
Cash	324,874				3,496,498	5,105,936		
Accounts Receivable	2,832,078	2,330,751	2,671,101	3,219,962	2,693,889	1,906,935	2,496,377	**
Inventories	590,624	500,000	579,266	559,302	564,124	544,989	820,472	
Prepaid Expenses & Deferred Charges	183,805	100,000	181,268	174,124	132,220	196,603	292,078	
Other Current Assets				32,014	2,570,159	0	0	
Total Current Assets	3,931,381	2,930,751	3,431,635	3,985,402	9,456,890	7,754,463	3,608,927	
Current Liabilities								
Short Term Borrowings		2,884,675	1,231,731	5,093			2,201,437	
Accounts Payable	3,147,774	2,209,724	3,015,266	1,946,381	5,482,141	5,955,942	2,680,836	
Employer Remittances	542,340	550,064	331,698	181,079	248,410	301,592	1,010,294	
Accrued Salaries	442,266	511,811	757,483	597,355	871,306	1,131,481	1,720,576	
Accrued Salaries - Under Negotiation	286,321			1,205,094	500,000	400,000		
Vacation Benefits Payable	1,779,755	1,706,465	1,346,183	1,333,611	1,552,122	1,831,233	2,372,937	
Statutary Holiday Benefits Payable			16,326	7,489	17,984	16,518	70,106	
Sick Leave Benefits	388,611	290,126	258,004	243,547	240,820	227,670	227,670	
Other Accrued Liabilities	301,278	247,741	628,048	1,759,072	5,236,345	1,025,789	253,644	
Payable to Foundation*	2,086,473	1,421,676	1,279,951	1,345,041	1,403,823	1,435,611	1,259,150	
Total Current Liabilities	8,974,818	9,822,282	8,864,690	8,623,762	15,552,951	12,325,836	11,796,650	
Working Capital Surplus/(Deficit)	(5,043,437)	(6,891,531)	(5,433,055)	(4,638,360)	(6,096,061)	(4,571,373)	(8,187,723)	
Current Ratio	0.438	0.298	0.387	0.462	0.608	0.629	0.306	**

Notes:

* Payable to Foundation for 1995/96 and 1996/97 restated as "current" liability. This loan is a deman loan, and therefore reclassified by auditors as a current liability in 1997/98.

** Hospital has not set up Ministry of Health receivable for "Restructuring" application for 2001/02 fiscal year. Total Restructuring costs for that fiscal year of $1,815,160. Potential receivable at 85% about $1.5 million. This would improve our working capital deficit and improve the current ratio to 0.433.

As noted previously, a review of annual financial statements does not always describe the true nature of the situation. Exhibit 3 shows a steadily deteriorating working capital position as reported at the end of each fiscal year. This picture does not fully reflect the cash situation of GGH during the Capital Redevelopment Project. The growth in the working capital deficit over the past year can be attributed to unfunded one-time costs associated with the Capital Redevelopment Project and equipment purchases. A long-term equipment purchase plan has been developed that projects equipment purchases that will have adequate funding sources by 2003/04 and will not have an impact on working capital. GGH has expensed all restructuring costs incurred in 2001/02 not approved by the Ministry for reimbursement. These expenses amounted to $1.8 million.

This accounting practice complies with the approach recommended by the Ministry. The Ministry has indicated that these expenses will not be eligible for reimbursement. One-time expenditures should also decline with the winding down of the Capital Redevelopment Project.

It should be noted that the working capital deficit had its origins before any capital redevelopment construction started. In 1995/96, a working capital deficit was reported (see Exhibit 3), and the net increase since that time has been modest.

Solutions to the working capital position need to be developed as a part of the recovery plan. Given the magnitude of the working capital issue across the province, the solutions for GGH will have to be multi-year, and will require contributions from GGH. Living with a balanced budget will not be adequate. The plan will need to take steps to restore working capital and build a sustainable and healthy organization.

Recommendation

We recommend that:

(28) The GGH Board develop a recovery plan to address the balance sheet.

5.4 PCOP/Budgeting

The annual operational planning and budgeting process has been a significant source of stress and conflict between GGH and the Ministry over the past few years. The process to develop, review and agree upon a PCOP methodology has been a long and drawn out process. Obtaining agreement on the approach to be followed and securing funding has taken longer than either party expected. This necessitated the use of one-time funding and the provision of cash advances to permit GGH to survive through this difficult period.

As noted previously, a clear agreement on methodology before initiating a PCOP process and ensuring all parties were aligned with the process that needs to be followed at the Ministry to secure funding would have contributed to a much better process for both parties.

GGH has a number of unique features in their PCOP/budgets.

- Program transfers occurred in advance of agreement being reached on the level of operating support or funding. This necessitated the development of departmental budgets that assumed the PCOP would be approved.

- The PCOP, Operating Budget and Operating Plan submission to the Ministry were identical. This is not a practice that is widely followed across the province. It is however a practice that contributed to difficult negotiations between the Ministry and GGH. By attempting to ensure the different documents remained consistent, GGH created an impression of being inflexible. For example, the application of accounting practices in one set of documents that may not have been appropriate in another, given the needs and requirements of different users, led to unnecessary misunderstandings and confusion.

GGH is to be commended for attempting to maintain consistency between the different Plans/Budgets. However, if both parties had understood this and the Ministry and

hospital representatives had been able to discuss issues without acrimony, the lack of trust and the concern about financial management processes that developed over the past few years would very likely never have occurred.

The Ministry and GGH are proactively working to develop and enhance their relationship, and positive outcomes are already noted by both parties.

5.5 Capital financing

Observations around the budgeting, managing and financing of the capital project were made in the discussion of project management in Chapter 3. Overall, we concluded that the project manager was very aggressive in the management of the budget and came very close to schedules and enhanced budgets for the construction under very trying circumstances. This is reflected in the capital financing arena, which also had few surprises. Exhibit 4 presents a summary of activity for the project.

Exhibit 4
GGH Redevelopment Project – Final Summary of Activity (May 2002)

Guelph General Hospital					
Redevelopment Project - Summary of Activity (Final - May02)					
A:\[g3.xls]Project Funding					
	Total Cost of Redevelopment	**Ministry of Health Portion**	**City of Guelph**	**County of Wellington**	**Guelph General Hospital**
General Ledger Accounts		011.405.850002	011.405.850005	011.405.850006	
Approved Amounts					
Original Project Amount - 1997	$ 68,991,283	$ 45,950,667	$ 20,304,796	$ 2,650,104	$ 85,716
Expanded Project Amounts - 2000					
First Submission	2,777,129	1,851,095	768,608	157,426	
Second Submission	4,333,532	2,889,021	1,198,944	245,567	
Non-shareable Expenses (paving & landscaping)	340,000		282,200	57,800	
Subtotal Expanded Project Amount	7,450,661	4,740,116	2,249,752	460,793	-
Total Project Costs Approved	**$ 76,441,944**	**$ 50,690,783**	**$ 22,554,548**	**$ 3,110,897**	**$ 85,716**
Funding Received					
Amounts Advanced as of March 31, 2001	71,233,208	49,897,703	18,662,570	2,672,935	
Amounts received in 2001/02:					
Funding Received Apr-01			622,594	-	
Funding Received Sept 25, 2001			2,931,098		
Funding Received Jan 7, 2002				226,647	
Funding Received May 22, 2002			338,287		
Funding receivable at year end				211,315	
Amounts Received To Date	**75,563,148**	**49,897,703**	**22,554,549**	**3,110,897**	
Amounts Owing	**$ 793,080**	**$ 793,080**	**$ (0)**	**$ 0**	

The major outstanding question at this time deals with the financing of the three story addition. No major amounts are outstanding with the project and the community has met its obligations with regard to their share of capital costs.

Exhibit 4 deals with costs directly associated with the Capital Redevelopment Project. Total identified project costs and total funding received for the project were very close. Consequently, the project did not have a major impact on the deteriorating working capital position. A question has been raised about whether there were additional costs associated with the project that were recorded outside of the redevelopment project. Typically, such costs would be included in capital equipment purchases. Analysis of this is complicated by the fact that, throughout any major capital project, a hospital must maintain, repair and replace existing equipment in addition to providing for the capital expansion. At times, the distinction between these two areas is not readily apparent.

Exhibit 5 presents a summary of the capital equipment budget/plan for GGH.

Exhibit 5
GGH Capital Budget – Funding Projection

Guelph General Hospital 31-Jul-02

Capital Budget - Funding Projection

	1999/00	2000/01	2001/02*	2002/03	2003/04	2004/05	Total
Sources							
Redevelopment project	$10,315,246						$10,315,246
Y2K compliance funding	$1,215,981						$1,215,981
Other reserves/donations	$168,175	$30,000					$198,175
Change Order 1		$535,592					$535,592
Change Order 2			$450,336				$450,336
Depreciation	$833,868	$834,989	$1,700,000	$2,300,000	$2,300,000	$2,300,000	$10,268,857
SuperBuild (Province)			$852,983		$0	$0	$852,983
Partners for Better Health Campaign		$982,900	$937,370	$1,402,200	$1,451,200	$1,426,330	$6,200,000
GGH Foundation	$613,766	$255,395	$182,008	$350,000	$400,000	$450,000	$2,251,169
	$13,147,036	$2,638,876	$4,122,697	$4,052,200	$4,151,200	$4,176,330	$32,288,339
Purchases							
Total annual purchases	$11,783,242	$4,541,348	$5,592,643	$5,709,647	$1,997,164	$827,455	$30,451,500
Cumulative purchases	$11,783,242	$16,324,591	$21,917,234	$27,626,881	$29,624,045	$30,451,500	
Surplus <Deficiency>	$1,363,794	-$1,902,472	-$1,469,946	-$1,657,447	$2,154,036	$3,348,875	$1,836,839
Cumulative cash flow	$1,363,794	-$538,679	-$2,008,625	-$3,666,072	-$1,512,036	$1,836,839	

Additional Y2K funding was also provided for capital equipment during the period under review. At the end of 2001/02, capital equipment purchase costs for the period from 1999/2000 (three years) amounted to $21.9 million. Capital equipment revenue over the same period was approximately $19.9 million. The resulting deficit contributed to the working capital deficit for last year. The capital equipment plan projects this deficiency will be eliminated by 2003/04 and needs to be built into the recovery and operating plan for GGH.