Thunder Bay Regional Health Sciences Centre

Board of Directors
Open Meeting
Wednesday, June 8, 2016 – 5:00 pm Boardroom, Level 3, TBRHSC
980 Oliver Road, Thunder Bay
AGENDA

Vision: *Healthy Together*
Mission: *We will deliver a quality patient experience in an academic health care environment that is responsive to the needs of the population of Northwestern Ontario*
Values: *Patients ARE First (Accountability, Respect and Excellence)*

#	Time (X)	Presenter	Item & Purpose (Y)	Expected Outcome (Z)			
				Recommendation /Decision/Action	Education	Discussion	Information
1.0	**CALL TO ORDER**						
2.0	**PATIENT STORY** –*Dr. Stewart Kennedy*						
3.1	1	N. Doucette	Quorum (8 members total required, 6 being voting)				
3.2	1	N. Doucette	Conflict of Interest				
3.3	1	N. Doucette	Approval of the Agenda	X			
3.4	3	N. Doucette	Chair's Remarks*				X
4.0	**PRESENTATIONS/EDUCATION**						
4.1	20	Dr. Kennedy	Physician Staffing Planning in the Region*		X		
4.2	20	Dr. Polonsky J. Bartkowiak	Thunder Bay Regional Research Institute Update*				X
5.0	**CONSENT AGENDA**						
5.1	-		Board of Directors Minutes – May 4, 2016*	X			X
5.2	-		Resource Planning Committee Meeting - May 17, 2016 5.2.1 Broader Public Sector Travel and Expense Report, for the period October 1, 2015 to March 31, 2016* 5.2.2 Broader Public Sector Accountability Act Attestation Certificate, for the period April 1, 2015 to March 31, 2016* 5.2.3 Hospital Service Accountability Agreement Declaration of Compliance for the period of April 1, 2015 to March 31, 2016* 5.2.4 Multi Sector Service Accountability Agreement Declaration of Compliance for the period of April 1, 2015 to March 31, 2016*				
5.3	-		Governance Committee Minutes – May 18, 2016* 5.3.1 Committee Work Plans* 5.3.2 Committee Terms of Reference* 5.3.3 Policies a. BD-81 Roles and Responsibilities of the Board* b. BD-45 Selection Criteria for Board and Community Members* c. BD-25 Education and Development*				

#	Time (X)	Presenter	Item & Purpose (Y)	Expected Outcome (Z)			
				Recommendation /Decision/Action	Education	Discussion	Information
			d. BD-55 CEO Succession Planning* e. BD-XX Criminal Record Checks for Board of Directors* 5.3.4 2020 Strategic Plan Values* 5.3.5 Framework for Ethical Decision Making* 5.3.6 By-Law Amendment*				
5.4	-		Accreditation Sub Committee Minutes – May 4, 2016				X
5.5	-		Accreditation Sub Committee Minutes – May 17, 2016				X
6.0	**REPORTS AND DISCUSSION**						
6.1	10	Senior Management	Report from Senior Leadership*	X		X	X
6.1.1	-	P. Myllymaa	Environmental Compliance and Fire Safety Update				X
6.2	10	J. Bartkowiak	Report from the President and CEO*			X	X
6.2.1	10	J. Bartkowiak	Board meeting Frequency*			X	
6.3	5	G. Craig	Report from the TBRHS Foundation*			X	X
6.4	5	Dr. Thibert	Report from the Professional Staff Association			X	X
6.5	5	Dr. Porter	Report from the Chief of Staff*			X	X
6.6	5	Dr. Crocker Ellacott	Report from the Chief Nursing Executive*			X	X
6.7	5	Dr. Moody-Corbett	Report from the Northern Ontario School of Medicine (NOSM)*			X	X
7.0	**COMMITTEE MATTERS** - None						
8.0	**FOR INFORMATION**						
8.1	-		Board Comprehensive Work Plan*				X
8.2	-		Webcast Statistics*				X
8.3	-		Report Thunder Bay Regional Research Institute*				X
8.4	-		Quarterly Performance Results (Scorecard)*				X
8.5	-		Strategic Indicators Summary Views*				X
8.6	-		REB Annual Report*				X
8.7	-		Critical Incidents Update*				X
9.0	**BOARD MEMBER COMMENTS**					X	
10.0	**DATE OF NEXT MEETING** – TBD						X
11.0	**ADJOURNMENT**						

Ethical Framework

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.

The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs & values of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate '**Respect**' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

http://intranet.tbrhsc.net/Site_Published/i5/render.aspx?DocumentRender.IdType=5&DocumentRender.Id=110784

BOARD OF DIRECTORS (Open) - REVISED
June 8, 2016 – DRAFT

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
3.3	Agenda – June 8, 2016	"That the Agenda be approved as circulated."	Moved by: Seconded by:
5.0	Consent Agenda	"That the Board of Directors: 5.1 Approves the Board of Directors Minutes of May 4, 2016; 5.2.1 Approves the Broader Public Sector Travel and Expense Report, for the period October 1, 2015 to March 31, 2016, upon recommendation from the Resource Planning Committee; 5.2.2 Approves the Broader Public Sector Accountability Act Attestation Certificate, for the period April 1, 2015 to March 31, 2016, in accordance with Section 15 of the Broader Public Sector Accountability Act, 2010, confirming that the Hospital attests to: (i) the completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants; (ii) the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds; (iii) the Hospital's compliance with any applicable expense claims directives issued under section 10 of the BPSAA by the Management Board of Cabinet; (iv) the Hospital's compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet; (v) the Hospital's compliance with any applicable procurement and directives issued under section 12 of the BPSAA by the Management Board of Cabinet, upon recommendation from the Resource Planning Committee; 5.2.3 Approves the Hospital Service Accountability Agreement Declaration of Compliance for the period of April 1, 2015 to March 31, 2016 confirming that the Hospital has complied with the following:	Moved by: Seconded by:

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
		(i) the HSP has complied with the provisions of the Local Health System Integration Act, 2006 and the Broader Public Sector Accountability Act (the "BPSAA") that apply to the HSP; (ii) the HSP has complied with its obligations in respect of CritiCall that are set out in the Agreement; (iii) every Report submitted by the HSP is complete, accurate in all respects and in full compliance with the terms of the Agreement; and; (iv) the representations, warranties and covenants made by the Board on behalf of the HSP in the Agreement remain in full force and effect, upon recommendation from the Resource Planning Committee; 5.2.4 Approves the Multi Sector Service Accountability Agreement Declaration of Compliance for the period of April 1, 2015 to March 31, 2016 confirming that the Hospital has complied with the following: (i) Article 4.8 of the M-SAA concerning applicable procurement practices; (ii) The Local Health System Integration Act, 2006; and (iii) The Public Sector Compensation Restraint to Protect Services Act, 2010; (iv) The following specific performance requirements as outlined in Schedule E4 of the 2014-2017 M-SAA: a. "Home First" Philosophy b. Diversity Planning requirement c. Behavioural Supports Ontario Action Plan d. Emergency Preparedness Plans e. E-Health requirement f. Information Technology requirement g. Health Services Blueprint — Community Engagement, upon recommendation from the Resource Planning Committee; 5.3 Accepts the Governance Committee Minutes of May 18, 2016; 5.3.1 Approves the 2016-2017 workplans for the Audit Committee, Fiscal	

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
		Advisory Committee, Resource Planning Committee, Governance/Nominating Committee and Quality Committee, as recommended by the Governance Committee; 5.3.2 Approves the terms of reference for the Audit Committee, Fiscal Advisory Committee, Resource Planning Committee, and Board/Privileged Staff Committee, upon recommendation from the Governance Committee ; 5.3.3a Approves changes to Policy BD-81 Roles and Responsibilities of the Board, upon recommendation from the Governance Committee; 5.3.3b Approves changes to Policy BD-45 Selection Criteria for Board and Community Members, upon recommendation from the Governance Committee; 5.3.3c Approves changes to Policy BD-25 Education and Development, upon recommendation from the Governance Committee; 5.3.3d Approves changes to Policy BD-55 CEO Succession Planning, upon recommendation from the Governance Committee; 5.3.3e Approves the Policy Criminal Record Checks for Board of Directors Policy, upon recommendation from the Governance Committee; 5.3.4 Approves the amendment to the 2020 Strategic Plan Values statement, upon recommendation from the Governance Committee; 5.3.5 Accepts amendments to the Framework for Ethical Decision Making, upon recommendation from the Governance Committee; 5.3.6 Approves the proposed changes to the Thunder Bay Regional Health Sciences Centre Corporate By-Laws to be confirmed at the Annual Meeting of the Corporation, upon recommendation from the Governance Committee, 5.4 Accepts the Accreditation Sub Committee Minutes of May 4, 2016; 5.5 Accepts the Accreditation Sub Committee Minutes of May 17, 2016, as presented."	
6.0	Reports and Discussion	"That the Board of Directors:	Moved by:

Agenda Item	Committee or Report	Motion or Recommendation	Approved or Accepted by:
		6.1Accepts the Report from Senior Leadership; 6.2 Accepts the Report from the President and CEO; 6.3 Accepts the Report from the TBRHS Foundation; 6.4 Accepts the Report from the Professional Staff Association; 6.5 Accepts the Report from the Acting Chief of Staff; 6.6 Accepts the Report from the Chief Nursing Executive; 6.7 Receives the Report from the Northern Ontario School of Medicine; Dated June, 2016 as presented."	Seconded by:

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6183
www.tbrhsc.net

Board of Directors
Conseil d'administration

Report from Nadine Doucette
Chair, Board of Directors
June 8, 2016

I am pleased to report that after several years of operating in an almost-constant state of surge capacity, the number of days operating in "Code Gridlock" has been drastically reduced. We have been out of surge capacity for 30 days of the last 35 (April 26-May30, 2016 inclusive). This is great news for everyone. Although the quality of care provided is never compromised, the strain of operating in surge capacity takes a toll on patients and families, as well as physicians, staff and volunteers, and it has a negative impact on our financial status.

This change did not occur without great effort. It has been a priority of the Board of Directors and the senior leadership team and as it is a complex, system-based issue, identifying solutions involved working closely with our partners along the way.

I am incredibly proud of the many individuals who have worked relentlessly to move us out of surge capacity. I applaud the entire Health Sciences Centre team for successfully implementing many initiatives and changes – large and small - to produce these results. I also celebrate the team's ongoing commitment to our patients and their families, regardless of capacity. Patient and Family Centred Care is truly at the centre of everything they do.

Recent successes do not mean we rest. We are committed to ongoing improvement, and will strive to eliminate days in surge capacity.

We are also seeking to improve our accessible environment for patients and families, visitors, volunteers and staff requiring accommodation. As we begin to develop the next five-year Accessibility Plan for our organization, we are inviting input from the community. I invite you to take a moment to complete our Accessibility survey at www.tbrhsc.net, and ask that you encourage others to do the same. This will help us to identify the most meaningful and impactful activities and changes we can implement.

Finally, I am pleased to share that staying connected to family and friends while at our Health Sciences Centre has become a lot easier thanks to a partnership with Tbaytel, Free WiFi is now accessible to patients, families and visitors throughout the Hospital. Providing WiFi is another opportunity to enhance patient experiences at Thunder Bay Regional Health Sciences Centre. It is through partnerships and collaborations such as this that we are able to advance and be *healthy together*.

Overview of Human Resources in Ontario and the Impact at Thunder Bay Regional Health Sciences Centre

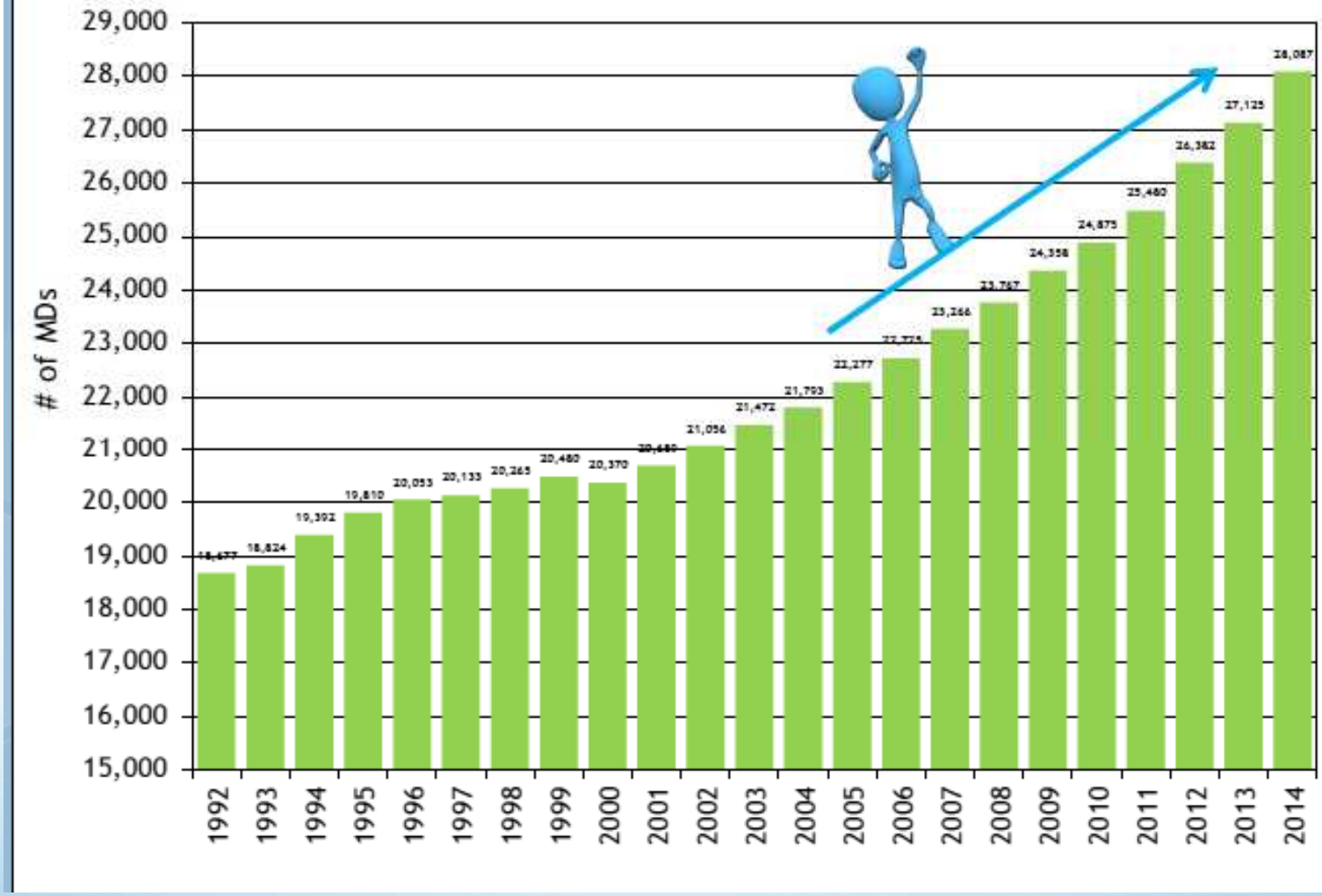
TBRHSC Board Meeting: June 8, 2016

Dr. Stewart Kennedy
EVP Medical & Academic Affairs

Outline

- Current status of MD Resources in Ontario
- Current status of MD Resources at Thunder Bay Regional Health Sciences Centre
- Projected 5 year plan by Department at Thunder Bay Regional Health Sciences Centre

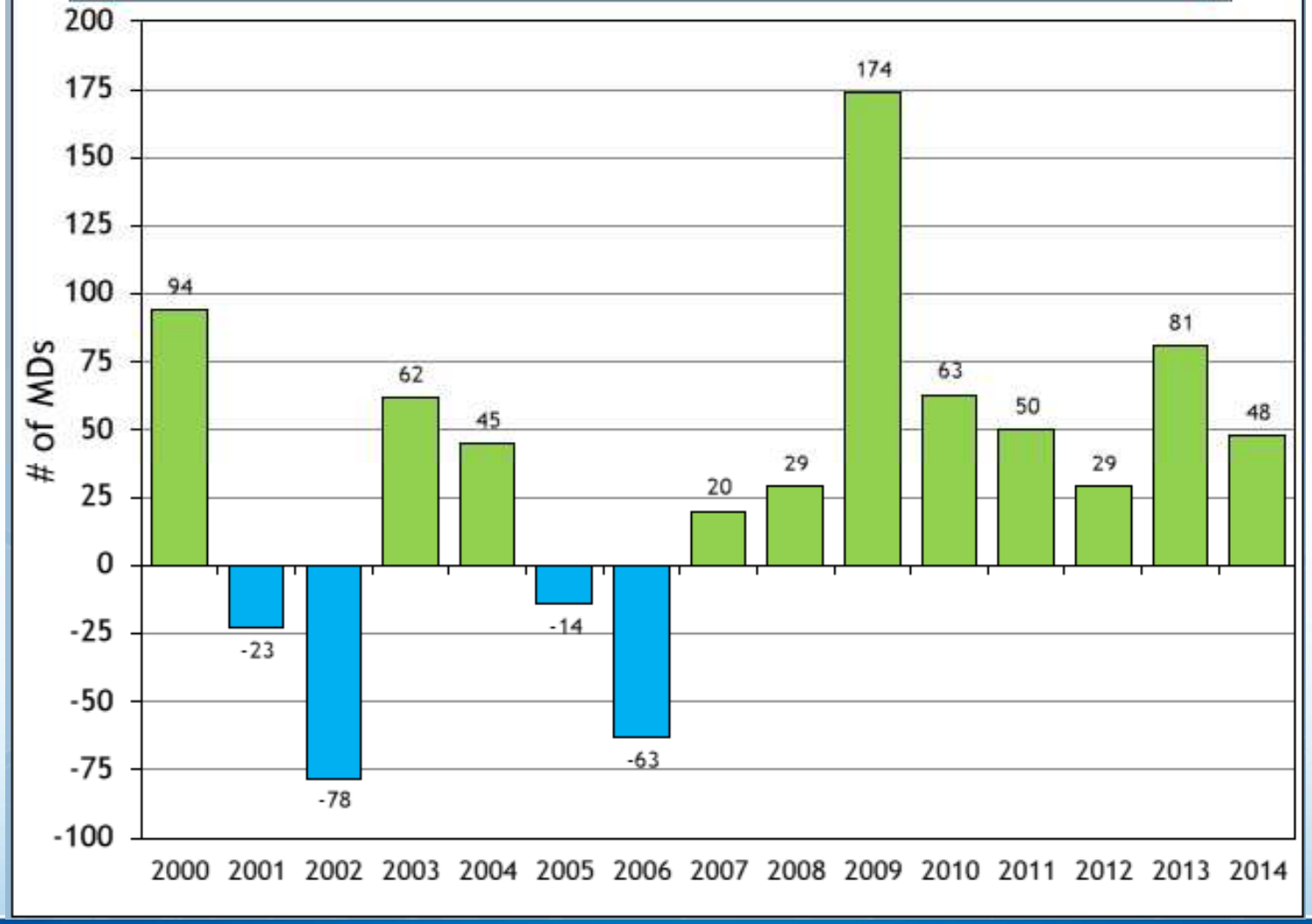
Total Ontario Physician Supply, 1992-2014



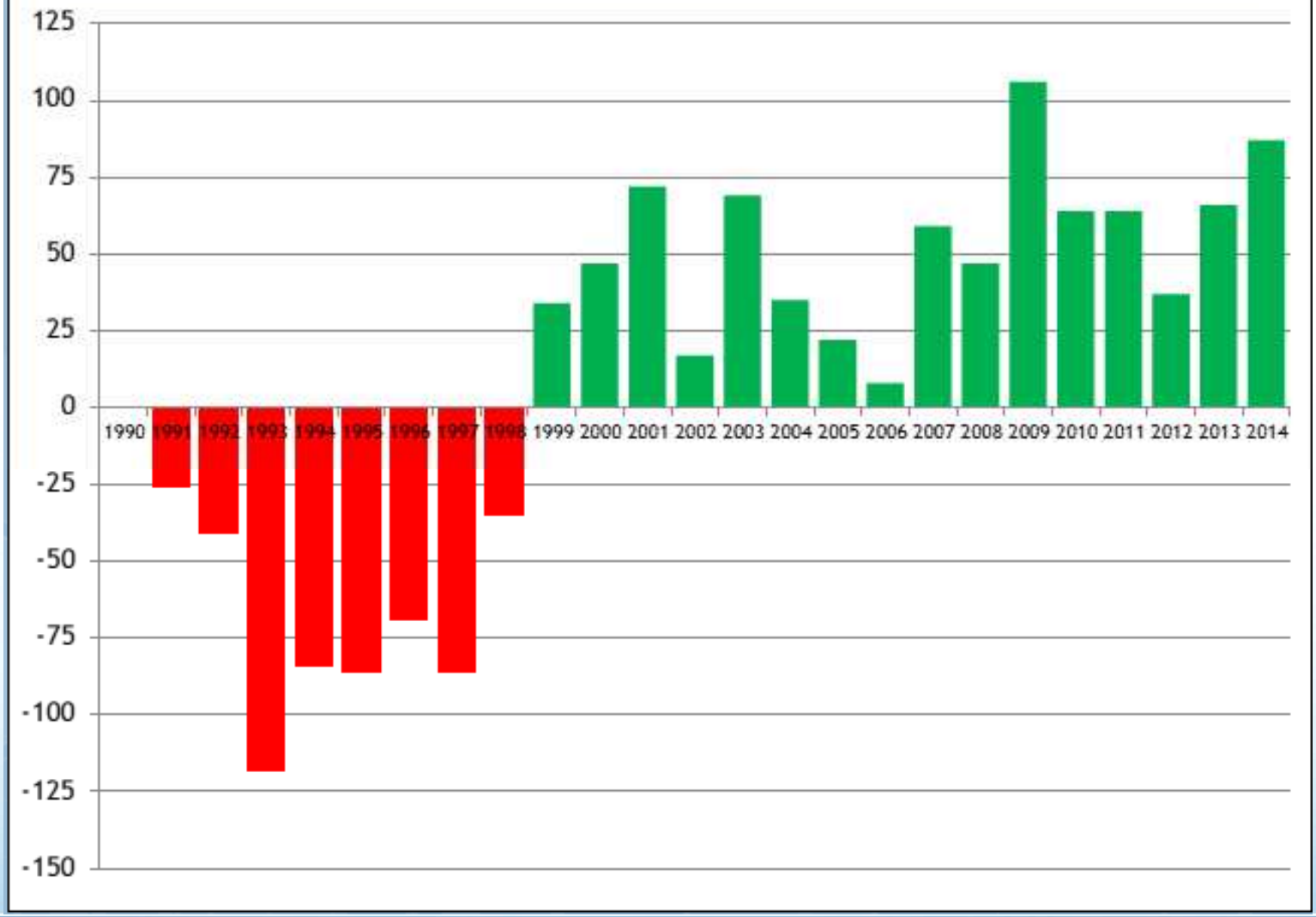
Thunder Bay Regional Health Sciences Centre

healthy together

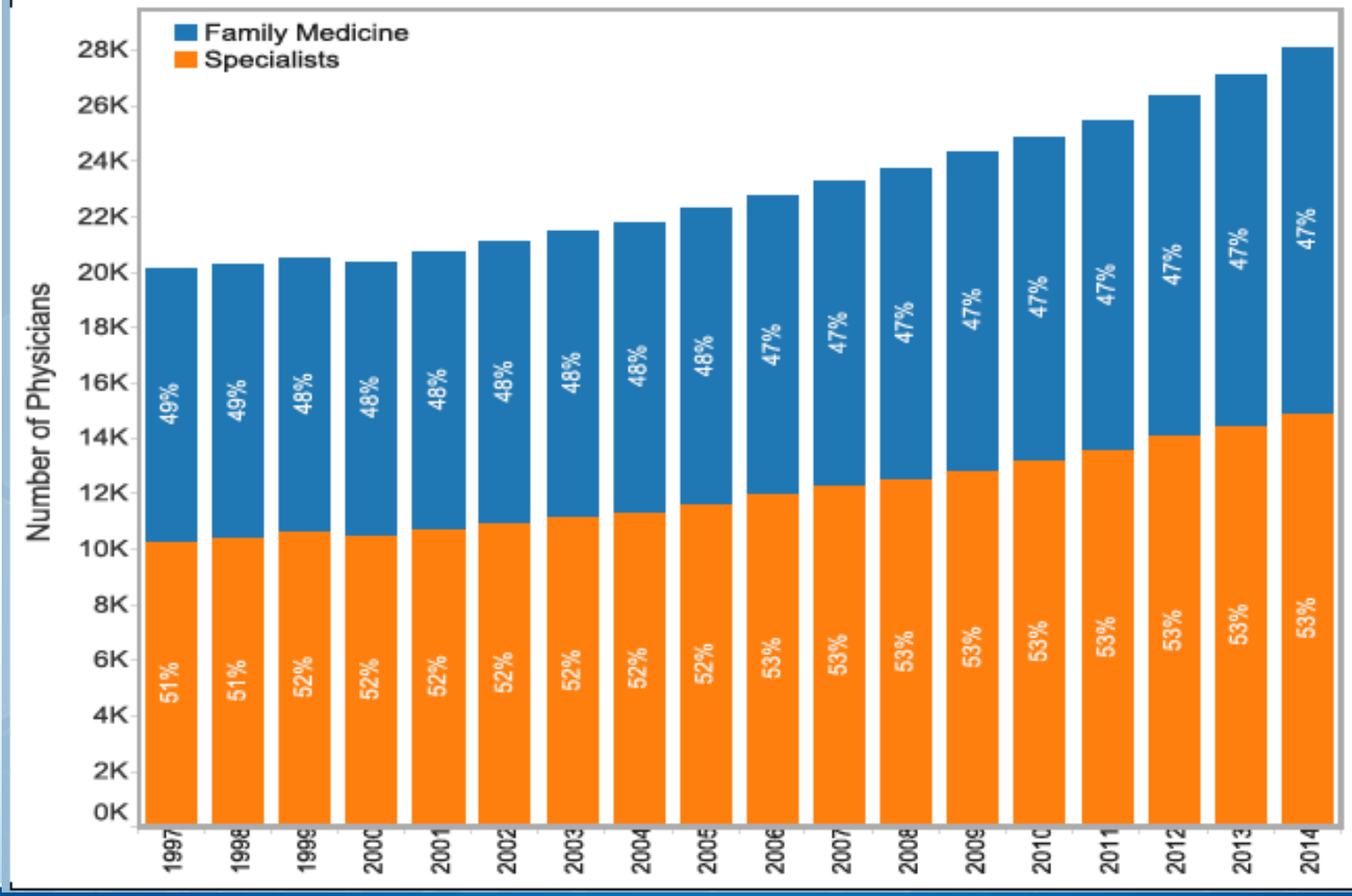
Net Total Migration of MDs to Ontario



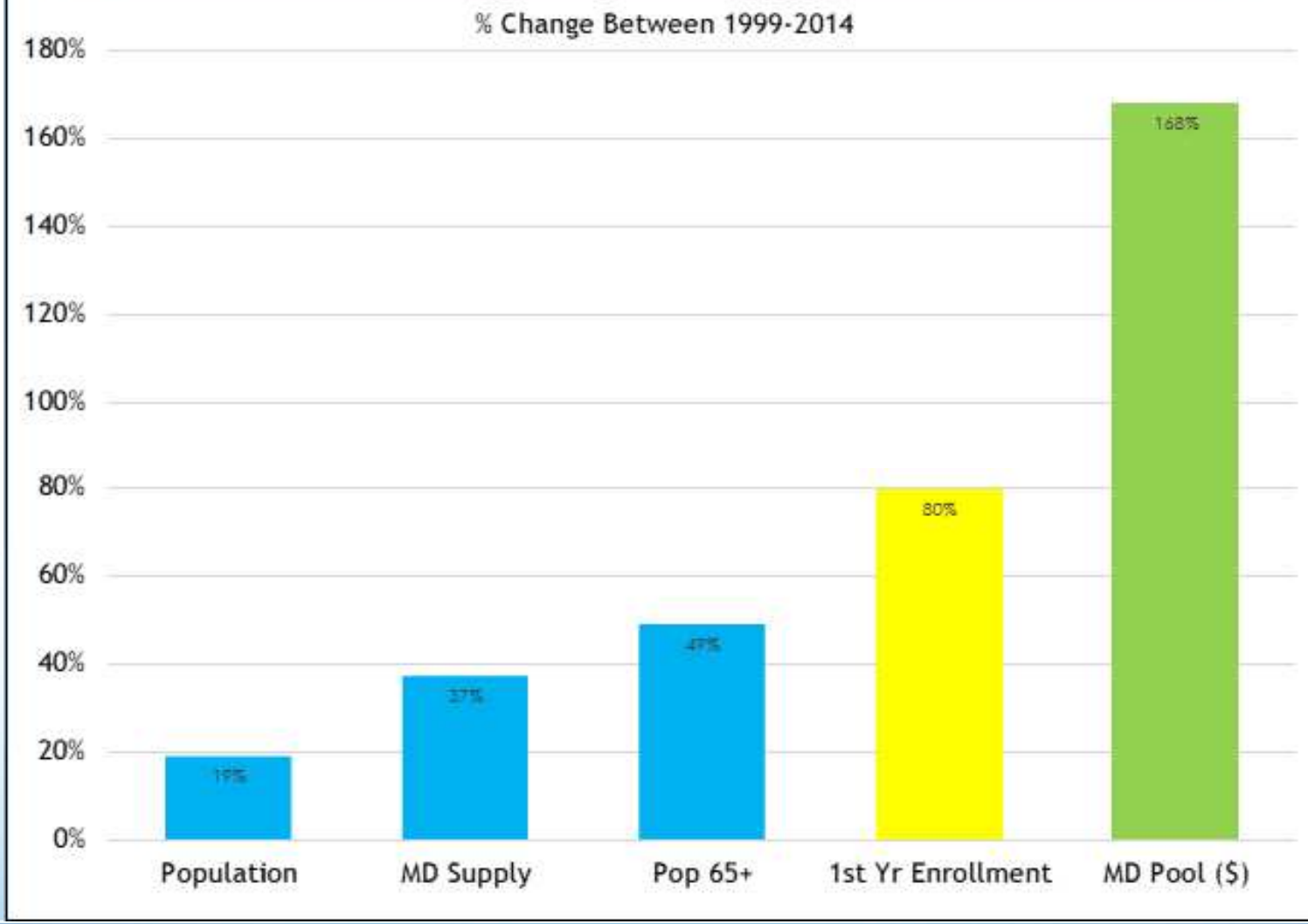
Net GP Migration - Ontario



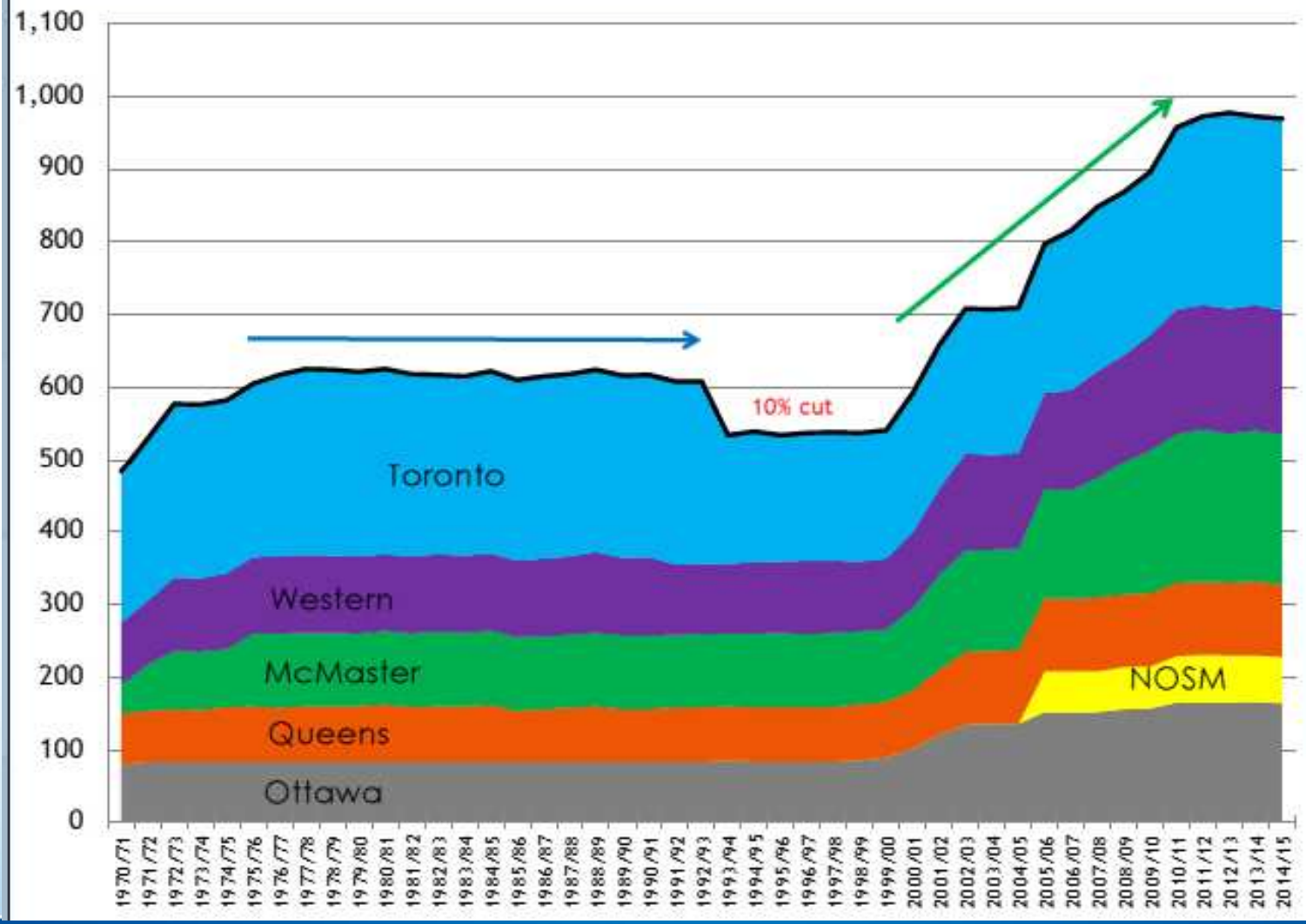
Active Physicians by FM & Spec and Year



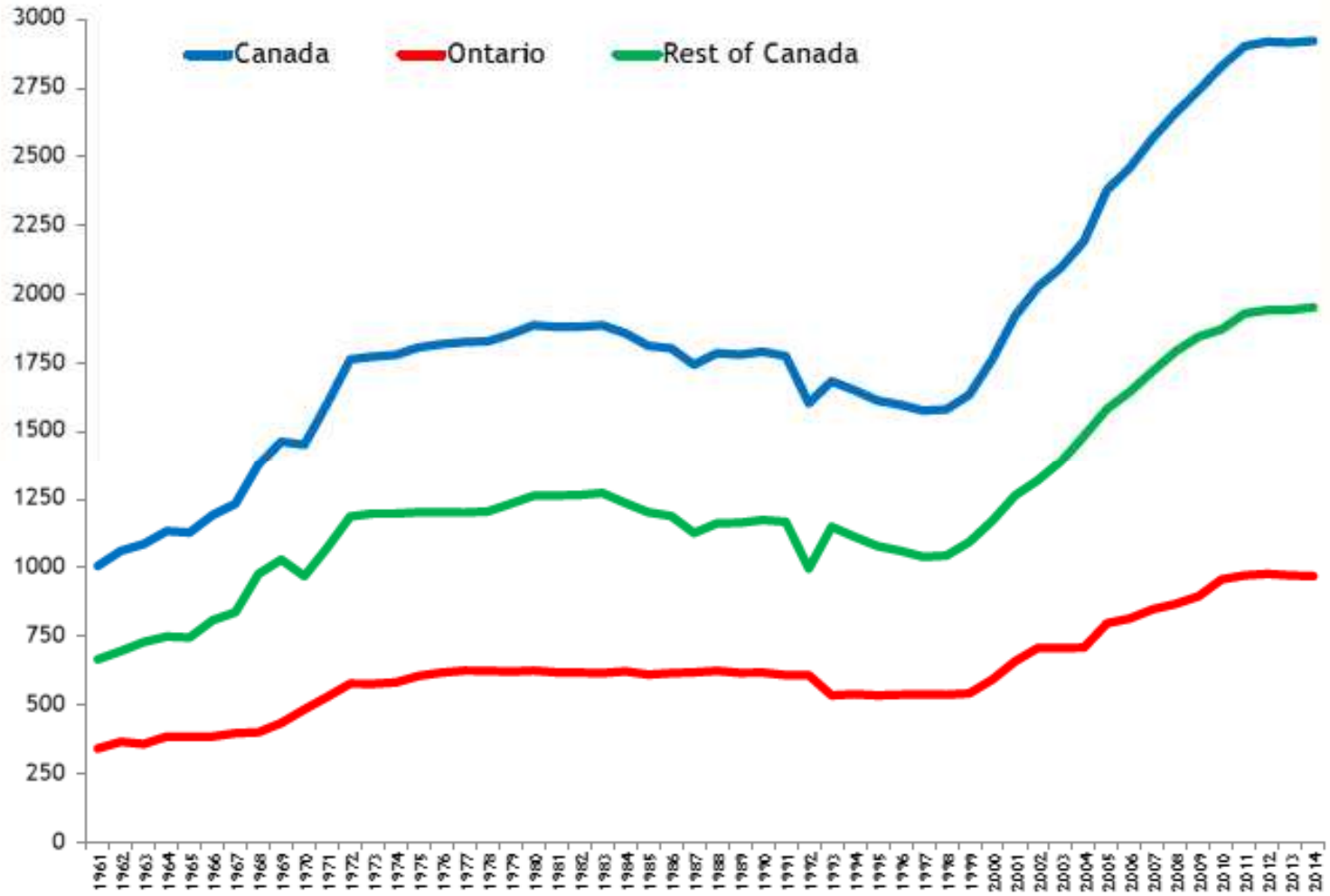
What else has changed since 1999?



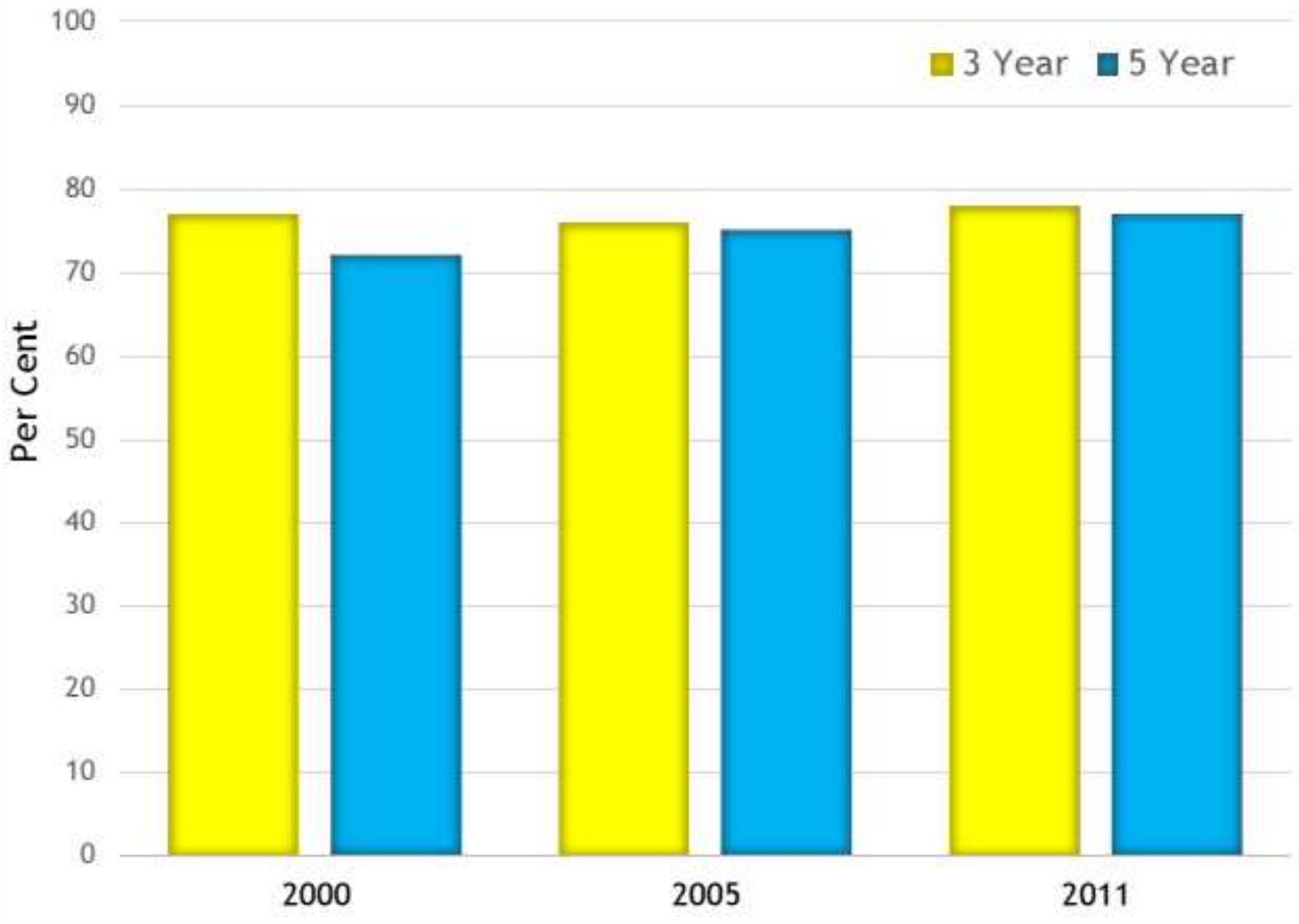
First Year Enrollment in Ontario Medical School



First Year Enrolment in Canadian Faculties of Medicine, 1970-2014



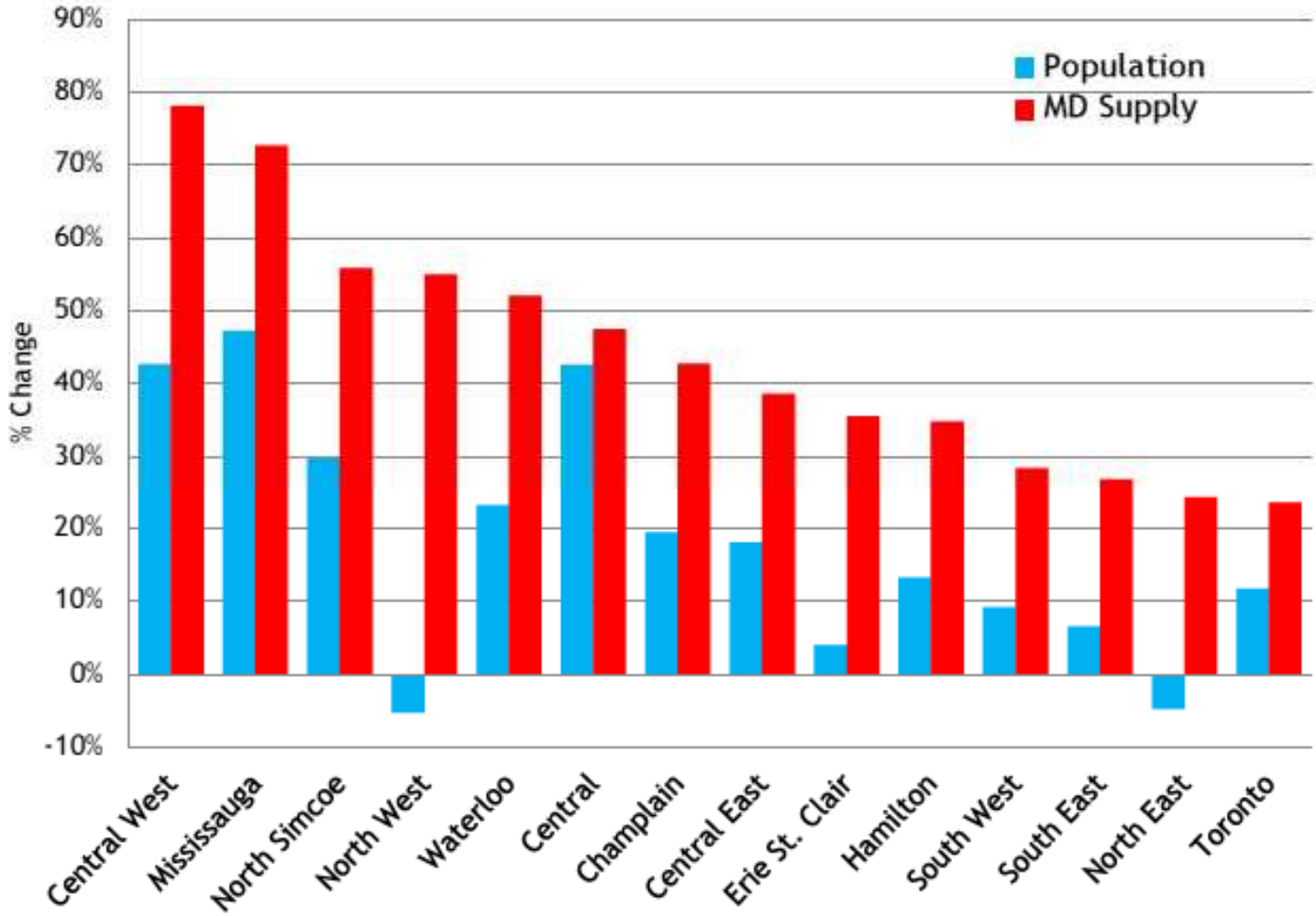
Percent of Ont Post-MD Trainees located in Ontario, 3 & 5 Years Later



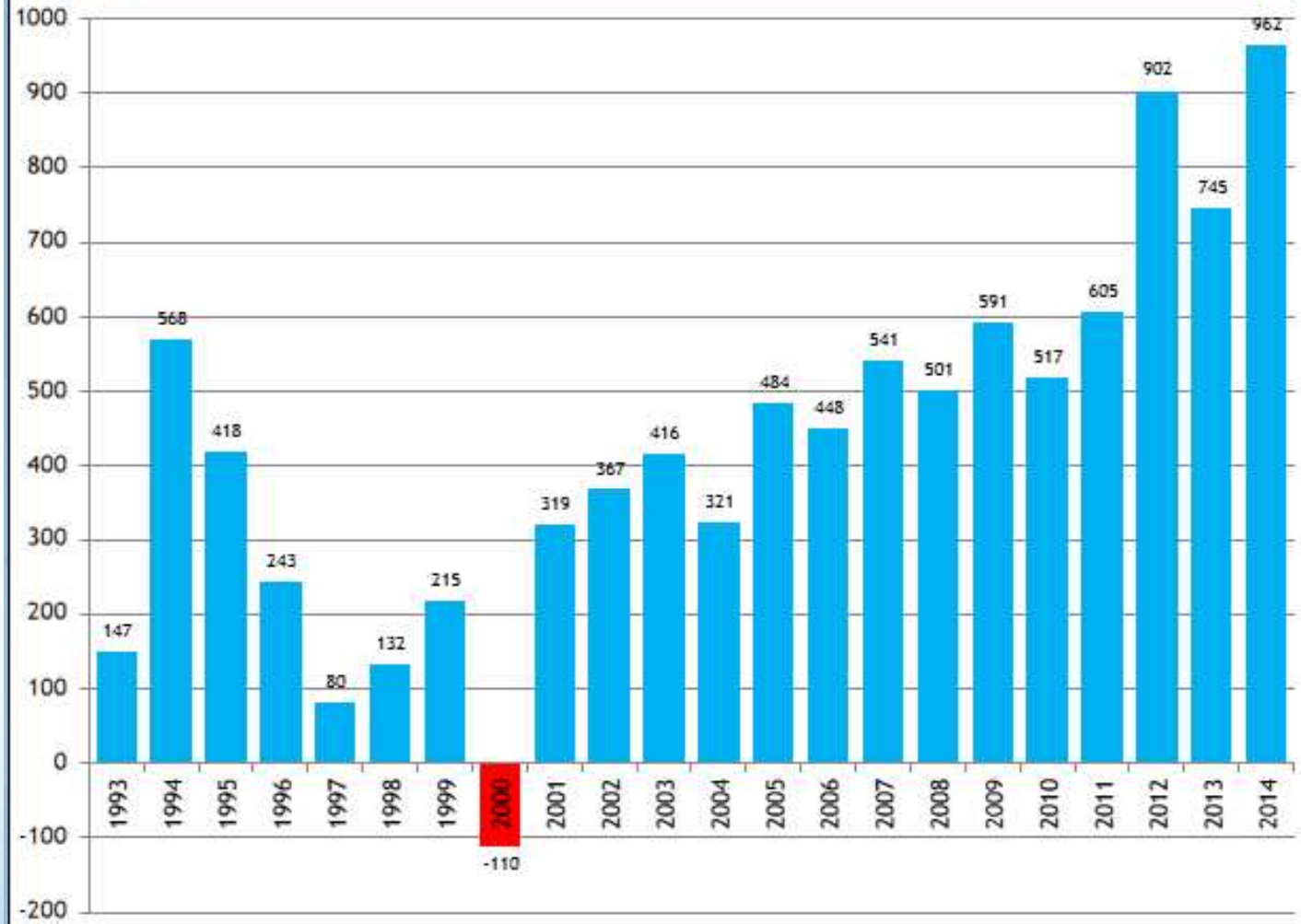
Effect of NOSM

- 90% of students who complete their medical school and post graduate training in the north, stay in the north.

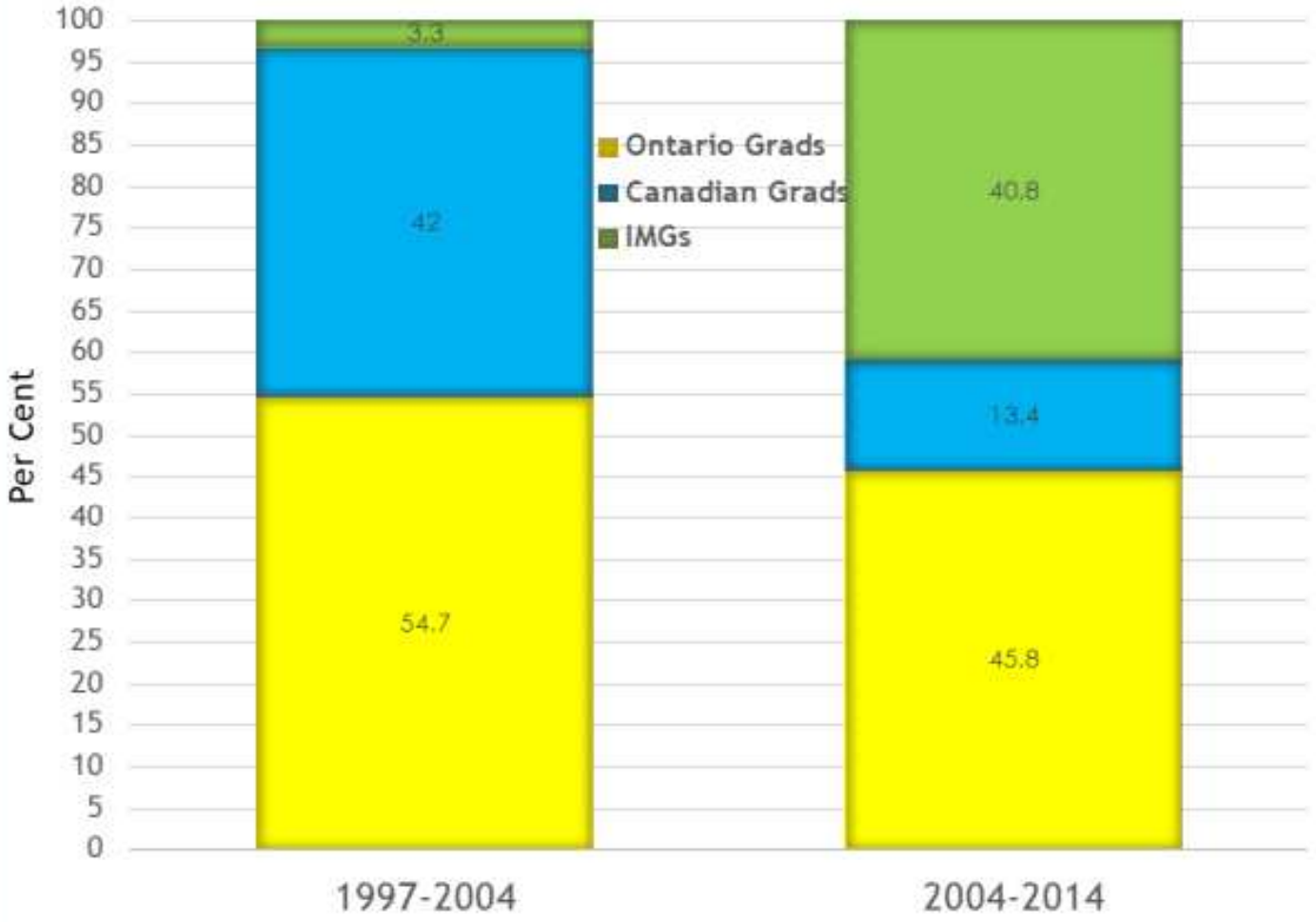
Physician & Population Growth by LHIN, 1998-2014



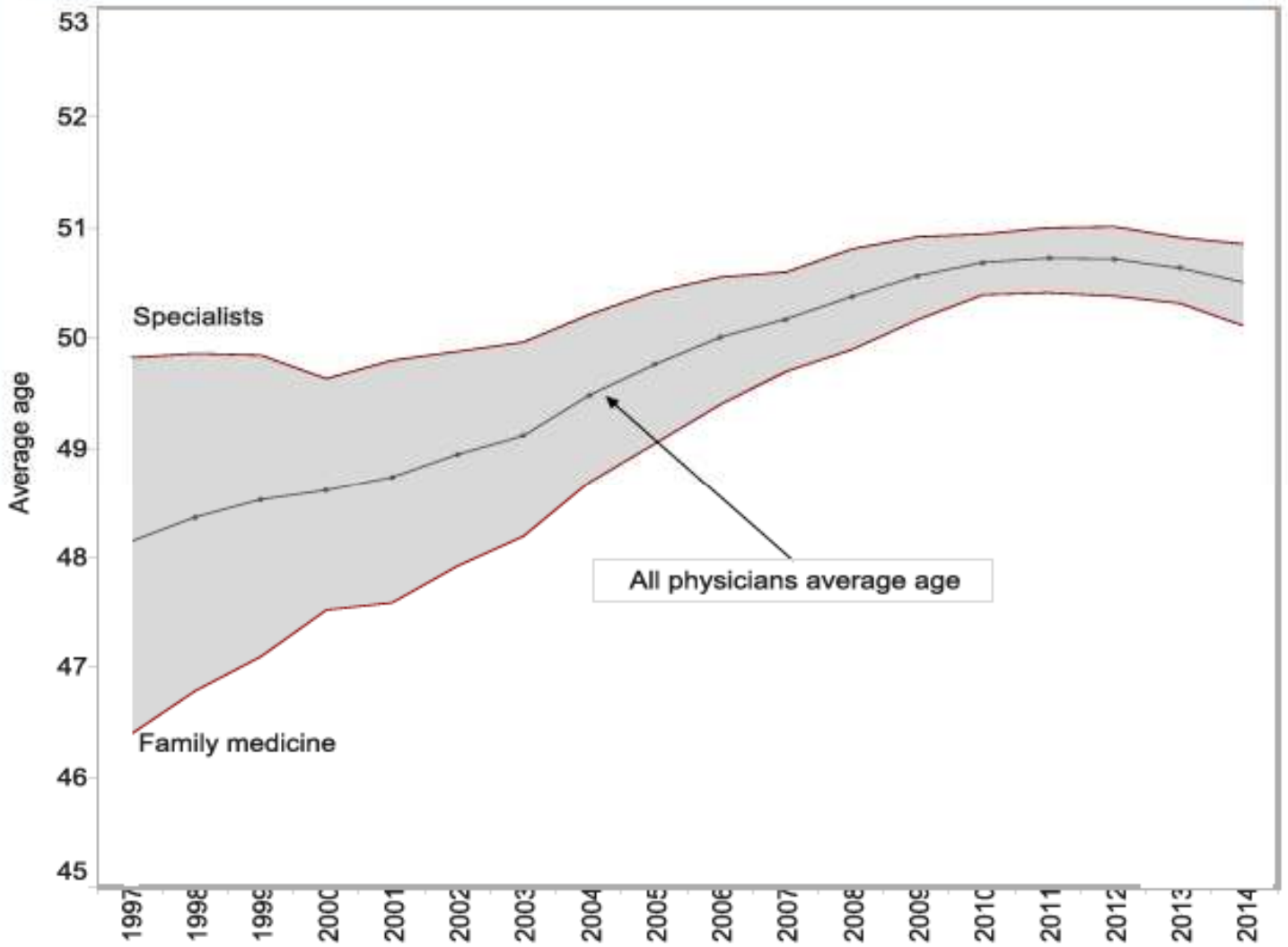
Net Additions to Ontario MD Supply



Contribution to Growth in Ontario Physician Supply



Physician Average Age, by Year



Age Distribution of Selected Specialities (2014)

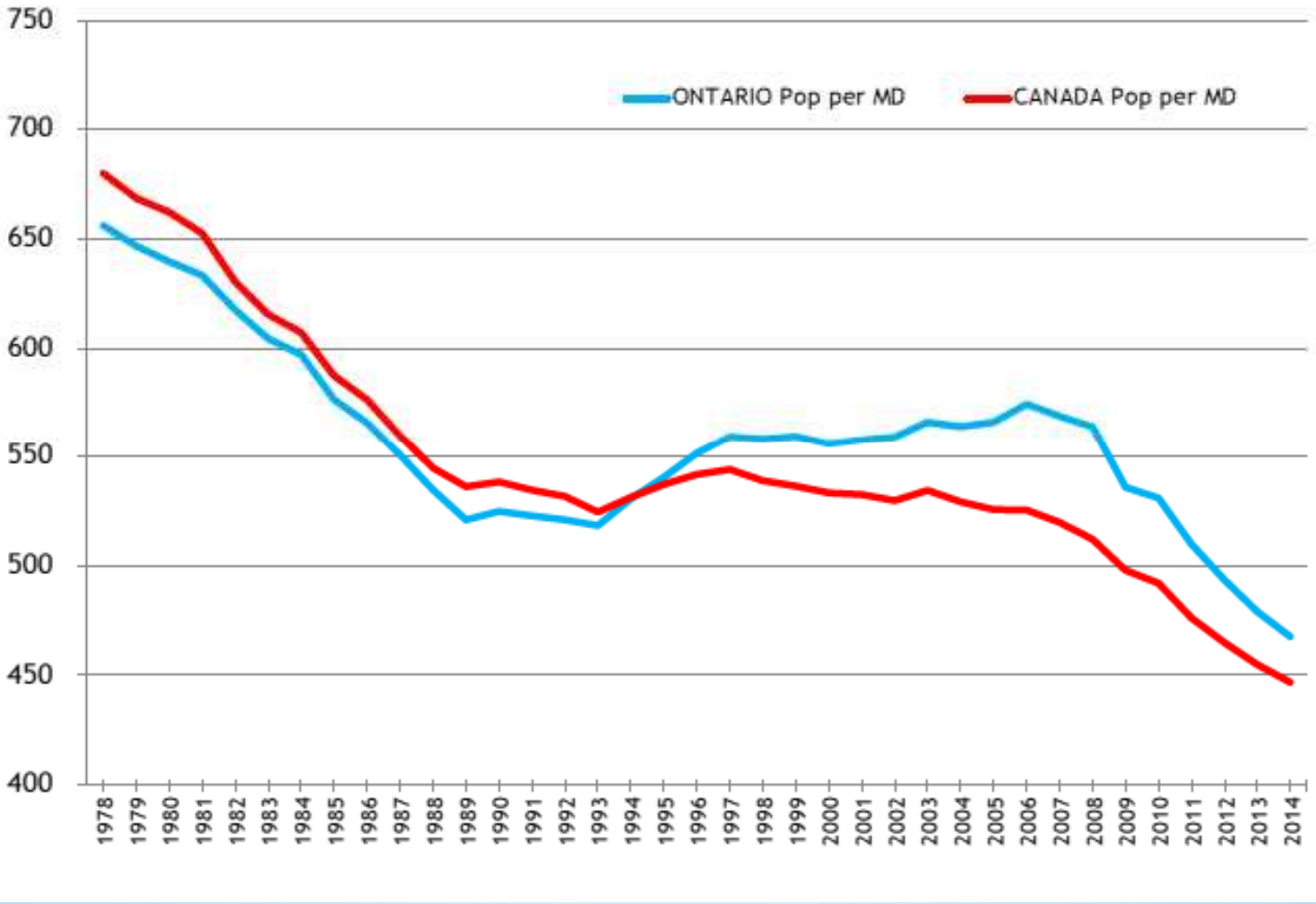
Selected Specialty	Number of MDs	Average Age	Median	25th percentile	75th percentile
Emergency Medicine	499	44.2	42	37	50
Psychiatry	2,325	54.3	55	44	63
Family Practice	13,134	50.1	50	40	59
Overall	28,087	50.5	50	41	60

Physician Median Retirement Age

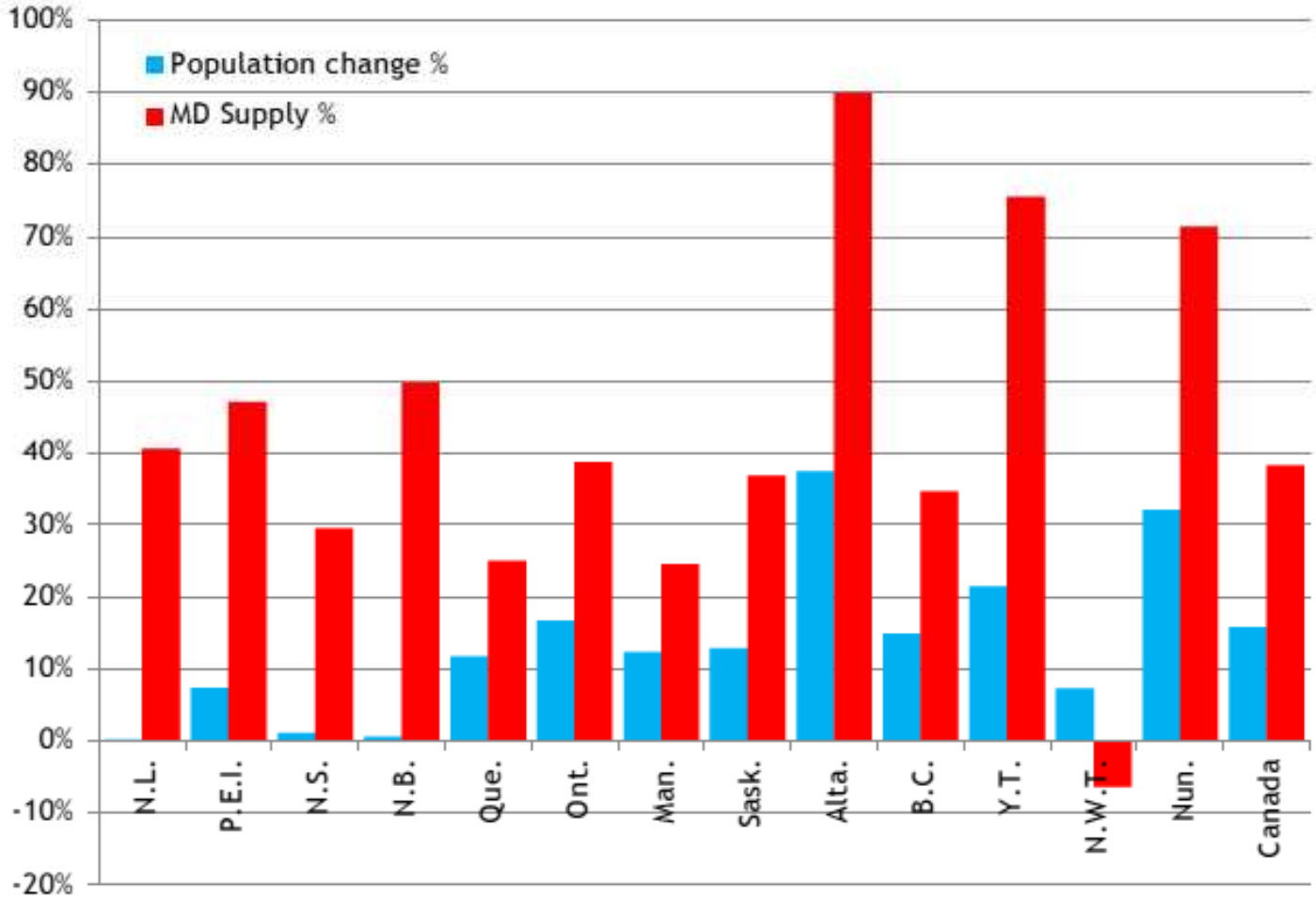
Physician Median Retirement Age Over Time, by GP/Spec & Gender

Time Period	GP/FP			Spec.			All MDs		
	All	Male	Female	All	Male	Female	All	Male	Female
2000 to 2014	68	69	65	70	70	66	69	70	66
2000 to 2004	68	68	63.5	68	69	66	68	69	65
2005 to 2009	69	70	66	70	71	66	70	71	66
2010 to 2014	68	70	64	70	71	68	69.5	70	66

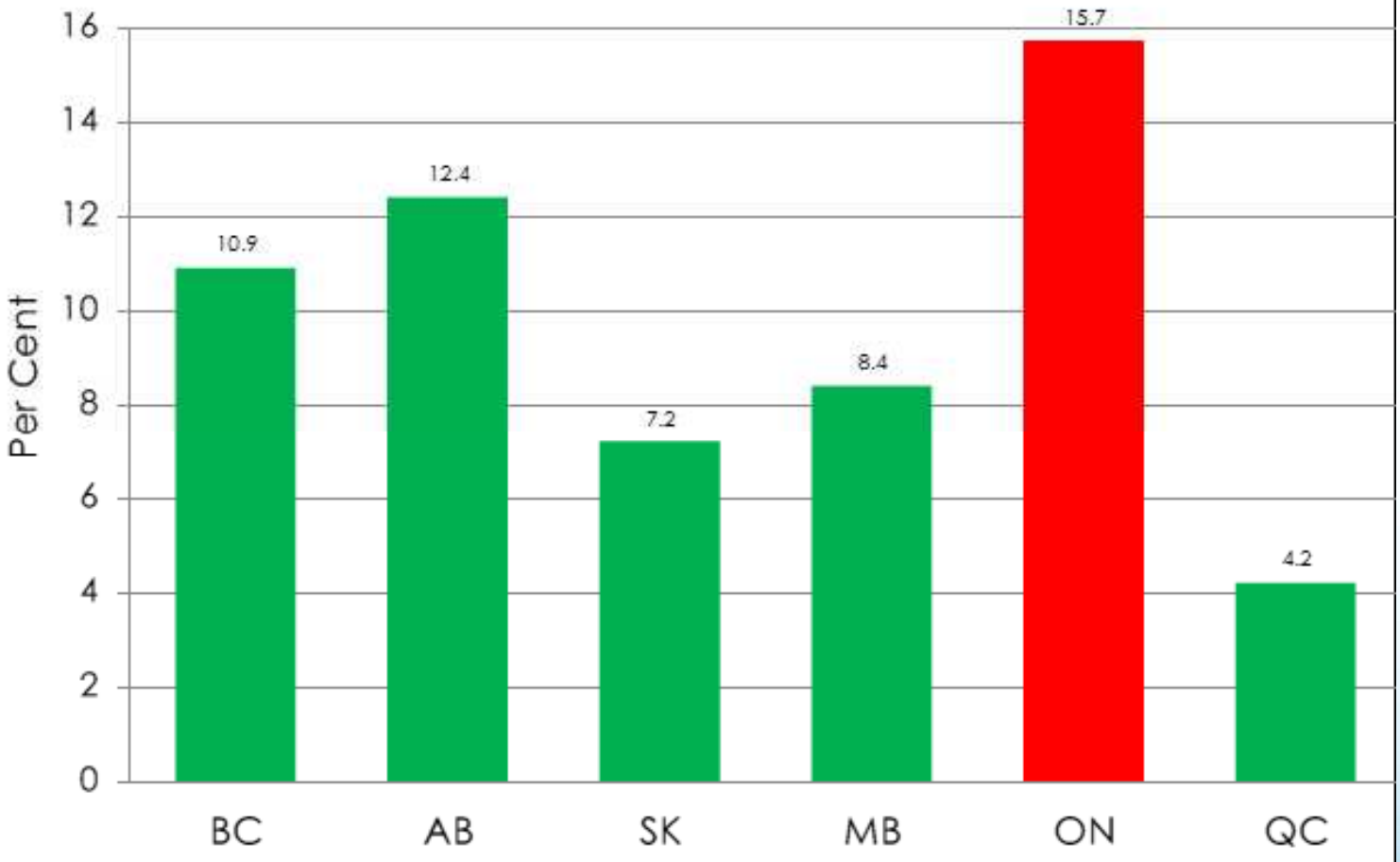
Population per MD Ratio: 1978-2014



Population and Physician Growth (percent), 2000-2014



Physician Underemployment By Province: Under 35 Years of Age



Source: 2013 National Physician Survey

Some Simple Arithmetic

1% population growth ≈ 140,000 persons

Pop/MD ratio ≈ 470 persons per MD

- How many additional MDs are needed to serve 140,000 new people?

Need is for 300-375 additional MDs annually
BUT we are producing ≈ 800-900!

ratio of 400:

140,000 ÷ 400 ≈ 350 MDs

- Patients MUCH more complex you say? So lets use a pop/MD ratio of 375:

140,000 ÷ 375 ≈ 375 MDs

Professional Staff Human Resource Plan

The Next 5 Years

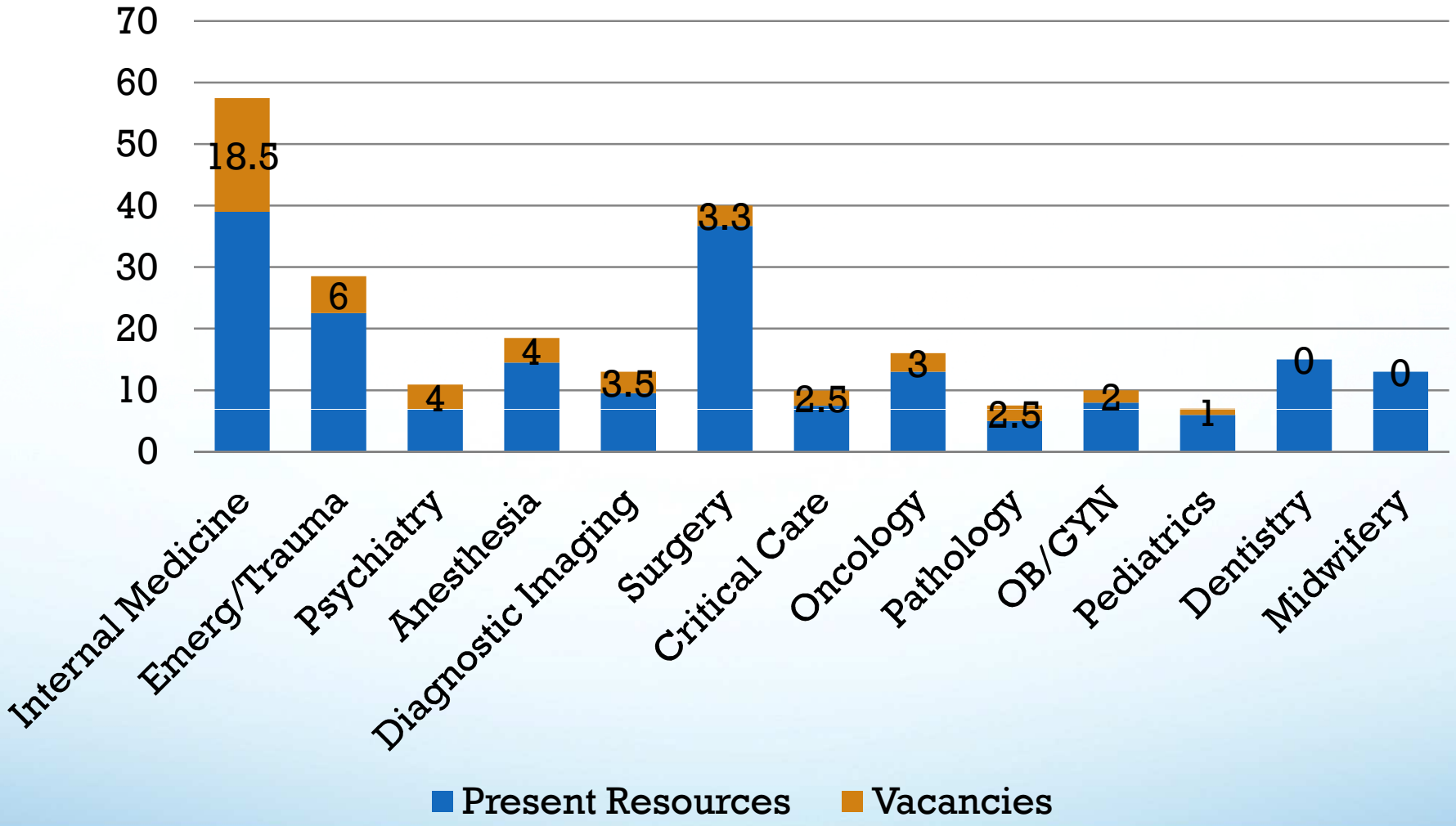
Human Resource Plan

- Provides future projections with respect to the management and appointment of Professional Staff
- Identifies priorities for recruitment
- Developed by Department Chiefs in collaboration with Program Directors and with input from members of department

For Consideration…

- The mission, vision and strategic plan of the hospital
- Changes in type of service provided
- Changes in population needs
- Expected retirements, maternity leaves, LOAs or resignations
- On call requirements
- Scholarly requirements (teaching and research)

Departmental Level - Overview



Internal Medicine

Requirements within 1 year

- General Internal Medicine (1)
- Endocrinology (1)
- Rheumatology (1)
- Interventional Cardiology (1)
- Non-Interventional Cardiology (1)
- Infectious Disease (0.5)
- Gastroenterology (1)
- Dermatology (1)
- Respirology (1)
- Hospitalists (2)
- Physiatry (1)

Additional Requirements within 5 years

- General Internal Medicine (1)
- Endocrinology (1)
- Nephrology (1)
- Gastroenterology (1)
- Neurology (1)
- Hospitalists (1)
- Allergy/Immunology (1)

Emergency/Trauma

- 6 vacancies encompassing current openings and possible future changes in department membership
- 3 long term locums providing support
- Plan to recruit 2 physicians per year over the next three years

Psychiatry

Adult Psychiatry

- 2 vacancies including 1 entrance and 1 exit

Child Psychiatry

- 2 vacancies (community and hospital)

Anesthesia

- **3-5 vacancies**
- **On call structure to reduce potential for fatigue requires additional staff person per day**
- **Anticipate several retirements within 5 years**
- **Lack sufficient staff to develop other services beyond the OR**
- **Goals**
  - dedicated obstetric anesthesia coverage during weekdays
  - Pain management services
  - Off-service sedation for MRI
  - Additional staff for cardiac surgery in future

Diagnostic Imaging

- **3.5 vacancies after new Interventional Radiologist starts July 2016**
- **Requirements (varying FTEs)**
  - General Radiology to reduce locum dependency
  - Interventional Radiology on call service
  - Possibility of expanding breast services may require an additional FTE Mammographer
- **Goals**
  - General Radiology to service Regional Sites and SJCG

Surgery

- **3 vacancies**
  - Vascular surgery (2)
  - General surgery (1.3)
- **No anticipated retirements within next 5 years**
- **Increase in teaching and research contributions as per hospital academic mandate**

Critical Care

- **2-3 vacancies resulting in need for 40 weeks of locum coverage due to:**
  - January 2016 – 1 resignation
  - June 2016 – 1 LOA (likely permanent)
  - June 2016 – 1 staff reducing to part-time

Oncology

- 2 vacancies (Medical Oncology and Radiation Oncology)
- Potentially 2 retirements in Medical Oncology group over the next few years

Palliative Care

- 1 vacancy

Pathology

- 7 FTEs currently, funded for 8 FTEs
- 2 departing and 0.5 future retirement resulting in 2.5 vacancies
- Significant academic duties
- Current focus is on recruiting pathologists with specialization in hematopathology
- Future focus on recruiting pathologist with expertise in cardiac pathology
- Possibility of forensic pathologist eventually

Obstetrics & Gynecology

- **Based on data provided in 2014**
- **2 vacancies**
  - advanced urogynecological skills for complex cases and/or laparoscopic surgery for advanced stage IV endometriosis
  - General Obstetrician (potential resident candidate)

Pediatrics

- Approval for additional 1 FTE (for a total of 7)
- Requesting through MOHLTC an additional 1 FTE (for total of 8)
- Two potential candidates (current residents)
- One potential retirement in 2-5 years

Dentistry

- Fully staffed with no retirements anticipated in next few years
- An additional oral surgeon (similar to earlier complement) would be beneficial to lessen the burden of on call

Midwifery

- Fully staffed
- 13.25 FTEs including 1 LOA returning Oct 2016
- Several part-time staff
- 1 casual locum midwife

Summary

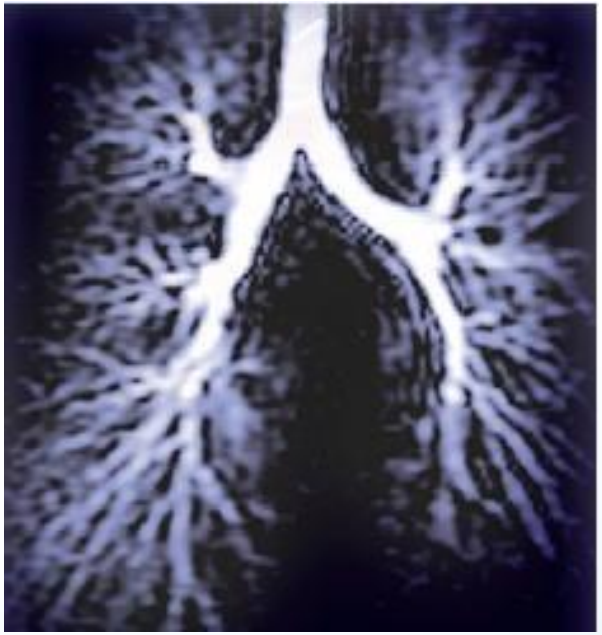
- **Actively recruiting for all vacancies**
- **Urgency placed on:**
  - Pathology
  - Dermatology
  - Endocrinology
  - Psychiatry
  - Critical Care
  - Vascular Surgery

TBRRI Strategic Plan 2012-2016 Progress Report and 2020 Strategic Plan Update to TBRHSC Board

Jean Bartkowiak, CEO
Gary Polonsky, Chair

June 8, 2016

Goal 1: Impact through Excellence in Imaging



- **Foundational XLV Technology**
  - Dr. Rowlands & Dr. Reznik
- **Evolving PET-based Mammography**
  - Dr. Reznik
- **New Ultrasound Transducer**
  - Dr. Curiel, Dr. Pichardo, Dr. Rubel
- **Probes Discovered for Detecting**
  - Dr. Phenix

Goal 2 Enabling of Research Strategic to TBRHSC …. Clinical Trials in TBRHSC 2015 priority areas

Goal 2 continued … growth in Indigenous research and understanding

Tackling Narcotic Addictions During Pregnancy

Wool Felt Project Helping Increase Screening of Cervical Cancer Among Indigenous Women

Goal 3: Economic Growth and Sustainability

Measures of Scientific Excellence

Major awards

RBC Innovation Award 2015
Cyclotron, TBRRI Innovative Project of the Year

CQCO Quality and Innovation Award 2011
Dr. Ingeborg Zehbe, Aboriginal HPV screening study

Ontario Brain Institute Entrepreneur Awards
Grad students secured 1 of 7 competitive awards - twice

Thunder Bay Chamber of Commerce Award
2012 Not-for-Profit Excellence Award

2 Spin-off Companies

115 PAPERS in peer- reviewed journals

58 Agreements and/or collaborations with external organizations in 2014-2015

50 PhD's & MD's actively engaged in research in 2014-2015

38 Grad students working in TBRRI labs in 2014-2015

40 Additional research staff conducting research in 2014-2015

35th on Canada Info$ource List of Research Hospitals

1,200+ Participants enrolled in clinical trials

$15M In annual economic development for Northwestern Ontario

$21M+ Scientific grants awarded

$5M In funding from the Thunder Bay Regional Health Sciences Foundation

Research Institute New 2020 Strategic Plan

Vision: Bringing Discovery to Life

Mission: To be an international leader in medical imaging research, and discovery that improves the health of the people of Northwestern Ontario

Values:

- Excellence
- Collaboration
- Innovation
- Integrity
- Respect
- Accountability

Strategic Direction #1

Healthier: Lead research to improve the health outcomes of the people of Northwestern Ontario and beyond

Goal 1: Develop a research model that engages patients and families at all stages.
Goal 2: Partner with Indigenous communities and Indigenous researchers to develop research that is relevant to their health priorities.
Goal 3: Build local clinical research.
Goal 4: Develop screening and diagnostic tools that are responsive to our geographic challenges.
Goal 5: Foster adoption of strategic health-related technology.

Strategic Direction #2

Wealthier: Advance philanthropic support and generate revenue through science and partnerships

Goal 1: Engage stakeholders in philanthropy to support research.
Goal 2: Commercialize our medical imaging research products.
Goal 3: Enhance our partnerships to leverage research resources.
Goal 4: Develop a robust clinical research program.
Goal 5: Implement a sustainable business model for the cyclotron.

Strategic Direction #3

Smarter: Enhance the academic environment

Goal 1: Participate in development of academic programs relevant to our health and research priorities.
Goal 2: Participate in the development of the academic framework with the Hospital.
Goal 3: Attract and engage researchers to build a cluster of academics.
Goal 4: Grow strategic partnerships and networks to expand capacity and impact.

Questions?

Thunder Bay Regional Health Sciences Centre

Board of Directors - *Open*

Wednesday, May 4, 2016

Boardroom – 5:00 p.m.

Action

***Present*:**

Nadine Doucette, (*Chair*)	Dr. Andrew Turner*	Dick Mannisto
Jean Bartkowiak*	Doug Shanks	Grant Walsh
Gary Whitney	John Friday	Dr. Mark Thibert*
Dr. Rhonda Crocker Ellacott*	Georjann Morriseau	Anita Jean

By Invitation – Senior Leadership:

Peter Myllymaa	Dr. Stewart Kennedy	Glenn Craig
Anne-Marie Heron	Dr. Mark Henderson	Amy Carr

By Invitation:

Jessica Nehrebecky, *Rec. Sec.*	Michael Del Nin	Carolyn Freitag
Holly Freill	Michelle Allain	Cathy Covino

Regrets Board of Directors:

Dr. Penny Moody-Corbett	Gerry Munt

1.0 CALL TO ORDER

The Chair called the meeting to order at 5:00 p.m. The Chair welcomed Board members, Senior Leadership, guests, and the webcast audience. Ms. Shameema Warsallee a student intern working under the mentorship of the President and CEO was introduced and welcomed.

2.0 PATIENT STORY

Ms. Holly Freill, Registered Dietician and recent winner of Cancer Care Ontario's Human Touch Award Shared a patient story.

3.1 **Quorum** – Quorum was attained.

3.2 **Conflict of Interest** - None.

3.3 **Approval of the Agenda**

Motion

Moved by: ***Anita Jean***
Seconded by: ***John Friday***

* Denotes Non-Voting Member

healthy together En santé ensemble

"That the Agenda be approved, as circulated."

CARRIED

3.4 Chair's Remarks - For Information.

The By-Laws specifically state that Community members may serve on Board Committees. The Governance Committee has been asked to develop a process to recruit and select potential Community to members participate on Committees of the Board.

4.0 PRESENTATIONS

4.1 Medical Assistance in Dying

Dr. Andrew Turner, Acting Chief of Staff, Ms. Cathy Covino, Senior Director, Quality and Risk Management and Ms. Michelle Allain, Bioethicist, provided an update on the Medical Assistance in Dying proposed legislation.

In the interim period before sanction of this legislation (February 6 to June 6, 2016), individuals can apply to the Ontario Superior Court of Justice for an exemption, however they must meet the Supreme Court criteria and must find a physician to assess their eligibly.

An internal working group has been struck to develop an appropriate pathway, general request forms and resources for patient and families. The Chief of Staff's Office will identify which physicians and nurse practitioners are willing to provide the service. In case of a conscientious objection, it is the professional staff's responsibility to refer the patient.

The President and CEO will seek a legal opinion regarding the Hospital and Board of Directors' responsibility regarding the legislation regarding implementation of this. ***Action***

Ms. Allain and Ms. Covino were excused.

5.0 CONSENT AGENDA

Moved by: ***Doug Shanks***
Seconded by: ***John Friday*** ***Motion***

"That the Board of Directors:
5.1 Approves the Board of Directors Minutes of April 6, 2016;

5.2 Accepts the Q4 2015-2016 Wages and Sources Deduction Attestation,

as presented."

CARRIED

6.0 REPORTS AND DISCUSSION

6.1 Report from Senior Leadership

The following information was highlighted from the report:

- The Hospital celebrated National Volunteer Week on April 10-16, 2016;
- The current Ontario Nurses Association (ONA) central contract expired on March, 2016. Mediation and arbitration have been completed and an award is expected in early June, 2016;
- The Hospital has no outstanding orders under the Fire Code (as overseen by the Fire Department) or Environmental Protection Act (as overseen by the Ministry of Environment) and is not aware of any non-compliances in regard to the requirements of these legislations;
- The Emergency Department continued to perform at or better than provincial targets for non-admitted high acuity patients with a length of stay (LOS) of 6.7 hours (target 7 hours), and low acuity LOS of 3.9 hours (target 4 hours).

Dr. Mark Henderson, Executive Vice President, Patient Services and Regional Vice President, Cancer Care Ontario will provide an update and history on the cardiovascular surgery project to new Board members and those that are interested. ***Action***

6.2 Report from the President and CEO

The President and CEO highlighted the following:

- Interviews for the Vice President, Human Resources position will occur next week. An announcement is anticipated in June, 2016;
- The job description for the Vice President, Research is under review. The recruitment process will begin before the summer;
- Dr. Scott Sellick has announced his retirement and consequently, his resignation as the Chair of the Research Ethics Board at the end of June, 2016. Recruitment will begin shortly and one Board member will be asked to serve on the Selection Committee.

6.2.1 Third Party Review

Hay Group has been selected as the successful third party consultant to conduct the review. The North West Local Health Integration Network (NW LHIN) will be providing the Hospital with financial assistance for the review. A report of the findings and recommendations is anticipated in the Fall.

6.2.2 2015-2016 Budget Year End Allocation

A year end funding adjustment award from the NW LHIN is anticipated to address the financial shortfall for the 2015-2016 year.

6.3 Report from the TBRHS Foundation

The President and CEO, Thunder Bay Regional Health Sciences Foundation (the Foundation) highlighted the following:

- The Presidents' Reception will be held on Thursday, May 12 to thank major donors and express our gratitude;
- The Foundation is currently engaging key community leaders to strike a campaign task force in support of the implementation of the cardiovascular surgery program.

6.4 Report from the Professional Staff Association - For information

6.5 Report from the Acting Chief of Staff - For information

6.6 Report from the Chief Nursing Executive

The Chief Nursing Executive highlighted the following:

- National Nurse's Week will take place on May 9-15, 2016.

6.7 Report from the Northern Ontario School of Medicine - For information | ***Motion***

Moved by: ***Doug Shanks***
Seconded by: ***Dick Mannisto***

"That the Board of Directors:
6.1 Accepts the Report from Senior Leadership;
6.2 Accepts the Report from the President and CEO;
6.3 Accepts the Report from the TBRHS Foundation;
6.4 Accepts the Report from the Professional Staff Association;
6.5 Accepts the Report from the Acting Chief of Staff;
6.6 Accepts the Report from the Chief Nursing Executive;

6.7 Receives the Report from the Northern Ontario School of Medicine;

dated May 2016 ,as presented."

CARRIED

7.0 COMMITTEE MATTERS

7.1 2020 Strategic Plan Indicators and Targets

Ms. Carolyn Freitag, Director, Strategy and Performance Improvement and Mr. Michael Del Nin, Manager, Strategy and Performance Improvement, provided a summary of the proposed 2020 Strategic Indicators for Board monitoring. It was noted that the data highlighted in red has changed from the version that was included in as previously circulated Board meeting materials.

There was discussion regarding the wording of the 'Psychiatrist full-time equivalent staffing as percentage of required full-time equivalent complement' indicator, however the proposed list of indicators were accepted as submitted. | ***Motion***

Moved by: *Doug Shanks*
Seconded by: *Georjann Morriseau*

"That the Board of Directors approves the strategic indicators and related targets, as presented."

CARRIED

8.0 FOR INFORMATION

8.1 Board Comprehensive Work Plan - For information

8.2 Webcast Statistics - For information

8.3 Report Thunder Bay Regional Research Institute - For information

8.4 Correspondence from Governor General - For information

8.5 North West LHIN Primary Care Physician Lead - For information

8.6 2020 Strategic Plan Progress Report - For information

Action

8.7 **NW LHIN Governance to Governance Session**

Board members were asked to advise Ms. Jessica Nehrebecky if they are available to attend.

8.8 **Nurses Week Celebration/BPSO Spotlight Media Event**- For information

9.0 **BOARD MEMBER COMMENTS**

10.0 **DATE OF NEXT MEETING** – June 8, 2016

11.0 **ADJOURNMENT** - The meeting adjourned at 6:16 p.m.

_____ _____

Chair Board Secretary

_____

Recording Secretary

Expense Reporting - Board of Directors				
Name:	**Doucette, Nadine**			
Title:	**Chair, Board of Directors**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
October 29-30, 2015	302.27	Travel - Accommodation	Gairdner Awards	Toronto
October 29-30, 2015	(50.94)	Travel - Air/Rail	Gairdner Awards	Toronto
October 29-30, 2015	10.82	Travel - Incidentals	Gairdner Awards	Toronto
October 29-30, 2015	3.75	Travel - Meals	Gairdner Awards	Toronto
October 29-30, 2015	22.54	Travel - Taxi/Public Transport	Gairdner Awards	Toronto
November 11-14, 2015	1,799.59	Travel - Accommodation	World Business Forum	New York
November 11-14, 2015	51.18	Travel - Air/Rail	World Business Forum	New York
November 11-14, 2015	111.55	Travel - Meals	World Business Forum	New York
November 11-14, 2015	149.29	Travel - Taxi/Public Transport	World Business Forum	New York
December 22, 2015	100.04	Hospitality	Recruitment	Thunder Bay
Total for the period	**$ 2,500.09**			

Expense Reporting - Board of Directors				
Name:	**Jean, Anita**			
Title:	**Member, Board of Directors**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
September 14-15, 2015	70.66	Travel - Vehicle Rental/Mileage	LHIN Governance to Governance Session	Sioux Lookout
Total for the period	**$ 70.66**			

Expense Reporting - Board of Directors				
Name:	**Mannisto, Richard**			
Title:	**Member, Regional Representative, Board of Directors**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	
September 14-15, 2015	117.18	Travel - Accommodation	Travel as CEO of Nipigon District Memorial Hospital reimbursed to TBRHSC from Nipigon District Memorial Hospital	Thunder Bay
October 7-8, 2015	117.18	Travel - Accommodation	Meeting - Board	Thunder Bay
October 7-8, 2015	8.11	Travel - Meals	Meeting - Board	Thunder Bay
October 7-8, 2015	232.90	Travel - Vehicle Rental/Mileage	Meeting - Board	Thunder Bay
October 19-21, 2015	234.34	Travel - Accommodation	Meeting - Resource Planning, Quality, CEO Search	Thunder Bay
October 19-21, 2015	26.95	Travel - Meals	Meeting - Resource Planning, Quality, CEO Search	Thunder Bay
October 19-21, 2015	232.90	Travel - Vehicle Rental/Mileage	Meeting - Resource Planning, Quality, CEO Search	Thunder Bay
November 4-5, 2015	7.71	Travel - Meals	Meeting - Board	Thunder Bay
November 4-5, 2015	232.90	Travel - Vehicle Rental/Mileage	Meeting - Board	Thunder Bay
November 16-17, 2015	232.90	Travel - Vehicle Rental/Mileage	Meeting - Resource Planning	Thunder Bay
November 20-21, 2015	232.90	Travel - Vehicle Rental/Mileage	CEO Search	Thunder Bay
December 2-3, 2015	117.18	Travel - Accommodation	Meeting - Board	Thunder Bay
December 2-3, 2015	232.90	Travel - Vehicle Rental/Mileage	Meeting - Board	Thunder Bay
December 8-9, 2015	117.18	Travel - Accommodation	Meeting - Board with TBRRI and LHIN	Thunder Bay
December 8-9, 2015	18.69	Travel - Meals	Meeting - Board with TBRRI and LHIN	Thunder Bay
December 8-9, 2015	232.90	Travel - Vehicle Rental/Mileage	Meeting - Board with TBRRI and LHIN	Thunder Bay
December 14-17, 2015	351.52	Travel - Accommodation	Resource, Quality, Strategic Planning, CEO Search	Thunder Bay
December 14-17, 2015	62.31	Travel - Meals	Resource, Quality, Strategic Planning, CEO Search	Thunder Bay
December 14-17, 2015	232.90	Travel - Vehicle Rental/Mileage	Resource, Quality, Strategic Planning, CEO Search	Thunder Bay
December 21-22, 2015	115.19	Travel - Accommodation	Meeting - New CEO	Thunder Bay
December 21-22, 2015	8.11	Travel - Meals	Meeting - New CEO	Thunder Bay
December 21-22, 2015	232.90	Travel - Vehicle Rental/Mileage	Meeting - New CEO	Thunder Bay

Expense Reporting - Board of Directors				
February 3-4, 2016	117.18	Travel - Accommodation	Meeting - Board	Thunder Bay
February 3-4, 2016	8.11	Travel - Meals	Meeting - Board	Thunder Bay
February 3-4, 2016	232.90	Travel - Vehicle Rental/Mileage	Meeting - Board	Thunder Bay
February 16-17, 2016	117.18	Travel - Accommodation	Meeting - Resource Planning	Thunder Bay
February 16-17, 2016	7.70	Travel - Meals	Meeting - Resource Planning	Thunder Bay
February 16-17, 2016	232.90	Travel - Vehicle Rental/Mileage	Meeting - Resource Planning	Thunder Bay
February 25-26, 2016	117.18	Travel - Accommodation	Meeting - Quality Committee	Thunder Bay
February 25-26, 2016	232.90	Travel - Vehicle Rental/Mileage	Meeting - Quality Committee	Thunder Bay
March 2-3, 2016	117.18	Travel - Accommodation	Meeting - Board	Thunder Bay
March 2-3, 2016	7.70	Travel - Meals	Meeting - Board	Thunder Bay
March 2-3, 2016	232.90	Travel - Taxi/Public Transport	Meeting - Board	Thunder Bay
March 14-16, 2016	234.34	Travel - Accommodation	Meeting - Resource Planning and Quality	Thunder Bay
March 14-16, 2016	19.16	Travel - Meals	Meeting - Resource Planning and Quality	Thunder Bay
March 14-16, 2016	232.90	Travel - Vehicle Rental/Mileage	Meeting - Resource Planning and Quality	Thunder Bay
March 23-24, 2016	117.18	Travel - Accommodation	Meeting - Strategic Planning and Executive	Thunder Bay
March 23-24, 2016	8.11	Travel - Meals	Meeting - Strategic Planning and Executive	Thunder Bay
March 23-24, 2016	232.90	Travel - Vehicle Rental/Mileage	Meeting - Strategic Planning and Executive	Thunder Bay
Total for the period	**$ 5,666.17**			

Expense Reporting - Board of Directors				
Total Board of Directors Expense Claims for the period:				
	$ 8,236.92			

Expense Reporting - Executive Management				
Name:	**Bartkowiak, Jean**			
Title:	**President and CEO**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
January 28-29, 2016	538.45	Travel - Air/Rail	Meeting - Council of Academic Hospitals of Ontario	Toronto
January 28-29, 2016	197.70	Travel - Accommodation	Meeting - Council of Academic Hospitals of Ontario	Toronto
January 28-29, 2016	18.96	Travel - Taxi/Public Transport	Meeting - Council of Academic Hospitals of Ontario	Toronto
February 8, 2016	37.62	Travel - Meals	Local Meeting	Thunder Bay
February 22, 2016	21.62	Travel - Meals	Local Meeting	Thunder Bay
February 24-25, 2016	566.11	Travel - Air/Rail	Academic Health Sciences Network National Symposium	Ottawa
February 24-25, 2016	24.12	Travel - Incidentals	Academic Health Sciences Network National Symposium	Ottawa
February 24-25, 2016	128.93	Travel - Taxi/Public Transport	Academic Health Sciences Network National Symposium	Ottawa
October 2015 to March 2016	1,454.55	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 2,988.06**			
Name:	**Covino, Cathy**			
Title:	**Senior Director - Quality and Risk Management**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
Dececember 5-11, 2015	464.33	Travel - Air/Rail	Flight cancelled - credit to be applied to future travel	Orlando
Total for the period	**$ 464.33**			

Expense Reporting - Executive Management				
Name:	**Crocker-Ellacott, Dr. Rhonda**			
Title:	**Executive VP - Patient Services and Chief Nursing Executive**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
October 2015 to March 2016	1,942.34	Travel - Vehicle Rental/Mileage	Travel as CEO of Nipigon District Memorial Hospital reimbursed to TBRHSC from Nipigon District Memorial Hospital	Nipigon
October 2015 to March 2016	1,220.12	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 3,162.46**			

Expense Reporting - Executive Management				
Name:	**Henderson, Dr. Mark**			
Title:	**Executive VP - Patient Care Services**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
October 15-16, 2015	142.73	Travel - Air/Rail	Meeting - CCO Provincial Leadership Council	Toronto
November 12-14, 2015	241.24	Travel - Accommodation	Meeting - CCO Provincial Leadership Council	Toronto
November 12-14, 2015	184.02	Travel - Air/Rail	Meeting - CCO Provincial Leadership Council	Toronto
November 12-14, 2015	21.64	Travel - Incidentals	Meeting - CCO Provincial Leadership Council	Toronto
November 12-14, 2015	27.06	Travel - Taxi/Public Transport	Meeting - CCO Provincial Leadership Council	Toronto
December 10-11, 2015	197.70	Travel - Accommodation	Meeting - CCO Provincial Leadership Council	Toronto
December 10-11, 2015	161.11	Travel - Air/Rail	Meeting - CCO Provincial Leadership Council	Toronto
December 10-11, 2015	1.35	Travel - Incidentals	Meeting - CCO Provincial Leadership Council	Toronto
December 10-11, 2015	27.05	Travel - Meals	Meeting - CCO Provincial Leadership Council	Toronto
December 10-11, 2015	39.66	Travel - Taxi/Public Transport	Meeting - CCO Provincial Leadership Council	Toronto
January 7-8, 2016	25.47	Travel - Air/Rail	Meeting - CCO Provincial Leadership Council	Toronto
February 4-5, 2016	193.50	Travel - Accommodation	Meeting - CCO Provincial Leadership Council	Toronto
February 4-5, 2016	67.15	Travel - Air/Rail	Meeting - CCO Provincial Leadership Council	Toronto
February 4-5, 2016	21.42	Travel - Incidentals	Meeting - CCO Provincial Leadership Council	Toronto
February 4-5, 2016	18.02	Travel - Taxi/Public Transport	Meeting - CCO Provincial Leadership Council	Toronto
March 3-4, 2016	235.33	Travel - Accommodation	Meeting - CCO Provincial Leadership Council	Toronto
March 3-4, 2016	638.65	Travel - Air/Rail	Meeting - CCO Provincial Leadership Council	Toronto
March 3-4, 2016	16.00	Travel - Incidentals	Meeting - CCO Provincial Leadership Council	Toronto
March 3-4, 2016	27.05	Travel - Taxi/Public Transport	Meeting - CCO Provincial Leadership Council	Toronto
October 2015 to March 2016	1,221.82	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 3,507.97**			

Expense Reporting - Executive Management				
Name:	**Kennedy, Dr. Stewart**			
Title:	**Executive VP - Medical and Academic Affairs**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
January 5-6, 2016	131.44	Travel - Accommodation	Simulation Site Visit - Health Sciences North	Sudbury
January 5-6, 2016	777.67	Travel - Air/Rail	Simulation Site Visit - Health Sciences North	Sudbury
January 5-6, 2016	16.90	Travel - Incidentals	Simulation Site Visit - Health Sciences North	Sudbury
January 5-6, 2016	82.68	Travel - Meals	Simulation Site Visit - Health Sciences North	Sudbury
January 5-6, 2016	87.54	Travel - Taxi/Public Transport	Simulation Site Visit - Health Sciences North	Sudbury
October 2015 to March 2016	1,203.03	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 2,299.26**			

Expense Reporting - Executive Management				
Name:	**McCready, Dr. William**			
Title:	**Interim President and CEO**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
August 10-11, 2015	160.80	Travel - Vehicle Rental/Mileage	Satellite Visit - Hemodialysis	Sioux Lookout
September 25, 2015	11.72	Travel - Incidentals	Meeting - Council of Academic Hospitals of Ontario	Toronto
September 25, 2015	31.55	Travel - Taxi/Public Transport	Meeting - Council of Academic Hospitals of Ontario	Toronto
October 29-30, 2015	302.27	Travel - Accommodation	Gairdner Awards	Toronto
October 29-30, 2015	12.40	Travel - Incidentals	Gairdner Awards	Toronto
October 29-30, 2015	13.52	Travel - Meals	Gairdner Awards	Toronto
October 29-30, 2015	45.08	Travel - Taxi/Public Transport	Gairdner Awards	Toronto
November 1-4, 2015	611.90	Travel - Accommodation	OHA Health Achieve	Toronto
November 1-4, 2015	35.85	Travel - Incidentals	OHA Health Achieve	Toronto
November 1-4, 2015	118.91	Travel - Meals	OHA Health Achieve	Toronto
November 5-6, 2015	531.27	Hospitality	CEO Search Interviews	Thunder Bay
December 14-15, 2015	128.37	Travel - Accommodation	Satellite Visit - Hemodialysis	Sioux Lookout
December 14-15, 2015	425.90	Travel - Air/Rail	Satellite Visit - Hemodialysis	Sioux Lookout
December 14-15, 2015	20.51	Travel - Incidentals	Satellite Visit - Hemodialysis	Sioux Lookout
December 14-15, 2015	26.49	Travel - Meals	Satellite Visit - Hemodialysis	Sioux Lookout
December 14-15, 2015	131.95	Travel - Vehicle Rental/Mileage	Satellite Visit - Hemodialysis	Sioux Lookout
December 16-17, 2015	115.14	Travel - Accommodation	Satellite Visit - Hemodialysis	Fort Frances
December 16-17, 2015	246.20	Travel - Vehicle Rental/Mileage	Satellite Visit - Hemodialysis	Fort Frances
October 2015 to March 2016	3,040.00	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 6,009.83**			

Expense Reporting - Executive Management				
Name:	**Morrison, Rod**			
Title:	**Former Executive VP - Health Human Resources, Planning and Strategy**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
August 19-21, 2015	(50.94)	Travel - Air/Rail	Meeting - OHA Leadership Program	Toronto
December 4, 2015	76.47	Hospitality	Meeting	Thunder Bay
October 2015 to January 2016	800.00	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 876.47**			

Expense Reporting - Executive Management				
Name:	**Myllymaa, Peter**			
Title:	**Executive VP - Corporate Services and Operations**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
October 2015 to March 2016	1,221.82	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 1,221.82**			

Expense Reporting - Executive Management				
Name:	**Pothier, Chisholm**			
Title:	**Former VP - Communications and Engagement, Aboriginal Affairs and Government Relations**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
August 17, 2015	36.71	Hospitality	Meeting with President of Chamber of Commerce	Thunder Bay
September 14-15, 2015	128.37	Travel - Accommodation	LHIN Governance to Governance Session	Sioux Lookout
September 14-15, 2015	16.00	Travel - Incidentals	LHIN Governance to Governance Session	Sioux Lookout
September 14-15, 2015	81.63	Travel - Vehicle Rental/Mileage	LHIN Governance to Governance Session	Sioux Lookout
October 5-7, 2015	280.33	Travel - Accommodation	Conference - Creating a New Legacy 2015	Brandon, MB
October 5-7, 2015	423.09	Travel - Air/Rail	Conference - Creating a New Legacy 2015	Brandon, MB
October 5-7, 2015	31.33	Travel - Incidentals	Conference - Creating a New Legacy 2015	Brandon, MB
October 5-7, 2015	80.25	Travel - Meals	Conference - Creating a New Legacy 2015	Brandon, MB
October 2015 to March 2016	1,040.00	Travel - Vehicle Rental/Mileage	Car Allowance	Thunder Bay
Total for the period	**$ 2,117.71**			

Expense Reporting - Executive Management				
Name:	**Turner, Dr. Andrew**			
Title:	**Acting Chief of Staff**			
Reporting Period:	**October 1, 2015 to March 31, 2016**			
Date	**Amount**	**Expense Category**	**Description**	**Location**
March 3, 2016	416.77	Hospitality	Site Visit Dinner with ENT Surgeon	Thunder Bay
Total for the period	**$ 416.77**			

Expense Reporting - Executive Management				
Total Executive Management Expense Claims for the period:				
	$ 23,064.68			

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6000
www.tbrhsc.net

ATTESTATION CERTIFICATE

Prepared in accordance with Section 15 of the Broader Public Sector Accountability Act, 2010 (BPSAA)

TO: The Board of Directors of Thunder Bay Regional Health Sciences Centre

FROM: Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

Date: May 17, 2016

RE: April 1, 2015 to March 31, 2016

On behalf of the Thunder Bay Regional Health Sciences Centre I attest to:

- The completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants;
- The Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;
- The Hospital's compliance with any applicable expense claims directives issued under section 10 of the BPSAA by the Management Board of Cabinet;
- The Hospital's compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet; and
- The Hospital's compliance with any applicable procurement directives issued under section 12 of the BPSAA by the Management Board of Cabinet,

during the applicable period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a President/CEO in these circumstances, including making due inquiries of Hospital staff that have knowledge of these matters.

I further certify that any material exceptions to this attestation are documented in the attached Schedule A and Appendix A.

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6000
www.tbrhsc.net

Dated at Thunder Bay, Ontario this May 17, 2016.

_____

Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

I certify that this attestation has been approved by the Board of the Thunder Bay Regional Health Sciences Centre on June 8, 2016.

_____

Nadine Doucette
Chair, Board of Directors
Thunder Bay Regional Health Sciences Centre

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6000
www.tbrhsc.net

Schedule A to Attestation

MATERIAL EXCEPTIONS TO DECLARE

1. Exceptions to the completion and accuracy of reports required in section 6 of the BPSAA on the use of consultants;

   No Known Exceptions.

2. Exceptions to the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;

   No Known Exceptions.

3. Exceptions to the Hospital's compliance with the expense claims directive issued under section 10 of the BPSAA by the Management Board of Cabinet, and

   No Known Exceptions.

4. Exceptions to the Hospital's compliance with perquisites directive issued under section 11.1 of the BPSAA by the Management Board of Cabinet,

   No Known Exceptions.

5. Exceptions to the Hospital's compliance with the procurement directive issued under section 12 of the BPSAA by the Management Board of Cabinet,

   As reported in Appendix A.

Jean Bartkowiak, MHSc, CHE
President and Chief Executive Officer
Thunder Bay Regional Health Sciences Centre
Chief Executive Officer
Thunder Bay Regional Research Institute

May 17, 2016

APPENDIX A TO ATTESTATION

Thunder Bay Regional Health Sciences Centre
BPSAA Exceptions 2015/2016

2015-2016				
Organization	**Description**	**Dollar Amount**	**Vendor**	**Rationale**
TBRHSC	Laboratory Supplies (Microbiology)	$175,154	Oxoide (Thermo-Fischer)	Pricing agreement was extended for one year in order to align with GPO (Medbuy) competitive procurement process. It is anticipated that TBRHSC will terminate the pricing agreement immediately upon a formal award being made by Medbuy, expected to be Fall 2016
TBRHSC	Non-Urgent Patient Transfer Services	$177,000	Ambutrans	(a) where an unforeseeable situation of urgency exists and the goods, services or construction cannot be obtained in time by means of open procurement procedures (Agreement on Internal Trade, Part IV, Chapter 5, Article 506). This exception was made as a result of the special circumstance that the time period required to prepare and conduct the complex and robust competitive RFP required for Non-Urgent Patient Transfer Services extended beyond the end of the current contract for this essential service. It was assessed that the risk of going out to market without the appropriate planning was too great. Accordingly, the contract extension period is being used to prepare and conduct the procurement. The contract extension will be terminated as soon as the Hospital is in a position to award the new contract.

Schedule D — Form of Compliance Declaration

DECLARATION OF COMPLIANCE
Issued pursuant to the Hospital Service Accountability Agreement

To: **The Board of Directors of the North West Local Health Integration Network (the "LHIN"). Attn: Board Chair.**

From: **The Chair of the Board of Directors (the "Board') of Thunder Bay Regional Health Sciences Centre (the "HSP")**

Date: June 8, 2016

Re: April 1, 2015 — March 31, 2016 (the "Applicable Period")

The Board has authorized me, by resolution dated June 8, 2016, to declare and attest to you as follows:

After making inquiries of the HSP's Chief Executive Officer and other appropriate officers of the HSP and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled its obligations under the Hospital Service Accountability Agreement (the "Agreement") in effect during the Applicable Period.

Without limiting the generality of the foregoing, the Board confirms that:

(i) the HSP has complied with the provisions of the Local Health System Integration Act, 2006 and the Broader Public Sector Accountability Act (the "BPSAA") that apply to the HSP;
(ii) the HSP has complied with its obligations in respect of CritiCall that are set out in the Agreement;
(iii) every Report submitted by the HSP is complete, accurate in all respects and in full compliance with the terms of the Agreement; and
(iv) the representations, warranties and covenants made by the Board on behalf of the HSP in the Agreement remain in full force and effect.

Unless otherwise defined in this declaration, capitalized terms have the same meaning as set out in the Agreement.

This Declaration of Compliance, together with its Appendix, will be posted on the HSP's website on the same day that it is issued to the LHIN.

Nadine Doucette
Chair, Board of Directors

SCHEDULE G — FORM OF COMPLIANCE DECLARATION

DECLARATION OF COMPLIANCE

Issued pursuant to the M-SAA effective April 1, 2014

To: **The Board of Directors of the North West Local Health Integration Network (the "LHIN"). Attn: Board Chair.**

From: **The Chair of the Board of Directors (the "Board") of Thunder Bay Regional Health Sciences Centre (the "HSP")**

Date: **June 8, 2016**

Re: **April 1, 2015 — March 31, 2016 (the "Applicable Period")**

Unless otherwise defined in this declaration, capitalized terms have the same meaning as set out in the M-SAA between the LHIN and the HSP effective April 1, 2014.

The Board has authorized me, by resolution dated June 8, 2016, to declare to you as follows:

After making inquiries of the President and Chief Executive Officer and other appropriate officers of the HSP and subject to any exceptions identified on Appendix 1 to this Declaration of Compliance, to the best of the Board's knowledge and belief, the HSP has fulfilled, its obligations under the service accountability agreement (the "M-SAA") in effect during the Applicable Period.

Without limiting the generality of the foregoing, the HSP has complied with:

i. **Article 4.8 of the M-SAA concerning applicable procurement practices;**
ii. **The *Local Health System Integration Act, 2006*; and**
iii. **The Public *Sector Compensation Restraint to Protect Services Act, 2010*;**
iv. **The following specific performance requirements as outlined in Schedule E4 of the 2014-2017 M-SAA:**
    a. **"Home First" Philosophy**
    b. **Diversity Planning requirement**
    c. **Behavioural Supports Ontario Action Plan**
    d. **Emergency Preparedness Plans**
    e. **E-Health requirement**
    f. **Information Technology requirement**
    g. **Health Services Blueprint — Community Engagement**

_____

Nadine Doucette
Chair, Board of Directors

Thunder Bay Regional Health Sciences Centre

Governance Committee

Wednesday, May 18, 2016

Boardroom – 7:30 a.m.

***Present*:**

Gerry Munt, *Chair*	Anita Jean	Doug Shanks
Nadine Doucette	Jean Bartkowiak* (t-con)	

Regrets:

Grant Walsh	Georjann Morriseau

By Invitation:

Angela Kutok, *Rec. Sec.*

1.0 CALL TO ORDER – The meeting was called to order at 7:33 a.m.

1.1 Quorum – *Quorum was achieved.*

1.2 Conflict of Interest – *None.*

1.3 Approval of the Agenda

Motion

Moved by: ***Doug Shanks***
Seconded by: ***Anita Jean***

"That the Agenda be accepted, as circulated."

CARRIED

2.0 PRESENTATIONS/EDUCATION – *None.*

3.0 CONSENT AGENDA

Motion

Moved by: ***NadineDoucette***
Seconded by: ***Doug Shanks***

"That the Governance Committee,

3.1 approves the Governance Minutes of February 17, 2016;

3.2 approves Nominating Minutes of April 20, 2016;

3.3 recommends that the Board of Directors approves the 2016-2017 workplans for the Audit Committee, Fiscal Advisory Committee, Resource Planning Committee, and Quality Committee;

3.4 recommends that the Board of Directors approves the terms of reference for the Audit Committee, Fiscal Advisory Committee, Resource Planning Committee, and Board/Privileged Staff Committee ;

as amended."

CARRIED

4.0 WORK PLAN

4.1 Governance/Nominating Workplan 2016-2017

The Governance/Nominating Workplan for 2016-2017 was reviewed noting that the most significant change is in moving the Board retreat from June to September of each year. It was also noted that workplans for all committees can be revised during the course of the year as required.

Moved by: ***Anita Jean***
Seconded by: ***Doug Shanks***

"That the Governance Committee recommends that the Board of Directors approves the 2016-2017 Governance/Nominating Committee workplan,

as presented."

CARRIED

4.2 Orientation Program

The orientation program for new Board members was reviewed. It was suggested that following orientation, new Board members be given an opportunity to provide feedback on the orientation process to determine what works well and areas for improvement.

4.3 Board Committee Attendance Summary

The Board of Directors' attendance at meetings was reviewed. It was noted that where a Director fails to attend 75% of the Board or Committee meetings in a 12-month period, the

Board Chair will discuss the reasons for the absences with that individual. The Board Chair will speak Directors who do not currently meet the 75% attendance threshold and provide formal notice of the attendance requirements, and that failure to meet these requirements may affect Board membership. ***Action***

It was also noted that as per the Board Member Skills Matrix, Directors may not sit on more than three other Boards if currently employed on a full time basis, or on six other Boards if retired or not employed on a full-time basis.

4.4 Board Annual Evaluation Tool Summary

The Annual Board Evaluation tool summary was reviewed. There was discussion about a formal evaluation process for Board members as well as whether a formal evaluation process is required for members who are seeking re-election.

Board Evaluations will be added to the September 21, 2016 Governance meeting agenda for further discussion. In preparation for this meeting, the President and CEO will investigate best practice for formal Board evaluations. ***Action***

5.0 COMMITTEE MATTERS

5.1.1 **BD-81 Roles and Responsibilities of the Board – Re: Process for Making Changes to Corporate Documents**

Policy BD-81 Roles and Responsibilities of the Board was revised in order to ensure appropriate consultation takes place when implementing changes and amendments to corporate documents or initiatives which fall under the purview of the Board of Directors.

The following amendments to the policy were recommended: ***Action***

- Ensure the use of the words "the Hospital" are clearly defined in the By-Law when it is reviewed and applied consistently across all policies and documents;
- The words "strategic direction" in paragraph 3, under Procedure will be changed back to "strategic plan";
- The words "and initiatives" in paragraph 4, under Procedure will be added back in.

Moved by: ***Doug Shanks*** ***Motion***
Seconded by: ***Anita Jean***

"That the Governance Committee recommends that the Board of Directors approves changes to Policy BD-81 Roles and Responsibilities of the Board,

as amended."

CARRIED

5.1.2 **BD-45 Selection Criteria for Board and Community Members**

Policy BD-45 Selection Criteria for Board and Community Members was revised to include a process for the recruitment of community members.

The following amendments to the policy were recommended: ***Action***

- The word "of" on page 2, numbers 4 and 5, will be changed to "or";
- The word "achievement" on page 2, number 7, will be changed to "experience";
- The word "are" on page 4, last bullet, will be changed to "may".

Moved by: ***Doug Shanks*** ***Motion***
Seconded by: ***Anita Jean***

"That the Governance Committee recommends that the Board of Directors approves changes to Policy BD-45 Selection Criteria for Board and Community Members,

as presented."

CARRIED

5.1.3 **BD-25 Education and Development**

Policy BD-25 Education and Development was revised to ensure the policy is more specific in its intent for required education for Board members.

The following amendments to the policy were recommended: ***Action***

- The word "expected" under the Policy statement, will be changed to "must";
- Remove the word "fiduciary" will be removed under the Policy statement.

Moved by: ***Anita Jean*** ***Motion***
Seconded by: ***Doug Shanks***

"That the Governance Committee recommends that the Board of Directors approves changes to Policy BD-25 Education and Development,

as amended."

CARRIED

5.1.4 **BD-55 CEO Succession Planning**

Policy BD-55 CEO Succession Planning was revised to ensure the policy is more specific; however the intent of the policy has not changed. There was discussion about the size and composition of the selection committee noted in the policy. There was agreement to remove the list of required selections committee members, and have further discussion at a future Board meeting. ***Action***

The following amendments to the policy were recommended:

- The word "vacancy" in section A of Procedures to be corrected;
- Section B of Procedures to read "The Board establishes a CEO Search Committee". Remove references to committee composition;
- The words "a short list of" on page 4, second last bullet, will be changed to "appropriate".

Moved by: ***NadineDoucette*** ***Motion***
Seconded by: ***Doug Shanks***

"That the Governance Committee recommends that the Board of Directors approves changes to Policy BD-55 CEO Succession Planning,

as amended."

CARRIED

5.1.5 **Draft Criminal Record Check Policy**

A Criminal Records Check policy has been developed as Board Directors may be subject to heightened public scrutiny and accountability, and thorough background checks are an essential component of the Board recruitment process. Adopting this process provides a measure of due diligence by reducing potential risks, as well as being in alignment with the Hospital's current practice of requesting Criminal Record Checks for staff and volunteers.

Motion

Moved by: ***Doug Shanks***
Seconded by: ***Anita Jean***

"That the Governance Committee recommends that the Board of Directors approves the Criminal Record Checks for Board of Directors Policy,

as presented."

CARRIED

5.2 **Revised 2020 Strategic Plan Values Definitions**

The revised 2020 Strategic Plan Values definitions were reviewed. It was agreed that further consultation with the full Board is required.

The following amendments were suggested:

- Agreement to the addition of the word "expectations" in the Patients First value definition;
- The word "provide" will be changed back to "advance" in Excellence value definition.

Ms. Anita Jean was excused from the meeting.

Motion

Moved by: ***Doug Shanks***
Seconded by: ***Nadine Doucette***

"That the Governance Committee recommends that the Board of Directors accepts amendments to the 2020 Strategic Plan Values,

as amended."

CARRIED

5.3 **Framework for Ethical Decision Making**

The Framework for Ethical Decision Making was revised to include the changes to the values definitions. The Committee agreed to the revisions as noted in item 5.2 above.

Motion

Moved by: ***Doug Shanks***
Seconded by: ***Nadine Doucette***

"That the Governance Committee recommends that the Board of Directors accepts amendments to the Framework for Ethical Decision Making,

as amended."

CARRIED

5.4 **Board and Committee Meeting Schedule 2016-2017**

5.4.1 **Board Meeting Frequency**

Members agreed with amending article 11.1 of the By-Law to state that there will be a minimum of eight meetings of the Board per year, rather than ten meetings per year. Although the Board agreed with the revision to the By-Law, further consultation is required with the full Board in regard to the actual reduction of meetings in the proposed 2016-2017 meeting schedule.

Motion

Moved by: ***NadineDoucette***
Seconded by: ***Doug Shanks***

"That the Governance Committee recommends that the Board of Directors accepts amendments to Thunder Bay Regional Health Sciences Centre By-Law, Article 11.1 Regular Meetings,

as presented."

CARRIED

Mr. Doug Shanks was excused from the meeting.

5.5 **Board By-Laws**

The Committee was presented with a preliminary review of By-Law revisions. A special meeting will be arranged to provide an in depth review of the By-Law in September 2016, once proposed revisions and consultation with the Medical Advisory Committee is complete. It was recommended that the approval of the revised By-Law be deferred to the next Annual General Meeting in 2017.

Action

5.6 **Ontario Medal for Good Citizenship Award**

The call for nominations notice for the Ontario Medal for Good Citizenship Award was shared for information.

6.0 FOR INFORMATION

6.1 Committee Meeting Evaluation

Committee members were requested to complete the committee meeting evaluation.

6.2 Team Effectiveness Scale

The Team Effectiveness Scale summary was reviewed with no issues or comments.

6.3 Annual Education Session Summary

The Annual Education Session summary was reviewed with no issues or comments.

6.4 All Board Committee Meeting Evaluations for the Quarter

The Board Committee Meeting Evaluations for the quarter were reviewed with no issues or comments.

7.0 BOARD MEMBER COMMENTS – *None.*

8.0 DATE OF THE NEXT MEETING – *September 21, 2016 at 7:30 a.m.*

9.0 ADJOURNMENT - The meeting adjourned at 9:07 a.m.

Governance/Nominating Committee 2016-17

Updated: May 10, 2016

Colour Legend
Completed by target
In progress but not
Not in progress, and not

Committee legend:
G - Governance
N - Nominating

Meetings Held:
Governance-September. November, February, May
Nominating-March, April (interviews)

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Governance	Review Gov/Nom Committee work plan for upcoming year	G				x								
2	Governance	Review Gov/Nom Committee terms of reference	G				x								
3	Governance	Board members identify education needs for coming year	G		x										
4	Governance	Review Board vacancies	G							x					
5	Oversight of Management	Review CEO/COS Performance Evaluation Process	G		x										
6	Governance	Review Board forms	G		x										
7	Governance	Review all Board policies - identify revisions required	G				x								
8	Governance	Plan annual Board retreat	G										x		Annual Retreat to be held in September of each year
9	Governance	Review all Board committee terms of reference	G										x		
10	Governance	Review all Board committees work plans	G							x					**Beginning in 2016-17:** all Committee workplans for the for next year's Board cycle will be reviewed at the Febraury Governance with approval at the March Board meeting

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
11	Governance	Review meeting evaluations for the quarter	G				x						x		
12	Governance	Review Board and Board Committee attendance summary	G										x		
13	Governance	Review team effectiveness scale summary	G							x			x		Distributed to Board members at December/April Board meetings.
14	Governance	Board Chair to review self assessment questionnaire	G							x					Only reviewed by the Board Chair
15	Governance	Appoint community member	N							x					
16	Governance	Review and approve nominating action plan	N							x					
17	Governance	Review Policy BD-45 Preferred Selection Criteria for Board Membership	N							x					
18	Governance	Review current Board member skills matrix inventory	N							x					Current Board members to complete at November Board meeting
19	Governance	Review and approve skills matrix for Board of Directors applicants	N							x					
20	Governance	Review and approve application for membership form	N							x					
21	Governance	Review and approve ad	N							x					
22	Governance	Review of Board of Directors applications	N								x				
23	Governance	Review and approve letters to applicants	N								x				
24	Governance	Review and approve interview questions	N								x				
25	Governance	Review and approve interview schedule	N								x				
26	Governance	Interview candidates	N									x			

#	Accountability	Activity	Committee	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
27	Governance	Review incumbents	N									x			
28	Governance	Review of applicant interviews	N									x			
29	Governance	Propose slate of nominees	N									x			
30	Governance	Review By-Laws	G										X		
31	Governance	Review orientation program	G										x		
32	Governance	Review Board annual evaluation tool summary	G										x		Distributed at April Board meeting
33	Governance	Review annual education session summary	G										x		

APPENDIX B - Quality Committee of the Board - 2016-17 Updated: April 28, 2016

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	April	May	September	October	November	December	January	February	March	Presenter	Comments
1	Quality Oversight	Programs & Services Presentations		x	x		x	x	x	x	x	x	Dyad Leads	
2	Quality Oversight	Comments / Compliments / Complaints					x				x		C. Covino	
3	Quality Oversight	Credentialing and Licensing Processes for Professional Staff and Health Professionals				x							M. Addison / Dr. M. Langlois	
4	Quality Oversight	Critical Incidents / MAC Recommendations		x				x					C. Covino	
5	Quality Oversight	Emergency Preparedness			x				x				C. Covino /K. Bell/F. Pennie	
6	Quality Oversight	Financial Pressures Relating to Risk	x										P. Myllymaa	
7	Quality Oversight	Patient Safety / Public Indicators			x	x			x			x	S. Craig	
8	Quality Oversight	Accreditation					x				x		G. Ferguson	
9	Quality Oversight	Quality and Risk Management Policies								x			C. Covino	
10	Quality Oversight	Quality Improvement Plan Excerpt from Balanced Scorecard					x		x			x	C. Covino / M. Del Nin	
11	Quality Oversight	Quality Improvement Plan Updates / Approval								x	x		All	
12	Quality Oversight	Risk Management / Enterprise Risk Management					x			x			C. Covino /K. Bell/F. Pennie	
13	Quality Oversight	Terms of Reference				x			x				D. Mannisto / C. Covino	
14	Quality Oversight	Work Plan				x						x	D. Mannisto / C. Covino	
15	Quality Oversight	Litigation		x									C. Covino	
16	Quality Oversight	Research Ethics Board			x	x		x				x	K. Bell	
17	Quality Oversight	Annual Quality Research Report							x				A. M. Heron	
18	Quality Oversight	Quality-Based Procedures		x									S. Craig	

RESOURCE PLANNING COMMITTEE WORK PLAN

2016-2017

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Oversight of Management	2016-17 Work Plan for information only		x	x	x	x	x	x	x	x	x		
2	Financial Oversight	ALC, LOS and Emergency Admissions Monthly Report for information only		x	x	x	x	x	x	x	x	x		
3	Financial Oversight	Board Attestation: Wages and Source Deductions		x	x			x			x			
4	Financial Oversight	Financial Statements and Variance Report		x		x			x			x		
5	Financial Oversight	Financial Statements for information only		x	x		x	x		x	x			
6	Financial Oversight	Investment Policy Annual Review		x										
7	Financial Oversight	Investment Portfolio Reviews		x							x			
8	Financial Oversight	Northwest Supply Chain Performance and Medbuy Update		x							x			
9	Oversight of Management	Work Plan Approval 2017-18									x			
10	Governance	Terms of Reference Annual Approval		x										
11	Performance Measurement and Monitoring	Corporate Balanced Scorecard			x			x			x			
12	Financial Oversight	H-SAA 2016-17 Operating Plan Submission			x									
13	Financial Oversight	CAPS Submission to LHIN			x									
14	Performance Measurement and Monitoring	Human Resources and Organizational Development Update		x	x	x	x	x	x	x	x	x		
15	Financial Oversight	Broader Public Sector Travel & Expense Report				x						x		
16	Financial Oversight	Budget Planning Targets and Directives Report				x								
17	Financial Oversight	Budget Planning Process Update				x								
18	Financial Oversight	Funding HBAM and Quality Based Procedures Update				x								
19	Financial Oversight	HAPS 2017-18 Update				x								
20	Financial Oversight	TBRRI and Sustainability Updates				x					x			

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
21	Financial Oversight	Capital Equipment and Capital Projects 2016-17 Update						x			x			
22	Financial Oversight	Insurance Review						x						
23	Risk Identification and Oversight	Data Centre Disaster Recovery Plan Update								x				
24	Performance Measurement and Monitoring	Labour Relations, Grievances and Arbitrations Update								x				
25	Legal Compliance	Occupational Health and Safety Program Update								x				
26	Financial Oversight	Operating Plan Update 2017-18		x	x	x								
27	Financial Oversight	Operating Plan Approval 2017-18					x							
28	Legal Compliance	Public Sector Salary Disclosure								x				
29	Financial Oversight	Capital Budget 2017-18 Update			x									
30	Financial Oversight	Capital Budget 2017-18 Approval					x							
31	Legal Compliance	Broader Public Sector Accountability Attestation Certificate										x		
32	Legal Compliance	Broader Public Sector Use of Consultants Attestation										x		
33	Oversight of Management	H-SAA Declaration of Compliance Attestation										x		
34	Oversight of Management	M-SAA Declaration of Compliance Attestation										x		
35	Risk Identification and Oversight	Non Patient Legal Matters Annual Review										x		
36	Financial Oversight	Numbered Companies Unaudited Financial Statements 2016-17										x		
37	Risk Identification and Oversight	TBRRI 2017-18 Operating and Capital Budget Report										x		
38	Risk Identification and Oversight	TBRRI 2016-17 Unaudited Financial Statements Review										x		
39	Financial Oversight	Unaudited Preliminary YE Financial Statements to 2017-03-31										x		

AUDIT COMMITTEE

2016-2017 WORK PLAN

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Oversight of Management	2016-2017 Work Plan for information only						x		x		x		
2	Financial Oversight	2016-2017 Audit Plan Overview - Grant Thornton						x						
3	Governance	Terms of Reference Annual Approval						x						
4	Performance Measurement and Monitoring	Review Results of May 2016 Evaluation of Auditors						x						
5	Financial Oversight	Independence Questionnaire 2016-2017						x						
6	Risk Identification and Oversight	Policy Reviews: Admin-19 & Admin-28						x						
7	Risk Identification and Oversight	Expense Test Audit						x						
8	Risk Identification and Oversight	Interim Audit Review 2016-2017								x				
9	Performance Measurement and Monitoring	Discussion of Year End Reporting Issues 2016-2017								x				
10	Financial Oversight	Audit Statement Review 2016-2017								x				
11	Financial Oversight	Individual Program Audit Reports								x				
12	Financial Oversight	Update on New Hospital Capital Audit								x				
13	Financial Oversight	Summary of Audit Fees Paid for 2016-2017								x				
14	Financial Oversight	2016-2017 Year End Financial statements for Board Approval										x		
15	Financial Oversight	2016-2017 Audit Results - Grant Thornton										x		
16	Oversight of Management	2016-2017 Management Letter										x		
17	Risk Identification and Oversight	2016-2017 Claims Summary										x		
18	Risk Identification and Oversight	Analysis of Legal Fees as at March 31, 2017										x		
19	Performance Measurement and Monitoring	Evaluation of Auditors for 2016-2017										x		
20	Performance Measurement and Monitoring	Recommend Appointment of Auditors for 2017-2018										x		
21	Oversight of Management	2017-2018 Work Plan Approval								x				

FISCAL ADVISORY COMMITTEE

2016-2017

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

#	Accountability	Activity	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Stakeholder Communication and Accountability	Financial Statements and Variance Report				x								
2	Stakeholder Communication and Accountability	Operating Plan 2016-17				x								
3	Stakeholder Communication and Accountability	Q2 2016-17 Financial Review				x								
4	Stakeholder Communication and Accountability	Work Plan 2016-17 For Information Only				x								
5	Stakeholder Communication and Accountability	Financial Statements as at 2016-08-31				x								
6	Stakeholder Communication and Accountability	Financial Statements and Variance Report									x			
7	Stakeholder Communication and Accountability	Operating Budget 2016-17									x			
8	Stakeholder Communication and Accountability	Q3 2016-17 Financial Review									x			
x	Stakeholder Communication and Accountability	Financial Statements as at 2016-02-28									x			
10	Stakeholder Communication and Accountability	Terms of Reference Annual Approval									x			
11	Stakeholder Communication and Accountability	Work Plan 2017-18 Approval									x			

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE
AUDIT COMMITTEE OF THE BOARD OF DIRECTORS

Terms of Reference

Duties/Responsibilities:
The Audit Committee is responsible to oversee the financial management, reporting and internal controls of the Hospital. This is accomplished through direct communication with the external auditors and Hospital management. The Audit Committee reports to the Board of Directors of the Hospital.

General

(a) review, with the external auditors, the proposed scope of the current year's audit;
(b) review and approve the auditor's engagement letter including the audit fee and expenses;
(c) periodically review the need to tender audit services and recommend appointment of auditors to the Board. It is important to note the external auditors are accountable to the members ,and to the Audit Committee and the Board of Directors as their representatives
(d) Ensure the independence of the auditors and obtain a statement of independence from the auditors
(e) maintain a high quality of financial reporting;
(f) assess whether appropriate assistance is being provided to the auditors by the organization's staff; and
(g) ensure finance staff have the appropriate qualifications and knowledge of internal control and financial management systems

Policies for Financial Operations and Systems of Internal Control

(a) inquire about changes in the financial systems and control systems during the year;
(b) ensure appropriate systems are in place to identify, monitor and mitigate significant business risks;
(c) ensure appropriate financial policies and procedures are in place and operating effectively;
(d) ensure that systems of internal control are operating effectively;
(e) review control weaknesses detected in the prior year's audit and determine whether all practical steps have been taken to overcome them.
(f) supervise the investigation of any instances of non-compliance and make recommendations thereon;
(g) inquire into the major financial risks faced by the organization, and the appropriateness of related controls to minimize their potential impact;

Annual Financial Statements

(a) review audited financial statements, in conjunction with the report of the external auditor, and obtain an explanation from management of all significant variances between comparative reporting periods;
(b) recommend approval of the financial statements to the Board;
    - inquire about changes in professional standards or regulatory requirements, and
    - review the annual report for consistency with the financial statements

Audit Results

(a) review the report of the external auditors on the annual financial statements;
(b) review the external auditor's post-audit or management letter which may document weaknesses in the accounting system or in the internal control systems and which may contain recommendations of the external audit, and management's response and subsequent follow-up to any identified weaknesses;
(c) review the results of any requested special procedures performed by the auditors as identified in the scope of the engagement
(d) review summary of legal claims and assess adequacy of disclosure
(e) meet privately with the external auditors (without the presence of management) with regard to the adequacy of the internal accounting controls and similar matters, and review management responses to ascertain whether there are concerns that should be brought up to the Committee's attention,
(f) review any problems experienced by the external auditor in performing the audit, including any restrictions imposed by management or significant accounting issues on which there was a disagreement with management, or situations where management seeks a second opinion on a significant accounting issue; and
(g) meet privately with management to determine whether the external audit was performed in a professional manner, in accordance with the audit engagement letter and any other contractual agreement in place for these services, and to receive management's recommendation regarding the appointment or re-appointment of external auditors.

Duty to Report

(a) report to the Board discussing the actions it has taken and the assistance the Committee has had in fulfilling its duties;
(b) prepare a report to Members describing the Audit Committee activities during the past reporting period that identifies how it fulfilled its role and mandate

Membership and Voting:

- Four (4) elected members of the Board (voting)
- Board Chair (voting)

    - One (1) member must possess an accounting designation, i.e. CA, CGA, CMA, CPA
    - If no member possesses an accounting designation, the Nominating Committee will recommend to the Board, a qualified individual from the community to serve a one year term as one of the five voting members of the Audit Committee.
- The President and CEO (non-voting)
- Members of the Committee should be financially literate and independent of the Hospital and External Auditors

Chair:
The Committee will be chaired by the Treasurer.

Frequency of Meetings and Manner of Call:

- The Audit Committee will meet at least three times per year.
- The meetings will be scheduled to permit timely review of the interim audit plans and annual financial statements
- Additional meetings may be held as deemed necessary by the Chair of the Committee or as requested by any member or the external auditors.

Quorum:
51% of the committee members, provided a majority of those present are voting members.

Resources:
The Executive Vice President, Corporate Services and Operations is assigned to the committee as a resource.

Reporting:
The Audit Committee reports to the Board of Directors

Authority:
n/a

Date of Last Review:
Approved January 11, 2016

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE
FISCAL ADVISORY COMMITTEE

Terms of Reference

Duties and Responsibilities

The Fiscal Advisory Committee shall make recommendations to the Board with respect to the operation, use and staffing at the hospital.

The Fiscal Advisory Committee shall:

a) adhere to the Ministry's guiding principles during the Operating Plan process.
b) make recommendations to the Board with respect to the annual Operating Plan focusing on the Hospital's objectives. The Operating Plan will include the following three components:
    1. Program and Services Plan
    2. Human Resources Plan
    3. Financial Plan
c) evaluate programs and services relative to their impact on human, fiscal and physical resources.
d) ensure that equitable opportunity to participate exists.
e) ensure all recognizable internal stakeholders will be formally involved in the consultation process.
f) review the annual operating plan consistent with the Ministry's policies, guidelines and requirements.
g) review on a semi-annual basis, the Hospital's internal management financial statements and variance reports.
h) consult on the development of the plan with internal and external stakeholders, as determined by the Board; consults with the ~~District Health Council~~ North West Local Health Integration Network on the process for external consultation.
i) monitor the implementation of the Operating Plan; identifies major variances and recommends in-year adjustments to the Board
j) address unresolved issues raised by committee members.

Membership and Voting:

The Fiscal Advisory Committee shall include:

a) Board Chair (voting)
b) President and CEO (non-voting)

c) one person representing both the medical staff and dental staff (voting)
d) one person representing nurses who are Managers (voting)
e) one staff nurse elected by his/her peers to represent O.N.A. (voting)
f) one staff person elected/appointed to represent C.O.P.E. (voting)
g) one staff person elected/appointed to represent S.E.I.U. (voting)
h) one staff person elected/appointed to represent O.P.S.E.U. Maintenance (voting)
~~h)~~i) one staff person elected/appointed to represent O.P.S.E.U. Paramedical (voting)
~~i)~~j) one staff person elected/appointed to represent P.I.P.S.C. (voting)
~~j)~~k) one staff person elected/appointed to represent P.I.P.S.C. Associates (voting)
~~k)~~l) one staff person representing non union staff (voting).
~~l)~~m) other individuals who by virtue of their position may make a contribution to the committee's deliberations (voting).

Chair:
The Fiscal Advisory Committee will be chaired by the President and CEO.

Frequency of Meetings and Manner of Call:
The frequency of meetings and number of calls are two times per year, at the call of the Chair, or as requested by the Board of Directors.

Quorum:
51% of the Committee members, provided a majority of those present are voting members.

Resources:
The Executive Vice President, Corporate Services and Operations and the Executive Vice President, Human Resources are assigned to the committee as resources.

Reporting:
The Fiscal Advisory Committee reports to the Board of Directors.

Authority:
n/a

Date of Last Review:
Approved ~~January 11~~April 12, 2016

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE

RESOURCE PLANNING COMMITTEE OF THE BOARD OF DIRECTORS

Terms of Reference

Duties/Responsibilities:

The Resource Planning Committee shall:

(a) review and make recommendations to the Board with respect to an annual budget for capital and operating revenues and expenditures for the ensuing fiscal year;

(b) review the financial statements on a timely basis and report thereon to the Board accordingly;

(c) advise the Board with regard to donations, bequests, endowments and investments;

(d) recommend to the Board the type and amount of insurance to be carried by the Corporation and review these annually;

(e) develop, evaluate, update and make recommendations to the Board on an implementation plan which supports the Hospital's key strategies for achieving its Mission and role;

(f) make recommendations to the Board with respect to priorities for future capital expenditures and resources as required to implement the strategic plan;

(g) participate in the ongoing assessment of the health care needs of the Hospital's community and catchment area; and

(h) inform and advise the Board on resource planning matters as requested.

Membership and Voting:

The Resource Planning Committee shall include:

(a) First Vice-Chair (voting)
(b) Board Chair (voting)

(c) Treasurer (voting)
(d) Chief of Staff ex-officio (non-voting)
(e) President & CEO ex-officio (non-voting)
(f) Three (3) other Elected Directors (voting)

Chair:
The Committee will be chaired by the First Vice-Chair.

Frequency of Meetings and Manner of Call:
The frequency of meetings and number of calls are at least ten times per year, at the call of the Chair of the Resource Planning Committee of the Board, or as requested by the Board.

Quorum:
51% of the committee members and a majority of the voting members are present.

Resources:
The Executive Vice President, Corporate Services and Operations and the Vice President, Human Resources ~~is~~are assigned to the committee as ~~a~~ resource~~s~~.

Reporting:
The Resource Planning Committee reports to the Board of Directors.

Authority:
The Resource Planning Committee is responsible for establishing the mandate for local union negotiations.

Date of Last Review:
June 11, 2015

THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE
BOARD/PRIVILEGED STAFF FORUM
JOINT STEERING COMMITTEE OF THE BOARD OF DIRECTORS

Terms of Reference

Duties/Responsibilities:
The Board/Privileged Staff Forum is a consultative engagement to ensure constructive dialogue between Privileged Staff and Board Members on matters related to the Strategic or Operational direction of TBRHSC. This Forum involves all members of the Board, Professional Staff Association and Senior Management and meets twice annually.

The Board/Privileged Staff Forum Joint Steering Committee's role is to oversee the facilitation of the Forum.

The Joint Steering Committee of the Board/Privileged Staff Forum is a representative group of the Board, Privileged Staff and Senior Management who:

- determine the relevant topics for engagement;
- provide guidance on the engagement process; and
- evaluate the outcomes of the engagement.

Membership and Voting:

The Board/Privileged Staff Forum Steering Committee shall include:

(a) The President & CEO
(b) Chief of Staff
(c) VP Medical & Academic Affairs
(d) Six Representatives of the Professional Staff Association
(e) ~~Vice President, Communications & Engagement, Aboriginal Affairs and Government Relations~~
(f) Three Elected members of the Board

Each committee member will have a vote.

Chair:
The Board Chair will Chair the Steering Committee.

Frequency of Meetings and Manner of Call:
The forum will meet twice annually or at the call of the Chair.

Quorum:
Quorum requires that both 50% of voting Board Members and 50% Professional Staff Association members be present.

Resources:
The Vice President, Communications & Engagement, Aboriginal Affairs and Government Relations is assigned to the Committee as a resource.

Reporting:
The Board/Privileged Staff Forum reports to the Board of Directors.

Authority:
n/a

Date of Last Review:
~~June 11~~May 18~~,~~ 2016~~5~~

Thunder Bay Regional Health Sciences Centre **Policies, Procedures, Standard Operating Practices**	No. BD-81
Title: Roles and Responsibilities of the Board	**X Policy** ☐ **Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Approval Date:** ~~Feb~~Jun. 8~~3~~, 2016 **Reviewed/Revised Date:** May~~Nov.~~ 25~~18~~, 2015 **Next Review Date:** Nov. 201~~76~~

CROSS REFERENCES: *if applicable*

PURPOSE

To ensure ~~that the Board has~~ a shared understanding of the Board of Directors ~~its~~ governance role.~~, the Board has adopted this Statement of the Roles and Responsibilities of the Board.~~

POLICY

Since t~~T~~he Board is responsible for the overall governance of the affairs of the Hospital, each~~corporation.~~

~~Each~~ Director is responsible to act honestly, in good faith and in the best interests of the Hospital~~corporation~~ and, in so doing, to support the Hospital~~corporation~~ in fulfilling its mission and discharging its accountabilities. ~~Each Director shall adopt the following roles and responsibilities.~~

PROCEDURE

Strategic planning and mission, vision and values

The Board participates in the formulation and adoption of the H~~h~~ospital's M~~m~~ission, V~~v~~ision and V~~v~~alues statements.

The Board ensures that ~~the hospital develops and adopts~~ a strategic plan ~~that is~~ consistent with its M~~m~~ission and V~~v~~alues, and which ~~will~~ enables the ~~h~~Hospital to realize its V~~v~~ision is developed. The Board participates in the development of and ultimately approves the strategic plan.

The Board oversees operations for consistency with the strategic plan. ~~strategic plan and strategic directions.~~

Comment [k1]: Changed back to "strategic plan" as recommended by Governance Committee.

The Board receives regular briefings or progress reports on the implementation of strategic directions and initiatives. ~~and initiatives~~.

Comment [k2]: "and initiatives" added back as recommended by Governance Committee.

The Board ensures that its decisions are consistent with the strategic plan and the Visions, M~~m~~ission, ~~vision~~ and values.

The Board annually conducts a review of the strategic plan as part of a regular annual planning cycle.

The Board ensures that appropriate stakeholder consultation similar to the initial plan development occurs for amendments to the strategic plan.

The Board approves amendments to the Vision, Mission, and Values and strategic directions of the plan following consultation with:

- Senior Leadership Council on an annual basis prior to the annual 5-Partner Accountability Session in May/June;

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- The Governance Committee acts as proxy to the original Strategic Planning Steering Committee and recommends changes to the Board.

The Board approves amendments to the goals related to the strategic directors following consultation as follows:
Stakeholder consultation occurs at established forums, including:

- Quarterly Planning and Performance (participants include health managers, physician leaders, research institute leaders); or
- A designated management forum;
- iLead (participants include health professionals and general staff);
- Focus Groups relevant to proposed changes;
- Annual 5-Partner Accountability Session (members include health managers, health professionals, policy makers, academic institutions and community representatives).

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Performance measurement and monitoring

The Board is responsible for establishing a process and a schedule for monitoring and assessing performance in areas of Board responsibility, including:

- Fulfillment of the strategic directions in manner consistent with the Vision, M~~m~~ission, ~~vision~~ and values.
  - Oversight of management performance;
  - Quality of patient care and H~~h~~ospital services;
  - Patient related research activities;
  - Financial conditions;
  - External relations; and
  - The Board's own effectiveness.

- The Board ensures that management has identified appropriate measures of performance.

Quality oversight

The Board ~~is responsible for~~ establishes~~ing~~ policies and plans related to quality, patient safety, research, patient experience, access and ~~including~~ Quality Improvement Plan.

~~The Board ensures that policies and improvement plans are in place related to quality of care and research, patient safety, patient experience and access.~~

The Board monitors quality performance against the Board-approved quality improvement plan, performance standards and indicators.

The Board ensures that management has plans in place to address variances from performance standards indicators, and the Board oversees implementation of remediation plans.

Financial oversight

The Board is responsible for stewardship of financial resources, ~~including~~ ensuring availability and overseeing the allocation of financial resources.

The Board approves policies for financial planning, and approves the annual operating and capital budget.

The Board monitors financial performance against budget.

The Board approves investment policies and monitors compliance.

The Board ensures the accuracy of financial information through oversight of management and approval of annual audited financial statements.

The Board ensures management has put measures in place to ensure the integrity of internal controls.

Risk identification and oversight

The Board is responsible to be knowledgeable about risks inherent in the ~~organization's~~ Hospital's operations and ensures that appropriate risk analysis is performed as part of Board decision-making.

The Board oversees management's risk management program.

The Board ensures that appropriate programs and processes are in place to protect against risk.

The Board is responsible for identifying unusual risks to the organization and for ensuring that there are plans in place to prevent and manage such risks.

Oversight of management

The Board recruits and supervises the President and CEO by:

- Developing and approving the President and CEO job description;
- Undertaking a ~~CEO~~ recruitment process and selecting the President and CEO;
- Reviewing and approving ~~the~~ the President and CEO's annual performance goals;
- Reviewing the President and CEO's performance and determining ~~CEO~~ compensation;
- Ensuring succession planning is in place for the President and CEO and senior ~~management~~leaders; and
- Exercising oversight of the President and CEO's supervision of senior leaders~~management~~ as part of the ~~CEO's~~ annual review.

The Board develops a process for selection and review of the Chief of Staff and ensures the process is implemented and followed.

The Board reviews, with the President and CEO, the Chief of Staff's performance and sets the Chief of Staff's compensation.

The Board tasks the President and CEO to develop, implement, and maintain a process for the selection of D~~d~~epartment C~~c~~hiefs and other medical leadership positions, as required under the hospital's ~~b~~By-L~~l~~aws or the *Public Hospitals Act.*

Stakeholder communication and accountability

The Board identifies the Hospital~~organization~~'s stakeholders and understands stakeholder accountability.

The Board ensures the ~~organization~~ Hospital appropriately communicates with stakeholders in a manner consistent with accountability to stakeholders.

The Board contributes to the maintenance of strong stakeholder relationships.

The Board performs advocacy on behalf of the hospital with stakeholders where required, in support of the Vision, M~~m~~ission~~, vision~~, values and strategic directions of the hospital.

Governance

The Board is responsible for the quality of its own governance.

The Board establishes governance structures to facilitate the performance of the Board's role and enhance individual Director performance.

The Board is responsible for the recruitment of a skilled, experienced and qualified Board.

The Board ensures ongoing Board training and education.

The Board assesses and reviews its governance by periodically evaluating Board structures, including Board recruitment processes and Board composition and size, number of committees and their Terms of Reference, processes for appointment of committee Chairs, processes for appointment of Board officers, and other governance processes and structures.

Legal compliance

The Board ensures that appropriate processes are in place to ensure compliance with legal requirements.

Amendment

This statement may be amended by the Board.

REFERENCES

OHA 'Guide to Good Governance' – Second Edition

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-45
Title: ~~Preferred~~ Selection Criteria for Board and Community Membersship	**X Policy** **X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Approval Date:** ~~Mar 2~~June 8, 2016 **Reviewed/Revised Date:** ~~Nov. 18 2015~~May 18, 2016 **Next Review Date:** Nov. 201~~6~~7

CROSS REFERENCES: *if applicable*

PURPOSE

To outline the preferred selection criteria ~~for Board membership~~and process for recruitment of Board or Community members. ~~.~~

POLICY

The ~~Board of Directors~~ Governance and Nominating Committee ~~will~~ reviews applicants for Board or Community membership in order to ensure appropriate mix of qualifications and experience to appropriately discharge of governance responsibilities. ~~comparison to the preferred selection criteria described below.~~

PROCEDURE

The following general selection criteria apply to all prospective Directors:

- Willingness to serve on the Board;
- Ability to meet the projected time commitment (including preparation, attendance at Board meetings, committee meetings, retreats, and keeping up to date with information provided by the Hospital and minimum commitment of **20** hours per month for Board members and less for Community members serving on Committees);
- Ability to function as a member of a deliberative team (to participate in group decision making using pre-established principles of the group and the ability to support Board decisions even when the individual votes against the majority);
- Willingness to participate in Board orientation and continuing education (time commitment to initial orientation process, attendance at a defined number of educational events per term, as well as regularly reading health care and governance books and articles provided by the Hospital);
- Objectivity;
- Communication/media relations skills;
- Integrity;
- Values consistent with those of the Hospital;
- Demonstrated leadership skills;

- Demonstrated *big picture thinking* ability;
- Demonstrated systems thinking capacity;
- Demonstrated record of community involvement and commitment;
- A minimum age of 18 years.

The following experience and qualification selection criteria are used to determine an appropriate balance of prospective Directors:

Competencies for Board and Board Committee Membership:

~~1. Values consistent with the Hospital: Patients First, Accountability, Respect and Excellence~~

1. Past experience on other Boards (such as experience as a health care organization Board member or on the Board of a large private sector corporation or nonprofit organization);
2. Community leadership;
3. Financial and business acumen;
4. Strategic planning and visioning;
5. ~~Time availability~~Communication or~~f~~ media relations skills;
6. Political ~~acumen~~involvement or~~f~~ connections;
7. Professional and business experience ~~achievement~~;
8. Membership balance based on specific occupations and skills, such as in business, medicine, law, nursing, or others;
9. Competencies aligned with the strategy and needs of the organization (such as experience in mergers, downsizing, reengineering in other organizations, integrating new business ventures into existing ones, or industries that have undergone major systemic change);
10. One executive or board member of a major user of the organization's services;
11. Professional experience in clinical health care;
12. Professional experience in health care administration;
13. Experience as a Patient Family Advisor.
14. Member who can provide a perspective of the Indigenous community;
15. Member who can provide a perspective of the Francophone speaking community;
16. Member from Northwestern Ontario who resides at least 80 km outside of Thunder Bay.

~~General Qualifications~~

- ~~Willingness to serve on the Board~~

- Ability to meet the projected time commitment (including preparation, attendance at Board meetings, committee meetings, retreats, and keeping up to date with information provided by the organization)

- Capacity for attention to this organization (minimum commitment of **20** hours per month)

- Ability to function as a member of a deliberative team (to participate in group decision making using pre-established principles of the group and the ability to support Board decisions even when the individual votes against the majority)

- Willingness to participate in Board orientation and continuing education (time commitment to initial orientation process, attendance at a defined number of educational events per term, as well as regularly reading health care and governance books and articles provided by the organization)

- Objectivity

- Communication/media relations skills

- Integrity

- Ideology and values consistent with those of the organization

Special Qualifications

- Past experience on other Boards (such as experience as a health care organization Board member or on the Board of a large private sector corporation or nonprofit organization)

- Professional and business achievement

- Membership balance based on specific occupations and skills, such as in business, medicine, law, nursing, or others

- Demonstrated leadership skills

- Demonstrated *big picture thinking* ability

- Demonstrated systems thinking capacity

- Demonstrated record of community involvement and commitment

- Political involvement or connections

- Competencies aligned with the strategy and needs of the organization (such as experience in mergers, downsizing, reengineering in other organizations, integrating new business ventures into existing ones, or industries that have undergone major systemic change)

- One executive or board member of a major user of the organization's services

- Professional experience in clinical health care

- Professional experience in health care administration

- Experience as a Patient Family Advisor

Typical Demographic Selection Criteria

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- ~~Certain percentage of members reside within communities served~~
- ~~Age parameters for Board membership: A minimum age of 18 years~~
- ~~Member who can provide a perspective of the Aboriginal community~~
- ~~Member who can provide a perspective of the French-speaking community~~
- ~~Member from Northwestern Ontario who resides at least 80 km outside of Thunder Bay~~

~~Education and experience sufficient to meet the above criteria~~

Selection Process

Interviewed candidates for a Board position may be considered for Community membership on a Committee of the Board.

The Governance and Nominating Committee is responsible for the following:

- Identify vacancies for the upcoming year;
- Develop a matrix of current Board members' skills and experience;
- Determine preferred qualifications required for vacant positions based on the criteria set out above;
- Place advertisements for the number of vacancies in local media and website;
- Actively recruit from current Board Committee members;
- Review all applications received and shortlist;
- Conduct interviews of those selected for an interview and prepare a slate of nominees for recommendation to the Board for ratification at the Annual General Meeting;
- Strong candidates who are not placed on the slate of nominees may be offered to sit as a Community member on a Board Committee based on their skill set, expertise and the required number of Community members on each Committee;
- Community members are appointed by the Board of Directors upon recommendation from the Governance and Nominating Committee and do not require ratification by the Corporate membership at the Annual General Meeting;
- The number of Community members on each Committee is determined by the Chair of the respective Committees on an annual basis in consultation with the Board Chair and the President and CEO;
- Community members serve a three year term on a Committee for a maximum of one (1) term. Board member terms are outlined in the By-Law;
- Community members may only sit on one or more Committee for the duration of their term;
- Community members may be ~~are~~ given preference when filling Board vacancies.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices		No. BD-25
Title: Education and Development	**X Policy**	**X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a	
Approved: Board of Directors **Signature**:	**Approval Date:** **Reviewed/Revised Date:** **Next Review Date:**	Feb. 3, 2016 ~~Nov. 18, 2015~~May 18, 2016 Nov. 2016

CROSS REFERENCES: *if applicable*

PURPOSE

~~To ensure education of the Board and development of its members.~~ To ensure the Board members are sufficiently informed to exercise their fiduciary responsibility.

POLICY

~~Ongoing education is a critical element of governance. Orientation, regular education programs, external educational events, subscribing to publications and webcast series designed for health care organization Board members, and membership in health care governance web sites are all part of a necessary continuing education process that helps Boards improve.~~

Every Board member ~~is expected to~~ must attend an orientation session when newly appointed and at least one internal or external education session annually thereafter to ensure they are sufficiently informed to exercise their ~~fiduciary~~ responsibilities.

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PROCEDURE

~~An orientation and education program will be provided for each new recruit to the Board and for other interested Board members.~~

There will be a minimum of one (1) Board retreat per year.

Educational topics and sessions are provided to Board members at every open Board meeting on a monthly basis. Educational topics may also be presented at ~~the~~ Board Committee meetings. ~~as well.~~

~~All Board members shall further develop their understanding of Hospital operations by participating on other Committees that are identified at the Inaugural Meeting of the Board, which is the first meeting of the Board following the Annual Meeting of the Corporation.~~

~~Through the Chair,~~ Board members ~~are encouraged to participate~~request participation in educational programs and conferences through the Board Chair. ~~New Board members shall participate in at least one educational session or conference during their term of appointment.~~ Board members are required to report to the Board information learned at the educational sessions they attend.

A record of attended educational sessions ~~will be~~is maintained by the Board Liaison. Arrangements for registration and attendance at approved external educational sessions may be made through the Board Liaison.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices		No. BD-55
Title: CEO Succession Planning	**X Policy** ☐ **Procedure** ☐ **SOP**	
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a	
Approved: Board of Directors **Signature**:	**Approval Date:** **Reviewed/Revised Date:** **Next Review Date:**	March 4, 2015 Feb. 18, 2015 Nov. 19, 2015

CROSS REFERENCES: *if applicable*

PURPOSE

To outline the process for urgent, interim, or permanent succession for the President and CEO.

POLICY

~~The Thunder Bay Regional Health Sciences Board of Directors (the "**Board**") must ensure that provision is made for continuity of leadership for the Hospital. The Board will have in place a documented process for succession should the CEO position become vacant due to sudden loss, resignation, retirement or termination. Should the CEO require an extended leave of absence due to personal, health or other reasons, the succession plan should also specify the process for appointing an interim CEO.~~

The Board of Directors must ensure continuity of leadership with a documented process for succession should the CEO position become vacant.

PROCEDURE

A) Sudden Vacancy (e.g. death, resignation, termination, extended leave)

The CEO will identify in confidence to the Board Chair in writing at the beginning of each year two ~~potential replacements~~candidates to fill the role of interim CEO, if sudden ~~loss~~ vacancy of the CEO position occurs. The appointment of an interim CEO is subject to approval by the Board.

B) Vacancy

- The Board ~~will~~ establishes a CEO Search Committee. ~~consisting of: The Chair of the Board; two physicians: the Chief of Staff and the President of Professional Staff Association; the Dean of the Northern Ontario School of Medicine (NOSM); two Directors of the Thunder Bay Regional Research Institute; up to four other voting members of the Board, and; such other member(s) as may be appointed by the Board.~~

- So as to ensure continuity and the integrity of a search, an "ex officio" committee member as noted above whose tenure in a position as described comes to an end before the completion of a search, shall remain a member of the Search Committee with all of the rights and obligations of a member; ~~.~~

- The Chair of the Board ~~shall~~ acts as Chair of the Search Committee. Under circumstances as determined by the Board, the Board may appoint an alternate member of the Search Committee to act as its Chair; ~~.~~

- The Search Committee ~~shall~~ appoints a Secretary ~~who shall be~~ responsible for maintaining a record of the committee's activities;~~.~~

- The Search Committee may, at its discretion, select a search firm to assist with the process~~.~~;

- The Search Committee, after ~~will~~ interviewing appropriate ~~a short list of~~ candidates, ~~and~~ recommends to the Board its candidate of choice for approval; ~~by the Board.~~

- In the event a new CEO has not been appointed prior to the departure of the current CEO, the Board ~~will appoint~~appoints an interim CEO in accordance with section (A) of this Policy.

Thunder Bay Regional Health Sciences Centre Policies, Procedures, Standard Operating Practices	No. BD-NEW - ***DRAFT***
Title: Criminal Record Checks (CRC) – Board of Directors	**X Policy** **X Procedure** ☐ **SOP**
Category: Board of Directors **Dept/Prog/Service:** Board of Directors	**Distribution:** n/a
Approved: Board of Directors **Signature**:	**Approval Date:** **Reviewed/Revised Date:** **Next Review Date:**

CROSS REFERENCES: *If applicable.*

PURPOSE

Thunder Bay Regional Health Sciences Centre (the Hospital) has a legal responsibility to protect and act in the best interests of everyone it serves. As Board Directors may be subject to heightened public scrutiny and accountability, thorough background checks are an essential component of the Board recruitment process. Adopting this process provides a measure of due diligence by reducing potential risks.

POLICY

All prospective Board Directors, as well as Board Directors seeking re-election for a new term, must submit a satisfactory Criminal Record Check (CRC) to ensure the absence of relevant criminal convictions.

PROCEDURE

Prospective Board Directors:

1. Candidates selected for a Board Director interview, are first notified of the requirement of a CRC when completing the “Application for Membership Board of Directors/Board Committees” form which states that Director appointments is conditional upon a satisfactory CRC.

2. Following the selection process, and upon approval by the Board of Directors to include the candidate on the slate of nominees for Board Director elections, the candidate is notified in writing that a CRC is required prior to their name being added to the slate of nominees at the Annual General Meeting and that appointments as Board Directors are conditional upon satisfactory CRC.

3. Information received through a CRC is provided by the police to the candidate only. The candidate is required to provide the documentation to the Board Liaison, in the President’s Office. When the applicant shares this information, it is treated as confidential information and is safeguarded.

4. A CRC for volunteer Board Directors screening does not contravene the Ontario Human Rights Code and a positive response to a check does not necessarily preclude service.

Board Directors Seeking Re-election:

1. Board Directors seeking re-election are notified in writing of the requirement of a CRC, following approval from the Board to include his/her name on the slate of nominees at the Annual General Meeting. They are also notified that re-appointments as Board Directors are conditional upon a satisfactory CRC.

Search Requirements and Evaluating Results:

1. Candidate with a current CRC: If the candidate has a CRC which is dated less than six (6) months from the date of the Board Director elections, and they can provide the original document bearing the corporate seal of the verifying police agency, another CRC is not required.

2. Candidate without a current CRC: The applicant is given a standard form letter and instructed to take it to the verifying police agency. The standard form letter includes the following:

    a) name of the candidate;
    b) current address and known previous addresses for the past twelve (12) months;
    c) indication of the type of check required (i.e. Criminal Record Check);
    d) purpose of the request;
    e) signature of the Board Liason or designate.

3. If a candidate is unable despite best efforts to obtain a CRC prior to Board Director elections at the Annual General Meeting, the candidate must complete a "Declaration Form – Criminal Reference Check" form. Completion of this form, allows the candidate to be placed on the slate of nominees prior to receipt of a completed CRC, provided there is nothing noted that gives cause for concern to the Hospital. Please note, that the candidate remains responsible for following through with obtaining a CRC and that this form is in no way deemed to be a waiver of the requirement to provide a CRC satisfactory to Hospital as a condition of appointment.

4. The candidate provides a receipt from the police agency as proof that a search is being conducted within ten (10) days of the notification.

5. Reimbursement for the cost of the CRC is provided when the candidate has submitted an original receipt.

6. Satisfactory Results: If a satisfactory CRC is received, the "conditional" status of the Board Director candidacy/appointment is removed.

7. Positive Results: If an unfavourable CRC is received (a condition or issue has been identified), the Nominating Committee Chair and Board Chair review the circumstances, including but not limited to a consideration of the following factors:

    a) the nature of the matter of concern to the Hospital, including, if applicable, the nature of the offence;
    b) the relevance of the presenting issue or concern to the bona fide (genuine, good faith) requirements or qualifications for the position;
    c) the age of the candidate at the time the concerns, charges or convictions arose;
    d) the length of time since the charge and/or the conviction;
    e) whether or not a pardon for the offences has arisen or been granted through the operation of law, administrative processes, or the passage of time;
    f) if a pardon has been granted, the provision of documentary evidence of the pardon in a form acceptable to the hospital;
    g) rehabilitation efforts or other remedial measures or actions by the candidate irrespective of whether or not a pardon has arisen or been granted; and
    h) any other matter that is relevant and rationally connected to fulfillment of any legitimate Board of Director purpose.

    If after review, the positive CRC is deemed to be incompatible with the reasonable and bona fide qualifications for the position, and cannot be accommodated without undue hardship to the Hospital, the conditional appointment is withdrawn and the candidate is advised.

    If after review, the positive CRC is <u>not</u> deemed to violate the reasonable and bona fide qualifications for the position, the "conditional" status of the Board Director candidacy/appointment is removed.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Values Amendment
PREPARED BY	C. Freitag
APPROVED BY	J. Bartkowiak
PREPARED FOR: President &CEO ☒Board of Directors	
DATE PREPARED	May 31, 2016

PURPOSE/ISSUE(S)

To amend Policy BD-81 to include a consultation process when amending 2020 Strategic Plan, Vision, Mission or Values statements.

BACKGROUND

The CEO reviewed the ethical framework and recommended two amendments to the Values statements. At that time, the Senior Leadership Council was consulted on March 22nd and accepted the amendments.

The amendments were then presented to the Board at the April 6th meeting, where the CEO was asked to consult in a similar fashion to the original development of the 2020 Strategic Plan.

ANALYSIS/CURRENT STATUS

The engagement and approval of the 2020 Strategic Plan occurred at a retreat with the Board of Directors and Senior Leadership Team in December 2014.

They were then presented to the 2020 Strategic Planning Steering Committee, Leadership staff, 5 Partners, and focus groups during the extensive engagement strategy to develop the Strategic Goals.

The 2020 Strategic Planning Steering Committee's function was to develop and revise the strategic Goals. It did not advise on the Vision, Mission or Values statements, although it did advise on edits to the descriptions to the Strategic Directions. The time limited committee was disbanded following the adoption of the 2020 Strategic Plan by the Board in June 2015.

The Strategic Plan is a dynamic document and may require amendments to ensure it is relevant and meaningful over time. A process has been developed to achieve this by amending Board Policy BD-81 and assigning responsibility for reviewing suggested amendments to the Strategic Plan to the Governance Committee of the Board of Directors.

On May 18, 2016, the Governance Committee approved for recommendation to the Board of Directors one of the proposed amendments to the Values definitions (noted in red):

- Patients First: We are respectful of and responsive to the needs, values, and expectations of our patients, families and communities. Patient values guide all decisions.

The Governance Committee did not approve the following proposed amendment:

- Excellence: We foster an environment of innovation and learning to provide a quality patient experience.

The Excellence definition will remain as follows:

TOPIC	Values Amendment
PREPARED BY	C. Freitag
APPROVED BY	J. Bartkowiak

PREPARED FOR: President &CEO ☒Board of Directors

- Excellence: We foster an environment of innovation and learning to advance a quality patient experience.

RECOMMENDATION

Given that the Governance Committee is responsible for reviewing suggested amendments to the Strategic Plan, it recommends that the amendments outlined in policy BD-81 be accepted by the Board of Directors.

Further, it is recommended that the Board of Directors approves the amendment to the Values statement as recommended by the Governance Committee:

- Patients First: We are respectful of and responsive to the needs, values, and expectations of our patients, families and communities. Patient values guide all decisions.

NEXT STEPS

The Values statement will be amended in the 2020 Strategic Plan and Ethical Framework.

STAKEHOLDER REACTION

Positive.

COMMUNICATIONS

Once approved, the amended Values statements for the 2020 Strategic Plan will be communicated to the Leadership Team, 5 Partners and widely across the organization to staff, physicians, volunteers and patient and family advisors.

FINANCIAL IMPACTS

None.

APPENDIX SECTION

Board Policy BD-81

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community.
The following questions should be considered for each decision.

1. Does the course of action put '**Patients First**' by responding respectfully to needs and values of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate '**Respect**' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to advance a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making on the iNtranet under **Quality and Risk Management > Quality > ECFAA (Excellent Care for All Act) > Presentations.**

TBRHSC Framework for Ethical Decision Making
Updated: June 2016

Introduction

The basic and foundational statements about the ethical commitment of Thunder Bay Regional Health Sciences Centre (TBRHSC) are the Mission, Vision, and Values of the organization, adopted by the Board of Directors, and stating:

A) Mission: We will deliver a quality patient experience in an academic health care environment that is responsive to the needs of the population of Northwestern Ontario.

B) Vision: HEALTHY TOGETHER

C) Values:

Patients First: We are respectful of and responsive to the needs, values, and expectations of our patients, families and communities. Patient values guide all decisions.

Accountability: We are responsible to advance a quality patient experience. We commit to social and fiscal accountability to internal and external stakeholders and for the delivery of services to our patients.

Respect: We honour the uniqueness of each individual and his/her culture.

Excellence: We foster an environment of innovation and learning to advance a quality patient experience.

This Framework for Ethical Decision Making is a tool which will help us to assure that these basic ethical statements will inform and guide all decision making in TBRHSC.

Features of the Framework

- Upholding TBRHSC Mission, Vision, and Values
- Assuring that the Values of TBRHSC are expressed in all we think, say, print and do
- Coherent
- Practical to use
- Balancing attention to ends and means
- Useful for decision making at all levels, from the board level to the level of clinical, administrative, research and teaching units.

Range of Decisions Informed by the Framework

The framework will inform and guide decisions from the Boardroom to the bedside, including but not limited to decisions made by: the Board of Directors and its committees; Senior Leadership; Program and Service Directors; All teams and committees; Managers and Supervisors; Privileged Medical Staff; Educators; and Researchers.

The Framework will inform and guide all decisions made at TBRHSC, including but not limited to: program approval, review expansion or cancelling; policies approval and review; human resource management; financial management; strategic planning; organizational development; public relations/marketing; and others.

How to Use the Ethics Framework

1. Articulate the proposed decision and generate alternatives.

2. Ask, using the check list in the table below, how the proposed decision and each alternative supports the Mission and Vision and each of the four proclaimed Values.

3. Select the option which aligns best with the Mission, Vision and all our Values.

Note: A decision which does not, at least partially, uphold the Mission is inappropriate. If the decision does not express all or most of our Values or contradicts some of them, other options need to be considered. An exemption must be fully defensible.

Mission & Vision: ***Healthy Together*** We will deliver a quality patient experience in an academic health care environment that is responsive to the needs of the population of Northwestern Ontario.		**Does the Course of Action Uphold the Hospital Mission and Vision:**	**O yes** **O partially** **O no**	**Comments:**
Values:				
A. Patients first: We are respectful of and responsive to the needs, values, and expectations of our patients, families and communities. Patient values guide all decisions.		1. Does the course of action address a significant need of our patients or our community?	O yes O partially O no	
		2. Was there a fair consultation process about the course of action, including representation of those who are disadvantaged or unable to speak for themselves?	O yes O partially O no	
		3. Have we engaged the patients and families in dialogue, using language which they understand and encouraging open and honest expressions of opinions?	O yes O partially O no	
		4. Is the course of action guided by the values of patients and families, especially those most affected and most vulnerable?	O yes O partially O no	
		5. Would this course of action be defensible as "putting patients first" under tough scrutiny in the public forum?	O yes O partially O no	
B. Accountability: We are responsible to advance a quality patient experience. We commit to social and fiscal accountability to internal and external stakeholders and for the delivery of services to our patients.		1. Will the course of action improve safety and reduce risks to patients or could the course of action have an opposite effect?	O yes O partially O no	
		2. Is the course of action expected to improve the quality of care?	O yes O partially	

			O no	
		3. Is there a fiscal impact of the course of action on our organization?	O yes O partially Ono	
		4. Is the fiscal impact compatible with other important fiscal commitments?	O yes O partially Ono	
		5. Does the course of action represent prudent use of resources allocated ~~wisely~~ on the basis of fair and publicly-defensible reasons and procedures?	O yes O partially O no	
		6. Will the course of action promote the trust of patients, families, and the public in our organization?	O yes O partially Ono	
C. Respect We honour the uniqueness of each individual and his/her culture.		1. Does the course of action demonstrate due consideration for the dignity and rights of others?	O yes O partially Ono	
		2. Was there an effective process to learn about the uniqueness of every individual? (e.g. those who are hearing impaired, for whom English is not their first language, and those with mental illness)	O yes O partially O no	
		3. Is the course of action sensitive to the needs, interests, feelings and expectations of patients, which are diverse and can be influenced by a range of factors, including cultural, religious, and socioeconomic backgrounds?	O yes O partially O no	

		4. Does the course of action negatively impact a segment of the population or result in favouritism or reverse discrimination?	O yes O partially O no	
		5. Does the course of action provide a reasonable accommodation for individual needs, preferences, and expectations of our patients? (e.g.: Indigenous healing practices)	O yes O partially O no	
D. Excellence We foster an environment of innovation and learning to advance a quality patient experience.		1. Will the outcome surpass ordinary requirements or standards?	O yes O partially O no	
		2. Was a reasonable evaluation of the evidence conducted and does it support this course of action?	O yes O partially O no	
		3. Does this course of action support "Best Practice" that is the practice which has proven to be most effective in providing a certain outcome?	O yes O partially O no	
		4. Will the course of action advance the hospital as a leader in patient and family centred care?	O yes O partially O no	
		5. Does the course of action encourage and support learning and/or research?	O yes O partially O no	

ARTICLE 11- REGULAR AND SPECIAL MEETINGS OF THE BOARD

11.1 Regular Meetings

11.1 Regular Meetings

(a) There shall be at least eight~~ten~~ (8~~10~~) regular meetings of the Board each year, at such time and place as the Board may from time to time by resolution determine.

Thunder Bay Regional Health Sciences Centre

Accreditation Sub-Committee of the Board

Wednesday, May 4, 2016
Administration Boardroom – 2:00 - 3:00 p.m.

Present:
Dick Mannisto (Chair), Jean Bartkowiak, Gary Whitney, Grant Walsh

***Regrets*:**
Georjann Morriseau, Gerry Munt

By Invitation:
Cathy Covino, Senior Director, Quality and Risk Management
Gary Ferguson, Performance Improvement Consultant
Shameema Warsallee, Intern
Katrina Sutton, Rec. Sec.

1.0 CALL TO ORDER – The Chair called the meeting to order at 2:15 p.m.

1.1 Quorum – Attained.

1.2 Conflict of Interest – None.

1.3 Approval of the Agenda — ***Motion***

Moved by: ***Gary Whitney***
Seconded by: ***Grant Walsh***

"The agenda be approved as circulated."

CARRIED

2.0 BUSINESS/COMMITTEE MATTERS

2.1 Review Last Accreditation Results for Board Governance Standards and Identify Challenges

Mr. Gary Ferguson, Performance Improvement Consultant, and Mr. Dick Mannisto, Chair of the Sub-Committee, introduced the purpose of the Sub-Committee, which is to ensure that the Board of Directors is fully knowledgeable on its Accreditation Canada governance standards and that all Board members can provide examples of compliance when interviewed by Accreditation Canada as part of the 2018 Accreditation Survey.

2.2 Review Any Changes and/or New Standards in Preparation for 2018 Accreditation Survey

Mr. Gary Ferguson, Performance Improvement Consultant, briefly reviewed any changes or new standards in preparation for the 2018 Accreditation Survey.

2.3 Review Accreditation Standards #1.1 - #6.1

The Sub-Committee reviewed Accreditation standards #1.1 - #2.10 and the evidence of compliance for each standard. The evidence of compliance for each standard was pulled from the Board of Directors' By-Laws and Policies.

It was agreed that Accreditation standards #1.1 - #13.1 would be sent by email to the Sub-Committee to provide feedback on the evidence of compliance for each standard in advance of the next Sub-Committee meeting. ***Action***

3.0 FOR INFORMATION

3.1 COMMITTEE MEETING EVALUATION

Committee members completed their meeting evaluations.

4.0 BOARD MEMBER COMMENTS – None.

5.0 DATE OF NEXT MEETING

The next meeting is scheduled on May 17, 2016.

6.0 ADJOURNMENT - The meeting adjourned at 3:03 p.m.

Thunder Bay Regional Health Sciences Centre

Accreditation Sub-Committee of the Board

May 17, 2016

Administration Boardroom – 3:00 - 4:00 p.m.

Present:
Dick Mannisto (Chair), Jean Bartkowiak, Georjann Morriseau, Gary Whitney

***Regrets*:**
Grant Walsh

By Invitation:
Cathy Covino, Senior Director, Quality and Risk Management
Gary Ferguson, Performance Improvement Consultant
Katrina Sutton, Rec. Sec.

1.0 CALL TO ORDER – The Chair called the meeting to order at 3:02 p.m.

1.1 Quorum – Attained.

1.2 Conflict of Interest – None.

1.3 Approval of the Agenda

Moved by: *Georjann Morrisseau* — ***Motion***
Seconded by: *Gary Whitney*

"The agenda be approved as circulated."

CARRIED

2.0 BUSINESS/COMMITTEE MATTERS

2.1 Confirm Evidence of Compliance Submitted for Accreditation Standards #1.1 - #6.1

The Sub-Committee reviewed the evidence of compliance submitted for Accreditation Standards #1.1 - #6.1. The evidence of compliance for each standard was taken from the Board of Directors' By-Laws and Policies and was informed by Sub-Committee members' feedback.

The Sub-Committee confirmed the evidence of compliance submitted with the following

amendments:

- The evidence of compliance for #2.9 shall reflect that Board members are expected to provide a presentation back to the Board after attending an educational event and that there is a process to educate the Board as a whole, which will be part of the annual assessment of Board members' needs. It shall also reflect that Board agendas regularly include educational presentations, and that resources are available for Board members' attendance at educational events. — ***Action***
- Standards where it is felt that the Board is lacking in its evidence of compliance and can use improvement will be highlighted in red. — ***Action***

2.2 <u>Review Feedback Received re: Accreditation Standards #6.2 - #13.10</u>

The Sub-Committee reviewed Accreditation standards #6.2 - #12.3 and the evidence of compliance for each standard. The evidence of compliance for each standard was taken from the Board of Directors' By-Laws and Policies and was informed by Sub-Committee members' feedback.

The Sub-Committee confirmed the evidence of compliance submitted with the following amendments:

- For Standard #6.2, include in the evidence of compliance the Annual 5 Partner Accountability sessions and Strategic Goals by Senior Leader. — ***Action***
- For Standard #7.4, include in the evidence of compliance the June 2015 Executive Committee meeting and the Restricted In-Camera meetings where feedback is provided to the Chair of the Board of Directors and subsequently the President and CEO. Also include the 2017 CEO Evaluation Committee. — ***Action***
- For Standard #7.5, include in the evidence of compliance that the employment contract for the President & CEO provides resources for personal education and development on an annual basis. — ***Action***
- For Standard #7.7, include in the evidence of compliance the 360 Survey (not Summary). — ***Action***
- For Standard #7.9, include in the evidence of compliance that the Human Resources department oversees succession planning for the Hospital and potential vacancies as part of the Hospital's recruitment strategy. — ***Action***
- For Standard #8.1, include in the evidence of compliance the Board In-Camera minutes, the Medical Advisory Committee (MAC) minutes, and the Credentialing Committee minutes. — ***Action***
- For Standard #9.2, include in the evidence of compliance the Audit Committee of the Board, the annual external audit of the Hospital, and the Annual General Meeting. — ***Action***
- For Standard #9.3, include in the evidence of compliance the Resource Planning Committee of the Board compliance report, dashboard, and attestation statements. — ***Action***
- For Standard #9.4, remove from the evidence of compliance the RFP process. Mr. — ***Action***

Ferguson will follow-up with Mr. Peter Myllymaa regarding the threshold dollar value for major capital equipment purchases as approved by the Board of Directors and the associated policy.

- For Standard #10.1, include in the evidence of compliance the 2020 Strategic Plan and the Balanced Scorecard. ***Action***
- For Standard #10.5, Mr. Ferguson to seek further clarification. ***Action***
- For Standard #11.3, Mr. Ferguson to obtain the communication plan from Tracie Smith. ***Action***
- For Standard #11.5, include in the evidence of compliance the Annual 5 Partners Accountability session. ***Action***
- For Standard #11.7, include in the evidence of compliance the Annual 5 Partners Accountability session, the Hospital's annual report, and the Hospital's website. ***Action***
- For Standard #12.1.6, include in the evidence of compliance the CEO performance evaluation. ***Action***
- For Standard #12.2, include in the evidence of compliance the Quality Improvement Plan (QIP) submission to Health Quality Ontario (HQO). ***Action***
- For Standard #12.3, include in the evidence of compliance the Enterprise Risk Management (ERM) report that is presented on a quarterly basis to the Quality Committee of the Board. ***Action***

The Sub-Committee agreed that they would review and confirm the evidence of compliance submitted for Standards #12.4 - #13.10 via email. A motion will also be circulated via email to the Sub-Committee to recommend that the Board of Directors approves the evidence of compliance submitted for Accreditation Standards #1.1 - #13.10. ***Action***

3.0 CONSENT AGENDA

Moved by: ***Gary Whitney*** ***Motion***
Seconded by: ***Georjann Morrisseau***

"That the Accreditation Sub-Committee of the Board approves the Accreditation Sub-Committee of the Board minutes of May 4, 2016, as presented."

CARRIED

4.0 FOR INFORMATION

4.1 COMMITTEE MEETING EVALUATION

Committee members completed their meeting evaluations.

5.0 BOARD MEMBER COMMENTS – None.

6.0 DATE OF NEXT MEETING

The next meeting is to be determined.

7.0 ADJOURNMENT - The meeting adjourned at 3:58 p.m.

Thunder Bay Regional Health Sciences Centre

980 rue Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Tel: (807) 684-6007
www.tbrhsc.net

Senior Leadership Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre
June 8, 2016

Academics and Interprofessional Education

Medical Students and Residents

- Academics welcomed 27 new fourth year medical students in May. In July, we look forward to 23 new residents joining the organization; one of our largest and most robust classes of residents. Specifically, among the 23 residents, 9 different specialties are represented, 9 students just graduated from NOSM, 9 are from other universities and 5 are international medical graduates. Furthermore, we are excited to have a PGY3 resident continue their family medicine residency in Care of the Elderly (a first for us).

Supports and Structures for Education

- Interprofessional Education is piloting web-based software to assist with internal course registration, payment and attendance. The software will allow for easier access to training and a method to report on participant demographics.

Medical Affairs

- Dr. Bradley Jacobson accepted the position of Medical Lead, Emergency Service.
- Dr. Wendy Liu accepted a position with our Emergency Department with a tentative start date of July 1st.
- All Department Chiefs, in collaboration with Medical and Administrative Program Directors, have been updating their Physician Human Resource Plan, which will be reviewed with all parties in June.
- Three site visits took place during the month of May, with candidates for Interventional Cardiology, Vascular Surgery and Palliative Care.
- Our Physician Recruitment Assistant will be attending the Canadian Association of Pathologists Annual Meeting in Vancouver in July.
- We continue to actively recruit for many areas, with a focused effort at this time on Pathology, Hospitalist Medicine, Psychiatry, Dermatology and Vascular Surgery.
- Choosing Wisely Initiative: All departments have submitted their recommendations for consideration.

Pharmacy

Medication Reconciliation

- The medication reconciliation admission rate for April 2016 was 61.4 %, a decrease from 63.2% in March 2016.

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Anti-microbial Stewardship

- The 2015-16 Antibiogram has been recently completed. The Antibiogram is a summary of our current susceptibilities of different antibiotics to certain bacteria (i.e. drugs versus bugs and will be distributed to Professional Staff and medical learners.

EVP, Patient Services & Chief Nursing Executive

Emergency (ED) Patient Flow

- In April 2016, ED continued to perform at or better than provincial targets for non-admitted high acuity patients with a length of stay (LOS) of 6.6 hours (target 7 hours) and low acuity LOS of 3.4 hours (target 4 hours)
- In April, on average, 19 admitted patients waited 37 hours in ED for an in-patient bed

Emergency (ED) Return Visit Quality Program

- TBRHSC began participation in the ED Return Visit Quality Program in April 2016. This new provincial program requires that all EDs will review data on return visits, conduct audits to identify underlying causes of these return visits and take steps to improve processes.

National Surgical Quality Improvement Plan (NSQIP)

- NSQIP collects data that provides fair, in-depth and insightful analysis, helping Perioperative Services better understand their quality of care compared to similar hospital with similar patients
- The Perioperative Quality Improvement Plan (QIP) this year will focus on reducing the hip fracture patient's average length of stay from 7.9 to 6.7 days and average acute days from 5.9 to 4.8 days. The anticipated impact of the QIP implementation would be a decreased wait time for fractured hip patients to have surgical repair.

Acute Pain Service (APS)

- The APS will provide postoperative pain management for patients who have been admitted to the hospital having undergone surgery or intervention. Comprehensive pain management in the perioperative setting is intended to reduce or eliminate postoperative pain, improve mobilization, decrease stress on the organ systems and enhance overall patient satisfaction. This comprehensive pain management service has received base funding of $280,500 from the Ministry of Health and Long-Term Care to fill this gap in service. The start date for the APS is June 27, 2016.

New CT Scanner

- New Siemens Somotom Edge 128-slice CT scanner is installed and ready for clinical use.
- Applications training booked for May 30, 2016 with acceptance testing June 17, 2016.
- New technology will support increased patient volumes (5 additional patients per day initially), improve access to care and decrease wait times. As of April 16th, 12 additional slots have been added on Saturdays and Sundays (24 additional patients).

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PFCC

- TBRHSC will be hosting Health Quality Ontario (HQO) Patient Advisory Council on June 3, 2016 to provide an educational opportunity to see and learn how TBRHSC has become a regional and provincial leader in patient and family engagement. PFAs will also collaborate with HQO on June 4, 2016 to support the development of HQO's On-line Patient Engagement Resource and Tools Hub.

Corporate Services & Operations

Financial Services

- Due to additional LHIN funding for operating pressures the hospital was able to close fiscal 2015/16 with a deficit of $727,819.
- As at April 30, 2016 the deficit is $654,429 compared to a budget deficit of $569,519 and prior year deficit of $1,236,916.

Capital Planning & Operations

- TBRHSC has no outstanding orders under the Fire Code (as overseen by the Fire Department) or Environment Protection Act (as overseen by Ministry of Environment) - and TBRHSC is not aware of any non-compliances in regards to the requirements of these legislations.
- Nutrition and Food Services has implemented a Picture Menu that is utilized by Hostesses to allow patients to select their food choices for the following day. The purpose of the menu is to assist communicating the menu items to a Patient who may not understand English or has difficulty communicating with the Hostesses.
- A new parking directive has been issued by the MOHTLC that will be implemented by October 1, 2016 in order to provide more information about the reduction of hospital parking fees for frequent patients and visitors.

Northwest Supply Chain

- The NSC program moved one step closer in May to on boarding twenty four (24) Hospitals from LHIN 13 with NSC Steering Committee's approval of our Business Case that was earlier approved by the Matrix Management group at the Ministry of Government and Consumer Services. Transer Payment Agreement to be finalized in June.

Informatics

- Process for the new data centre is now underway. This initiative is expected to take 18 months to complete.
- Free WiFi service is now available to our patients and families. The service is being made available through the generosity of Tbay Tel.

Decision Support

- In May 2016, test data for 2015-16 data was submitted to the MOHLTC, the first major milestone on TBRHSC's journey to case costing. Once case costing is fully

deployed, its data will be used to better understand costs and quality of care, and to support evidence-based decision making.

Patient Services and Cancer Care Ontario

Adult and Forensic Mental Health Program

- The Mental Health Emergency Executive Committee continues to work towards the development of a Mental Health Emergency. Recently, surveys were sent to Emergency Departments throughout Canada in order to gather information about models of Emergency Mental Health Care. These will be followed by selected site visits in an effort to revise the plan and submission to the North West Local Health Integration Network.

Cardiovascular & Stroke Program

- Program representatives visited the Dryden, Fort Frances, and Kenora hospitals to share the North West Regional Stroke Report Card results, provide an update regarding the Cardiovascular Surgical Program development, and generally strengthen collaboration between our teams. We heard they appreciate our efforts to support regional care and expressed their desire for more face-to-face visits from our physician leaders.
- Discussions are ongoing with the Ministry of Health and Long-Term Care (MOHLTC) and the Cardiac Care Network around transitioning cardiac surgical patients to the University Health Network beginning in 2016/17. The MOHLTC states they are committed to a speedy process over the coming weeks so they can inform their internal 2017/18 budget process in August.

Prevention & Screening Services

- Pap-A-Palooza was a regional Cervical Cancer Awareness Month campaign that encouraged and provided incentive for women to complete their cervical cancer screening. 10 health clinics participated throughout the region and 170 women completed a Pap test.
- Mammothon was a one-day breast cancer screening marathon that occurred on May 4, 2016. 4 regional Ontario Breast Screening Program sites participated with a goal of screening 75 women. The result was that 135 women were screened, seeing 52 walk-in appointments and 35 initial screens.
- Dr. Claudette Chase, Regional Primary Care Lead, and Crystal Davey, Regional Aboriginal Cancer Lead, participated in a road show with healthcare providers in Fort Frances, Kenora, Dryden, and Sioux Lookout from May 9-12, 2016. The focus was on topics ranging from prevention to palliative care and survivorship and information that was pertinent for patients in their practices.

Regional Cancer Program

- Our program is participating in an Onco-Fertility trial with Mount Sinai Centre for Fertility and Reproductive Health. The trial provides opportunities for cancer patients

to have a rapid consultation with fertility experts prior to undergoing cancer treatment known to cause infertility. Through the use of telemedicine, this pilot is intended to minimize any delay in cancer treatment while accessing expert consultative services for fertility preservation.

- Recruitment is underway to replace Dr. Dorie-Anna Dueck, Medical Oncologist who has relocated. Dr. Sunil Gulavita, Radiation Therapy Lead is retiring in June and the department is currently recruiting for his replacement. Dr. Marlon Hagerty, a Northern Ontario School of Medicine graduate, will be joining the Radiation Oncology team in July, filling a fourth Alternate Funding Plan (AFP) position on this team.

Human Resources

Ministry of Labour (MOL) Site Visit-Update

- The Hospital received a total of 38 orders during the April 11-15, 2016 Ministry of Labour Site Visit. As of June 4, 2016 all orders have been complied with.

Sick Time Management Strategy

- Engagement was held with the leadership group during the May 25, 2016 Planning and Performance Review (Q4). The engagement focused on strategies which deal with absences of less than 7 days and available tools including Absence Reporting Procedures Checklist and Sick Leave Management policies and procedures.

Clinical Careers Open House

- A public event was held on May 30, 2016 where participants were invited to explore a career in healthcare. Various healthcare professionals were on site showcasing the many diverse and fascinating working environments available within TBRHSC. The open house also provided educational information needed to determine potential career paths and which programs can best position individuals for success in the healthcare field.

Leadership Enhancement Institute

- The second Leadership Enhancement Institute (LEI) session facilitated in partnership with Studer Group Canada will be held on June 8, 2016. The focus of this session is to elevate existing communication skills in order to create safety in the work environment, access critical information without fear or anxiety, clarify expectations with others respectfully, and support performance and individual achievement.

Indigenous Recruitment Engagement

- An engagement session was held with members if the Indigenous Advisory Council on May 30, 2016. Strategies are being developed to increase the recruitment of Indigenous staff at TBRHSC, provide cultural sensitivity training to staff, physicians and volunteers, and to continue to create an environment where Indigenous patients and families feel more comfortable.

Volunteer Services

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www.tbrhsc.net

- Jean Murray of the Volunteer Association to the TBRHSC presented a bursary at the annual Nursing Awards Reception.
- Volunteer Services provided general orientation to 11 new volunteers.

Research

Clinical Research Services Department

- Thunder Bay is partnered with Princess Margaret Hospital in a Pan-Canadian network which creates opportunities for sharing resources, staff training and support of operations, activities, and methods to facilitate faster start-up and increase recruitment to clinical trials.
- As part of this, the "ASK ME" campaign was rolled out in May – the campaign is a cross-Canada initiative to increase awareness of clinical trials.

Research Quality Oversight Program

- The following policies were recently submitted to the Hospital's Policy & Procedures Committee for review at their June meeting: *Conflict of Interest in Research; Scientific Authorship Guidelines; Clinical Research Support Services for Researchers; Investigator Responsibilities for the Conduct of Research Involving Humans*; and *Monitoring of Investigator Initiated Studies.*

TBRRI Annual General Meeting

- Ms. Ashley Challinor, Senior Policy Analyst with the Ontario Chamber of Commerce will deliver the keynote address "Health Care Transformation Through Value & Innovation" at our June 23rd AGM.
- The meeting starts at 2:00 in Auditorium A & B at TBRHSC and everyone is welcome
- The Institute's new Strategic Plan will also be launched at this event.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Fire & Environmental Compliance Update
PREPARED BY	Anne Marie Heron and Kathryn Shewfelt
APPROVED BY	Peter Myllymaa
PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other	
DATE PREPARED	May 27, 2016

PURPOSE/ISSUE(S)

To provide the Hospital Board of Directors with and update on Fire and Environmental Compliance.

BACKGROUND

The Hospital has no outstanding orders under the Fire Code (as overseen by the Fire Department) or Environment Protection Act (as overseen by Ministry of Environment) - and the Hospital is not aware of any non-compliances in regards to the requirements of these legislations.

ANALYSIS/CURRENT STATUS

Summary of status:

Fire Code

- Working with Thunder Bay Fire and Rescue to schedule inspection and minimum staffing drill for 2016
- No major issues identified at last inspection

Sterilization in SPD

- Usage of Ethylene Oxide (EtO) system for sterilization ceased in 2014 (replaced with peroxide-based sterilizer)
- Decommissioning of system to occur after approval of amendment to ECA received – awaiting final approval from Ministry of Environment; removal plan under development with Steris

Co-Generation

- ECA amendment – approval received July 2015
- Noise and emission testing completed as part of the requirements under the ECA amendment
- Reports submitted to MOE and awaiting final feedback and acceptance

Green Energy Act (Ministry of Energy)

- Annual energy reporting to commence July 2013 for all BPS establishments
- July 2014 five-year energy reduction program posted
- **Next update due July 1, 2016**

RECOMMENDATION

No further recommendations. Continue to implement projects and initiatives.

TOPIC	Fire & Environmental Compliance Update
PREPARED BY	Anne Marie Heron and Kathryn Shewfelt
APPROVED BY	Peter Myllymaa

PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other

NEXT STEPS

N/A

STAKEHOLDER REACTION

N/A

COMMUNICATIONS

N/A

FINANCIAL IMPACTS

N/A

APPENDIX SECTION

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community. The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs & values of our patients, families, and communities?
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For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making on the iNtranet under **Quality and Risk Management > Quality > ECFAA (Excellent Care for All Act) > Presentations.**

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Tel: (807) 684-6007
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President and CEO
Président directeur général

Report from Jean Bartkowiak
President and CEO
June 8, 2016

There is a palpable change in the atmosphere at our Health Sciences Centre. Staff, physicians and volunteers are feeling the difference brought about by the significant reduction in surge capacity over the past few months, and there is a level of calmness on the units. In the past year, our collaborative efforts resulted in improved bed occupancy rates. The average daily admitted patient census in both April and May was 386. These are the lowest months in the past two years. Last year, the same two months saw averages of 421 (April, 2015) and 404 (May, 2015). 14 of the last 15 months have shown improvement compared to the previous year.

Helping to achieve our goals in this area will be the newly appointed Chief of Staff. Dr. Gordon Porter is a familiar member of our team, and has served effectively in the role of Chief of Staff at our Health Sciences Centre in the past. His dedication to patient care is well known. Along with his passion for quality, he brings to the role extensive experience in medicine, research and teaching.

I am pleased to announce that the new Vice President, Human Resources, has been hired. Amanda Bjorn will begin August 2, and brings experience in organizational development, planning, implementation, monitoring and evaluation of corporate educational and people development services as they relate to the organization's Vision and Strategic Plan.

In addition, we have opened the competition for the position of Vice President, Research, and I look forward to announcing the successful candidate in the near future.

We will also be recruiting to fill the position of the Chair of the Research Ethics Board. Dr. Scott Sellick, who has been effectively serving in that capacity, has announced his retirement.

On that note, I was fortunate to be part of the May 10 celebration recognizing the contributions of the Health Sciences Centre employees who retired in 2015. Collectively, these individuals contributed an impressive 4,215,900 hours (based on 7.5 hour work day) to enable our progress and successes over the years, or the equivalent of a full year of operation from the current Hospital staff complement.

It was an honour to also commemorate the largest group of employees at our Health Sciences Centre during National Nursing Week. Many of our nurses were presented awards for their outstanding contributions. Nursing Week provides opportunity to recognize the ongoing dedication and achievements of Registered Nurses, Registered Practical Nurses and Nurse Practitioners. I commend their commitment to our patients and their families, 24 hours a day, 365 days per year.

We also recently celebrated those who help advance patient care through their philanthropic gifts. Together with our Health Sciences Foundation, we hosted the Presidents' Reception on May 12 to share with donors the extraordinary contributions their donations make in all clinical and scientific programs. I take this opportunity to extend my gratitude to all donors for their generosity.

On May 27, we received the latest data released from the Canadian Institute for Health Information (CIHI), which shows how health systems across the country compare with one another. The data reveals that our Health Sciences Centre compares favourably to other hospitals in several areas, including the cost of a hospital stay and Emergency Department wait times for physician initial

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assessment. Similarly, although our administrative expenses are above the Canadian average, they are considerably lower than the Ontario average, and well below the Ontario teaching hospital average. The CIHI data provides a welcome means to show improvement, and also identifies where more work is needed in order to better serve our patients and their families.

On May 16, I met with Joint Executive Psychiatry Governance Committee to review practices. Our intent is to develop recommendations regarding Emergency Department activity, and a new structure to best assist and orient patients who require immediate acute psychiatric care.

On May 24, I also met with the new Executive Director of Shelter House Thunder Bay and the NorWest Community Health Centre's Clinical Director. Together, we are working to provide access to the most appropriate care for non-acute addictions cases. Many patients could receive the care they need in the community, and relieve pressure in the Emergency Department.

This month, we launched an operational review, which we believe will support existing evidence that the Health Sciences Centre operates efficiently and continues to put quality care at the forefront. Despite ongoing efforts and commitment to quality, effectiveness and efficiency, our Health Sciences Centre continues to face service and financial pressures as a result of many fiscal, demographic and health care system challenges. These challenges are recognized by leadership at the North West Local Health Integration Network (LHIN). That is why the LHIN is supportive of the operational review by Hay Group Health Care Consulting.

In addition to a Hospital Improvement Plan – one outcome of the operational review, we have much to look forward to. Our Accreditation sub-committee is gearing up for next year's survey. Also, we will launch the new Strategic Plan for our research arm, the Thunder Bay Regional Research Institute. The strategic plan shapes research activity over the next four years, and supports our growth as an academic health sciences centre.

The following reports from my portfolio include more highlights of recent activities.

Quality and Risk Management

Enterprise Risk Management:

- Our Insurance Company Marsh is supporting streamlining the risk identification, analysis and evaluation process.
- Marsh updated the online risk gap reporting tool.
- We are planning to refresh the hospital's risk registry and will meet with Leadership to:
  - Implement a standardized risk categorization and rating system for risks not identified through the online system;
  - Introduce 3 new modules to identify risks related to finance, environmental services and clinical trials.

Quality - Enhancing the Quality Patient Experience:

- The Patient Experience project team has established a definition of quality and will complete the framework;
- To achieve a quality patient experience, the hospital has identified that we will provide care that is: safe, effective, patient /family centred, efficient, timely, and equitable:

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- **Safe:** Do no harm;
- **Effective:** Use best practices to improve patient outcomes;
- **Patient /Family Centred:** Respect and respond to individual patient/family expectations, needs and values;
- **Efficient:** Optimize resources to avoid waste;
- **Timely:** Avoid harmful delays;
- **Equitable:** Provide access to fair and appropriate care for all patients;

- An integrated approach ensures that patients and their families receive safe quality care supported by evidence that improves outcomes.
- Engagement with the Patient and Family Advisorsand Professional Practice Leads has occurred and we will engage the Medical Advisory Committee this month.

Communications, Indigenous Affairs & Engagement

Indigenous Affairs:

- A Traditional Practices & Knowledge Working Group has been established and has begun to shape a plan of action. We are grateful that Dr. William McCready has agreed to participate as a physician champion. Membership also includes representation from PFCC, Spiritual Care, Professional Practice, Medical Affairs and Nursing. Initial activities will include an environmental scan, best practice research and engagement, and partnership building.

- A Working Group was also struck to develop a Directory of Services to be used primarily by front-line staff, and shared with our partners, that would include service options for patients returning to remote First Nation communities. It was determined that several Directories of Services currently exist at various levels. To truly address patient needs and enhance transitions, we must develop internal and external discharge processes and stronger relationships with the Health care providers and Health Service Coordinators in the communities. The Services Directory Working Group is developing recommendations to support a transition to the Patient Flow Strategy Discharge Working Group.

- The Indigenous Advisory Committee was expanded to include additional internal representation by leaders responsible for activities within the Indigenous Health Strategic Direction.

- Indigenous Affairs is actively participating in a Working Group to develop Sensitivity & Knowledge Training for future implementation across our Health Sciences Centre.

- Again this year, we successfully applied for funding from Heritage Canada to support National Aboriginal Day celebrations. Patients, family members, visitors, staff and volunteers are welcome to participate in a variety of activities planned for June 21, including an opening ceremony with traditional drumming.

- As a result of engagement with the Indigenous Advisory Committee, a draft definition of a welcoming environment has been developed, along with recommendations to support the same at our Health Sciences Centre.

Engagement:

- An Accessibility Plan Engagement Open House was hosted on June 2 to gather public input for the Health Sciences Centre's next 5-year Accessibility Plan. An on-line survey will remain open

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until June 17 for additional input. A Working Group, comprised on internal and external members, will collate all responses and develop recommendations for consideration by the Accessibility Implementation Team.

- Engagement support was provided at the Quarterly Planning & Performance session for the Hospital leadership staff, with a focus on improving sick time management.

- Engagement with the 5 Partners in Health will occur at the annual Accountability Session (June 9), with a focus on gathering input in the areas of Patient Satisfaction Surveys and identifying success criteria for a respectful environment.

Communications:

- Recent media activity include an event to announce free WiFi services at our Health Sciences Centre, release of data from the latest CIHI data, an update on the Mobile Screening Coach and a CBC Radio Canada interview regarding accessibility.

- The team developed on-line and print summaries of the annual report for release at the Annual General Meeting.

- In collaboration with Strategy & Performance, communications templates are in development to support staff awareness of Strategic Plan progress.

Strategy & Performance

Strategic Plan 2020:

- The project teams responsible for the delivery of care that is Sensitive for Patient Experience, Seniors' Health, Indigenous Health and Acute Mental Health and will have a coordinated education plan developed by late September;
- We have facilitated the development of the Research Institute Strategic Plan 2020 for presentation to the Board of Directors in June. Following approval, we will support the Research Institute team to develop action plans and finalize indicators;
- Further development of the Indigenous Health Strategic Monitoring Indicators will take place in June. We will be meeting with Indigenous leaders to gather their input in said Strategic Monitoring Indicators, with presentation of findings in September.

Accreditation:

- On May 24th, the Accreditation Decision Committee provided a letter indicating that we have satisfied the review requirements and remain accreditated.

Organization Committee Structure Review:

- Leading a project team to assess the current committee structure state and endorse meetings for results, effective decision-making and increased productivity. A committee inventory is complete and analysis underway. On June 22nd we will engage the Leadership Team to provide feedback on the analysis and reintorduce meetings for results.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	Reduction in Board Meetings
PREPARED BY	Jessica Nehrebecky, Board Liaison
APPROVED BY	Jean Bartkowiak, President and CEO
PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other	
DATE PREPARED	June 1, 2016

PURPOSE/ISSUE(S)

To reduce the obligation to hold Board meetings from ten to eight.

BACKGROUND

Article 11.1 (a) currently states that "There shall be at least ten (10) regular meetings of the Board each year, at such time and place as the Board may from time to time by resolution determine". Given the direction in the By-Laws, the Board currently has had regularly scheduled meetings monthly from September until June. However in the month of September and January,, given the summer and holidays reduction in governance activity, it is sometimes challenging to assemble enough subjects and material to hold a meaningful meeting agenda.

ANALYSIS/CURRENT STATUS

The Governance Committee has recommended an amendment to the By-Laws to read as follows: "There shall be at least eight (8) regular meetings of the Board each year, at such time and place as the Board may from time to time by resolution determine".

The above noted will allow for more flexibility should the Board activity require less than ten meetings per year.

RECOMMENDATION

It is recommended that the Board of Directors reduce the obligation to hold Board meetings from ten to eight eliminating the September and January meetings annually. Rationale is as follows:

- Committees of the Board do not meet in June; therefore there is hardly any material to bring forward to the September meeting;
- July, August and September generally have less activity due to vacations and less to report on in September and January respectively;
- Propose to have an annual retreat and orientation sessions in September in lieu of a regular Board meeting;
- Less onerous on the Board members' time;
- Committees are shifting to doing more of the "work" versus the Board as a whole.

Administrative supports for each of the Board Committees have been canvassed to ensure that the work plans can be achieved with the elimination of the Board meetings in September and January.

It should be noted that the reduction of two Board meetings does not restrict additional meetings being scheduled at the discretion of the Board Chair or at the call of at least three Directors.

NEXT STEPS

Communicate the new schedule to all Board members.

STAKEHOLDER REACTION

TOPIC	Reduction in Board Meetings
PREPARED BY	Jessica Nehrebecky, Board Liaison
APPROVED BY	Jean Bartkowiak, President and CEO

PREPARED FOR: President & CEO ☐ Board of Directors ☒ Other

A positive reaction is anticipated from Senior Leadership and staff. A neutral reaction is anticipated from the general public.

COMMUNICATIONS

Noted in next steps.

FINANCIAL IMPACTS

Reduction of approximately $900.00 annually for catering expense.

Reduction in banked time for support staff.

APPENDIX SECTION

See attached proposed meeting schedule.

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THUNDER BAY REGIONAL HEALTH SCIENCES CENTRE
Board of Directors – Board and Committee Meeting Schedule 2016-17 ***(Revised June 3, 2016)***

Board of Directors	Resource Planning	Audit Committee	Executive	Quality	Governance / Nominating	Fiscal Advisory Committee	Tri-Board Foundation/ TBRRI/TBRHSC Meetings	Annual & Inaugural/ Retreats and Other
1st Wednesday 5:00 p.m. Boardroom	**3rd Tuesday 7:30 a.m.** Boardroom	**7:30am** Boardroom	**Call of the Chair** Boardroom	**3rd Tuesday 4:30 p.m.** Boardroom	**3rd Wednesday 7:30 a.m.** Boardroom	**Bi-Annually** 9:00am		**Yearly** 7:00 p.m.
2016	**2016**	**2016**	**2016**	**2016**	**2016**	**2016**	**2015**	**2016**
NO MEETNG	September 20			September 20	September 21		September (Mtg of the CEOs)	Retreat (will be held in Sept beginning in 2017)
October 5	October 18			October 18			October (CEO/Chair and Vice Chairs)	Oct 20-21 Retreat
November 8	November 15			November 15	November 16	November 7	November (Mtg of the CEOs)	
December 7	December 13			December 13)				
2017	**2017**	**2017**	**2017**	**2017**	**2017**	**2017**	**2017**	**2017**
NO MEETING	January 17	January 11		January 17				
February 1	February 14			February 14	February 15		February (Mtg of the CEOs)	
March 1	March 21	March 29		March 21	March 22		March (CEO/Chair and Vice Chairs)	
April 5	April 18			April 18	April 19 (5pm interviews)	April 10		
May 3	May 16	May31		May 16	May 17		May (Mtg of the CEOs)	
June 7								June 22 – 7pm (AGM and Inaugural)

Indicates Changes/Additions

Thunder Bay Regional
Health Sciences
Foundation

980 Oliver Road
Thunder Bay ON
P7B 6V4 Canada

TEL: 807 345 4673
FAX: 807 684 5802
TOLL FREE: 1 877 696 7223

Northern Cancer Fund

Northern Cardiac Fund

Health Sciences Discovery Fund

Report to the Thunder Bay Regional Health Sciences Centre Board of Directors
June 2016

What will you do with your new home?
On July 1, one lucky person will be named the winner of the luxury home in Sherwood Estates, thanks to the 30th Annual Canada Day House Lottery. Fort William Rotary is proudly selling only 10,000 tickets for this fantastic prize and we're all eligible! Stop by the Foundation office today to purchase your ticket for $100 or 3 for $250. $50,000 is available in early bird cash draws every Thursday.

Who are you riding for?
Over 180 people are already registered for the 2016 **Tbaytel Motorcycle Ride for Dad** in support of the Prostate Cancer fund of the Northern Cancer Fund. Riders will all start their engines together on June 18/16 in a 'Roar for a Cure' and then head out on a day-long poker run in and around the city. Opening and closing ceremonies will take place at the Victoria Inn.

Interested in participating (register online today at www.healthsciencesfoundation.ca) or volunteering for this fantastic event? Please contact Tim Bernardi at 684-7278.

Ladies, register online today!
Queens, unite! June 14/16 marks the 10th Annual **Remax Queen of Hearts Ladies Golf Classic** where over 100 women gather to golf, be pampered and raise funds for the Northern Cardiac Fund. This event is for golfers and those looking to spend a day with friends alike. Register online today at www.healthsciencesfoundation.ca – spots are going quickly for this fantastic tournament. For questions or interested in volunteering please contact Devon Sokoloski at 684-7113.

Will you play on Team Staal?
On May 2 the Foundation through collaboration with the **Staal Foundation Open** held a media conference to announce the Team Staal Video Challenge and highlight the many family friendly events that will be happening at the Staal Open from July 11-17. The top 3 fundraisers who enter videos will get the chance to play alongside the Staal brothers at a road hockey tournament during the week of the Staal Open. Full details available at www.staalopen.ca/teamstaal or contact Lindsey Doran at 684-7010.

Planning your summer? Make your legacy.
You're finally grilling outside, planning vacations and soaking up some warm sunshine. With all this fun around the corner, it's time to plan in earnest for your future – near or far. Before you map out your herb garden, book an appointment to review your Will and consider a gift to the Health Sciences Foundation.

Every gift – regardless of size – impacts the care offered to all of us in Northwestern Ontario. Your Health Sciences Foundation helps make possible things like new new infant warmers for the tiniest residents, just starting their lives through to new vital signs monitors machines for patients receiving care here at the Health Sciences Centre and regional sites, including Marathon.

Every gift makes a difference and we hope that you've taken the time to think about what your legacy could be. Haven't had a chance? Want to know where your gift could make a difference? Please contact Terri Hrkac, Senior Director, Planned and Major Gifts at 684-7109 for more information.

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Chief of Staff Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre

June 2016

Department Chiefs

- We are pleased to announce the re-appointment of Dr. Justin Jagger as Chief of Pediatrics

Annual Doctors' Day Celebration

- A Doctors' Day celebration was held on April 29 with treats served in the Physicians' Lounge along with a photograph presentation of our Professional Staff over the years
- This day was in appreciation for our physicians for the excellent work they do all year round

Length of Stay (LOS)

- Over the last several months, the Department Chiefs of the five groups with the most potential for bed savings were tasked with engaging their members to develop an action plan to achieve a reduction in average LOS for their program/service
- During the month of May, the Physician LOS working group received several finalized plans from Department Chiefs and they along with their section members are now beginning on the tasks

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Chief Nursing Executive Open Report

to the
Board of Directors
Thunder Bay Regional Health Sciences Centre

June 2016

Best Practice Spotlight Organization (BPSO)

- The Registered Nurses Association of Ontario (RNAO) renewed the BPSO Designation for TBRHSC and awarded continued BPSO status for 2016 to 2018. TBRHSC was deemed eligible to continue in the program based on an assessment of our nursing and interprofessional team capacity to maximize the use of RNAO Best Practice Guidelines (BPGs) to advance clinical excellence and evaluate outcomes.
- We were commended on our revitalization efforts of previously implemented best practice guidelines to ensure sustainable outcomes and build capacity for practice changes that ensure continued best practice. In addition, we were commended for our collaboration with patients/families, use of advanced clinical fellowship to advance education and participation in research.

Regional Transfer Nurse Program

- Effective May 24th, TBRHSC has resumed the Regional Transfer Nurse (RTN) Program
- The RTN service provides a scheduled TBRHSC Registered Practical Nurse to care for inpatients transferred from regional hospitals for diagnostic and other outpatient services, and prevents "sending" hospitals from having to provide a nurse escort to care for patients during their stay at TBRHSC
- The benefits of the program include improved quality and safety of health services and access to care; decreased overtime and overall hours for regional transfer nurses; preserved nursing resources for regional hospitals; improved patient care through the standardization of practices; improved patient and staff satisfaction; and, supports the development of formal relationships between hospitals within an integrated model of care

Professional Recognition

- RNAO held its Annual General Meeting (AGM) in Toronto on May 5-6, 2016
- As part of the AGM, outstanding RNAO members were honoured with Recognition Awards
- Recognition Awards acknowledge the contributions made by volunteers and long-time members within the association. They also foster excellence in the nursing profession and promote the profession to the public by highlighting the best of nursing practice, education, research, administration and policy.

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- This year Melanie Cates, Nursing Practice Leader at TBRHSC, received the Leadership Award in Nursing Education (Staff Development). This award is presented to an RN who excels as a nursing educator in a health-care organization. The individual who receives this award acts as a role model and mentor, and enhances Nursing by encouraging critical thinking, innovation and debate.

Activity Report

Dr. Roger Strasser, Dean-CEO

May – June 2016

A Decade of Making A Difference

Your Medical School

The Northern Ontario School of Medicine (NOSM) is a medical school made in the North, for the North. As the School celebrates its 10th anniversary, we want to let you know what we've been doing for the last decade, and how we've been working with our many partners to build a healthier Northern Ontario. After all, NOSM really is your medical school—we exist for you!

NOSM medical students (pictured above) complete more than 40% of their education in Indigenous, Francophone, small rural, and mid-sized communities in the North.

Une amélioration qui dure depuis dix ans

Votre école de médecine

L'École de médecine du Nord de l'Ontario (EMNO) a été créée dans le Nord pour le Nord. À l'occasion de son 10e anniversaire, nous désirons vous montrer ce que nous faisons depuis dix ans et comment nous travaillons avec nos nombreux partenaires pour améliorer la santé dans le Nord de l'Ontario. Après tout, l'EMNO est votre école – nous existons pour vous!

Les étudiants en médecine de l'EMNO (ci-dessus) effectuent plus de 40% de leur formation dans des collectivités autochtones et de petites et moyennes communautés rurales du Nord.

Read the newly released NOSM's Report to Northern Ontario here:
http://www.nosm.ca/uploadedFiles/About_Us/Media_Room/Publications_and_Reports/Community%20Report%202015-WEB.pdf

NOSM Holds Face-to-Face Board Meeting in Hearst/ L'EMNO tient une réunion du conseil en personne à Hearst

Members Tour Hôpital Notre-Dame Hospital and Nord-Aski Family Health Facility, Participate in Interactive Learning Sessions, and Interact with Community Members/ Les membres du conseil visitent l'Hôpital Notre-Dame Hospital et l'établissement de santé familiale Nord-Aski, participent à des séances de formation interactives et échangent avec des membres de la collectivité

The Northern Ontario School of Medicine (NOSM) held its annual Board of Directors face-to-face meeting in Hearst, Ontario on May 12 and May 13, 2016.

On the first morning together, NOSM Board members enjoyed a tour of Hearst's Hôpital Notre-Dame Hospital and Nord-Aski Family Health Facility organized by France Dallaire, Hospital CEO, Dr. Richard Claveau, Chief of Staff and Site Liaison Clinician for NOSM, and Maryléne Comeau, Physician Recruiter and Site Administrative Coordinator for NOSM.

Board members heard how the Hôpital Notre-Dame Hospital, a Francophone establishment in which all populations are treated with respect for their culture and language, works to contribute to improving the health of communities through leadership rooted in partnerships. The Nord-Aski Family Health Facility provides its mostly Francophone and Indigenous population with varied services that emphasize health promotion, illness prevention, early detection, and education. Each year, the City of Hearst, the Hôpital Notre-Dame Hospital, and the Nord-Aski Family Health Team welcome NOSM medical students and residents to live and learn in Hearst.

During the two-day meeting, Board members heard updates on behalf of NOSM's Indigenous Reference Group and the Francophone Reference Group, and participated in several presentations and interactive sessions on the topics of postgraduate education, risk management, public relations, Board effectiveness, and community engagement.

Members welcomed Dr. Pierre Ouellette, Recteur de l'Université de Hearst, who shared exciting developments at the university that offers undergraduate programs in French on three campuses located in Hearst, Kapuskasing, and Timmins.

In the evening, NOSM Board members enjoyed a lumberjack-themed dinner at Hearst's Heritage Sawmill Marketplace with local community members, including several representatives from the health and municipal organizations of Hearst. Following the dinner, several members enjoyed an optional community tour at the small, artisan Rheault Distillery, which prides itself for creating hand crafted, small batch spirits.

The Directors received reports from Academic Council and Admissions, and the newly released NOSM's *Report to Northern Ontario*, which, at the near conclusion of NOSM's 10th anniversary year, describes how the School has been working with communities and partners across the North to build a healthier Northern Ontario.

The Directors received a Financial Report for the 10-month period ending February 28, 2016. In addition, the Board approved the proposed balanced budget of $44.07 million for the fiscal year May 1, 2016 to April 30, 2017, as presented.

At the formal Board meeting, members paid tribute to Dr. Robert Kerr, retiring Vice-President, Academic and Provost at Laurentian University, and thanked him for his outstanding commitment to NOSM as past Board Chair and Vice-Chair, as well as Chair of the Board's Executive Committee.

The next meeting of the Board of Directors is scheduled to occur on September 21, 2016.

For a complete list of Board members, please visit our website at nosm.ca.

Le texte en français :
http://www.nosm.ca/about_us/media_room/media_releases/media_release.aspx?id=21512&langtype=3084

NOSM Adopts "Indigenous Peoples" Terminology
The Northern Ontario School of Medicine (NOSM) and the School's Indigenous Reference Group (formerly

known as Aboriginal Reference Group) together announce NOSM's adoption of the terminology "Indigenous Peoples" in place of "Aboriginal Peoples."

This change in terminology, recommended by NOSM's Indigenous Reference Group (IRG) was motivated by the Canadian Government's recognition of the United Nations Declaration of Rights of Indigenous People, included within the "Calls to Action" made by the Truth and Reconciliation Commission of Canada (TRC). The term "Indigenous," used by the United Nations, is meant not to refer to people living in any particular region, but recognizes first peoples and their rights around the world.

"It is the role of the Indigenous Reference Group to advise NOSM's Dean on matters that are important to the Indigenous Peoples of Northern Ontario," says Dot Beaucage-Kennedy, Chair of NOSM's Indigenous Reference Group. "The adoption of the term 'Indigenous' by NOSM is important to acknowledging the 94 Calls to Action of the Truth and Reconciliation Commission, and is another way that NOSM is demonstrating its acknowledgement of the rights of Indigenous Peoples in Northern Ontario, and the importance of the participation of Indigenous Peoples in the education of future health professionals."

"I have deep gratitude for the advice provided to me from the Indigenous Reference Group, and I appreciate the importance of the terminology used by the Truth and Reconciliation Commission to acknowledge the rights of Indigenous Peoples," says Dr. Roger Strasser, NOSM's Dean. "The Northern Ontario School of Medicine remains committed to addressing the needs of Indigenous Peoples across the region to ensure that NOSM is accountable to the cultural diversity of Northern Ontario."

NOSM is guided by a social accountability mandate to contribute to improving the health of the people and communities of Northern Ontario. NOSM serves as the Faculty of Medicine of Lakehead University in Thunder Bay and Laurentian University in Sudbury, with over 90 teaching and research sites across NOSM's wider campus of Northern Ontario.

As part of their education, NOSM medical students spend four weeks living and learning in one of more than 40 Indigenous communities across Northern Ontario during their first year of the MD program. NOSM and the Indigenous Reference Group periodically host Indigenous Partnership Gatherings that bring together Indigenous Peoples from across the region to discuss how NOSM can better serve Indigenous communities.

Le texte en français :
http://www.nosm.ca/about_us/media_room/media_releases/media_release.aspx?id=21493&langtype=4105

NOSM Site Administrative Coordinator Honoured with CASPR Lifetime Achievement Award

The Canadian Association of Staff Physician Recruiters (CASPR) presented awards recognizing excellence in Canadian physician attraction, recruitment, and retention at the 12th annual CASPR conference, which took place in Vancouver from April 24-26, 2016. Among the recipients is Mr. David Gravelle, NOSM Site Administrative Coordinator in Midland, and Physician Recruitment Officer, Southern Georgian Bay. Gravelle was named recipient of the 2016 Lifetime Achievement Award recognizing his commitment to physician recruitment through involvement with CASPR. Gravelle's role as a physician recruiter includes recruiting and retaining individual physician candidates and partners. He works to match candidates to community needs and new recruits to the lifestyle the region has to offer. Gravelle and his team go above and beyond to help candidates integrate into their new medical role and to make their new community their home. Congratulations, David, on your much deserved award!

ICEMEN 2016 – JUNE 20-25, 2016 | SAULT STE. MARIE, ONTARIO, CANADA

Through the diverse global interest of speakers and participants, ICEMEN 2016 will promote international dialogue and exchange and strengthen awareness of distributed, community-engaged medical and health professional education, research, and service. Delegates will have an opportunity to visit and engage with communities in Northern Ontario through Conference on the Move (June 20-21). The Indigenous Research Gathering (June 23-24) and the Northern Health Research Conference (June 24-25) may also be of interest to participants. Sessions will run concurrently throughout the conference.

On ***Thursday, June 23*** for our ***10th Anniversary Celebration***. This special evening caps off a year of saying “Thanks, Merci, Miigwetch” to individuals and community partners who have contributed to the School’s accomplishments over the last decade. This very special reception and dinner will be held at the historic Machine Shop on Huron Street. The theme for the evening is *Stories Around the Campfire*. We invite you to join past, present, and future friends of NOSM as we hear stories from our first decade. The evening will also include a rich cultural experience with our Indigenous and Francophone community partners. Tickets are $100 each or can be purchased as tables (a table of 10 for $950 or a table of 8 for $750). The tickets can be purchased at any Scotiabank branch in SSM. Cash or cheques made out to NOSM will be accepted.
If you have any questions, Carrie Jones, Physician Recruitment/NOSM Site Administrative Coordinator will be pleased to assist. Carrie can be reached at 705-759-3725 or jonesc@sah.on.ca.

For more information, please visit www.icemen2016.ca or email icemen2016@nosm.ca .

Northern Passages Available Online
The latest issue of Northern Passages is now available online. Online: http://nosm.ca/northernpassages/

For more news and information visit **www.nosm.ca**

Respectfully submitted,

Dr Roger Strasser AM
Professor of Rural Health
Dean and CEO
Northern Ontario School of Medicine

Health Sciences Centre Board of Directors Comprehensive Work Pla

Updated: May 27, 2016

Colour Legend	
Completed by target	
In progress but not completed by target	
Not in progress, and not completed by target	

Legend:
BD: Board of Directors
EC: Executive Committee
Gov: Governance Committee
Nom: Governance/Nominating Committee
BL: Governance/By-Law Committee
Aud: Audit Committee
RP: Resource Planning Committee
Qual: Quality Committee
FA: Fiscal Advisory

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
1	Stakeholder Communication and Accountability	Set up partnership meetings for the year	BD		x										
2	Governance	Monthly education topics for the Board	BD		x	x	x	x	x	x	x	x	x	x	Education Topics plan developed for the next year.
3	Oversight of Management	Participate in CEO evaluation via website	BD									x			Given recent start of CEO, partial evaluation to be conducted in the fall with regular evaluation process beginning in 2017

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
4	Oversight of Management	Participate in COS evaluation via website	BD									x			Deferred until hire of new COS
5	Governance	Approval of By-Laws	BD										x		Comprehensive review underway - will be brought to the Board for approval in the fall.
6	Governance	Approve Slate of Nominees to fill Board vacancies	BD										x		
7	Oversight of Management	Approve CEO evaluation	BD											x	
8	Oversight of Management	Approve COS evaluation	BD											x	
9	Governance	Approval of Committee terms of reference and work plans	BD					x							
10	Legal Compliance	Environmental compliance and fire safety update	BD			x		x			x			x	
11	Legal Compliance	Accessibility update	BD						x						
12	Quality Oversight	Critical Incidents Presentation	BD					x					x		Was deferred to June meeting as it required to be reviewed by Quality Committee first.
13	Oversight of Management	Physician recruitment plan update	BD						x						
14	Performance Measurement and Monitoring	Strategic plan update	BD		x							x			

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
15	Quality Oversight	Research Ethics Board appointments	BD			x									No new appointments this year
16	Quality Oversight	Research Ethics Board report	BD								x				Will be presented in June annually.
17	Performance Measurement and Monitoring	Scorecard update	BD						x					x	
18	Governance	TBRRI update	BD				x						x		Deferred to June meeting.
19	Governance	TBRHS Foundation update	BD			x									
20	Governance	Occupancy update	BD		x		x			x			x		Deferred to June meeeting.
21	Oversight of Management	Evaluation of CEO	EC										x		Deferred until the fall (subset of the evaluation).
22	Oversight of Management	Evaluation of COS	EC										x		Deferred until a later date as COS was recently hired.
23	Oversight of Management	2015-16 Work Plan for information only	RP		x	x	x	x	x	x	x	x	x		
24	Financial Oversight	ALC, LOS and Emergency Admissions Monthly Report for information only	RP		x	x	x	x	x	x	x	x	x		
25	Financial Oversight	Board Attestation: Wages and Source Deductions	RP		x	x			x			x			
26	Financial Oversight	Financial Statements and Variance Report	RP		x	x	x			x			x		
27	Financial Oversight	Financial Statements for information only	RP		x	x		x	x		x	x			
28	Financial Oversight	Investment Policy Annual Review	RP		x										
29	Financial Oversight	Investment Portfolio Reviews	RP		x							x			

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
30	Financial Oversight	Northwest Supply Chain Performance and Medbuy Update	RP		x							x			
31	Oversight of Management	Work Plan Approval	RP		x								x		Completed in April
32	Governance	Terms of Reference Annual Approval	RP		x										
33	Performance Measurement and Monitoring	Corporate Balanced Scorecard	RP			x			x			x			
34	Financial Oversight	H-SAA 2015-16 Operating Plan Submission	RP			x									
35	Financial Oversight	CAPS Submission to LHIN	RP			x									
36	Performance Measurement and Monitoring	Human Resources and Organizational Development Update	RP			x						x			Completed in May
37	Legal Compliance	Legislated Compliance Report	RP			x			x			x			
38	Financial Oversight	Broader Public Sector Travel & Expense Report	RP				x						x		
39	Financial Oversight	Budget Planning Targets and Directives Report	RP				x								
40	Financial Oversight	Budget Planning Process Update	RP				x								
41	Financial Oversight	Funding HBAM and Quality Based Procedures Update	RP				x								
42	Financial Oversight	HAPS 2016-17 Update	RP				x								
43	Financial Oversight	TBRRI and Sustainability Updates	RP				x					x			
44	Financial Oversight	Capital Equipment and Capital Projects 2015-16 Update	RP						x			x			
45	Financial Oversight	Insurance Review	RP						x						
46	Financial Oversight	Capital Budget 2016-17 Planning Update	RP							x					
47	Oversight of Management	Physician Recruitment and Retention Update	RP							x					

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
48	Financial Oversight	Capital Budget Summary Review 2016-17	RP								x				
49	Risk Identification and Oversight	Data Centre Disaster Recovery Plan Update	RP								x				
50	Performance Measurement and Monitoring	Labour Relations, Grievances and Arbitrations Update	RP								x				
51	Legal Compliance	Occupational Health and Safety Program Update	RP								x				
52	Financial Oversight	Operating Plan Approval 2016-17	RP								x				
53	Legal Compliance	Public Sector Salary Disclosure	RP								x				
54	Financial Oversight	Capital Budget 2016-17 Review	RP									x			Completed in February
55	Legal Compliance	Broader Public Sector Accountability Attestation Certificate	RP										x		
56	Legal Compliance	Broader Public Sector Use of Consultants Attestation	RP										x		
57	Oversight of Management	H-SAA Declaration of Compliance Attestation	RP										x		
58	Oversight of Management	M-SAA Declaration of Compliance Attestation	RP										x		
59	Risk Identification and Oversight	Non Patient Legal Matters Annual Review	RP										x		
60	Financial Oversight	Numbered Companies Unaudited Financial Statements 2015-16	RP										x		
61	Risk Identification and Oversight	TBRRI 2016-17 Operating and Capital Budget Report	RP										x		Completed in April
62	Risk Identification and Oversight	TBRRI 2015-16 Unaudited Financial Statements Review	RP										x		
63	Financial Oversight	Unaudited Preliminary YE Financial Statements to 2016-03-31	RP										x		

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
64	Quality Oversight	Programs & Services Presentations	Qual			x	x	x	x	x	x	x	x		Dec. deferred/March deferred to May. April meeting rescheduled to May 4
65	Quality Oversight	Comments / Compliments / Complaints	Qual			x				x					
66	Quality Oversight	Credentialing and Licensing Processes for Professional Staff and Health Professionals	Qual		x										
67	Quality Oversight	Critical Incidents / MAC Recommendations	Qual				x					x			April meeting rescheduled to May 4
68	Quality Oversight	Emergency Preparedness	Qual					x					x		
69	Quality Oversight	Financial Pressures Relating to Risk	Qual	x											
70	Quality Oversight	Patient Safety / Public Indicators	Qual		x			x			x		x		
71	Quality Oversight	Accreditation	Qual			x				x					
72	Quality Oversight	Quality and Risk Management Policies	Qual						x						
73	Quality Oversight	Quality Improvement Plan Excerpt from Balanced Scorecard	Qual			x		x			x		x		
74	Quality Oversight	Quality Improvement Plan Updates / Approval	Qual							x	x				
75	Quality Oversight	Risk Management / Enterprise Risk Management	Qual			x			x			x	x		April meeting rescheduled to May 4
76	Quality Oversight	Terms of Reference	Qual		x			x							
77	Quality Oversight	Work Plan	Qual		x										
78	Quality Oversight	Litigation	Qual						x			x			April meeting rescheduled to May 4
79	Quality Oversight	Research Ethics Board	Qual		x		x				x		x		
80	Quality Oversight	Annual Quality Research Report	Qual					x							
81	Quality Oversight	Quality-Based Procedures	Qual									x			April meeting rescheduled to May 4

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
82	Oversight of Management	2015-16 Work Plan for information only	Aud						x		x		x		
83	Financial Oversight	2015-16 Audit Plan Overview - Grant Thornton	Aud						x						
84	Governance	Terms of Reference Annual Approval	Aud						x						
85	Performance Measurement and Monitoring	Review Results of May 2015 Evaluation of Auditors	Aud						x						
86	Financial Oversight	Independence Questionnaire 2015-16	Aud						x						
87	Risk Identification and Oversight	Policy Reviews: Admin-19 & Admin-28	Aud						x						To be reviewed in May
88	Risk Identification and Oversight	Interim Audit Review 2015-16	Aud								x				
89	Performance Measurement and Monitoring	Discussion of Year End Reporting Issues 2015-16	Aud								x				
90	Financial Oversight	Audit Statement Review 2015-16	Aud								x				
91	Financial Oversight	Individual Program Audit Reports	Aud								x				
92	Financial Oversight	Update on New Hospital Capital Audit	Aud								x				
93	Financial Oversight	Summary of Audit Fees Paid for 2015-16	Aud								x				
94	Financial Oversight	2015-16 Year End Financial statements for Board Approval	Aud										x		
95	Financial Oversight	2015-16 Audit Results - Grant Thornton	Aud										x		
96	Oversight of Management	2015-16 Management Letter	Aud										x		
97	Risk Identification and Oversight	2015-16 Claims Summary	Aud										x		
98	Risk Identification and Oversight	Analysis of Legal Fees as at March 31, 2016	Aud										x		

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
99	Performance Measurement and Monitoring	Evaluation of Auditors for 2015-16	Aud										x		
100	Performance Measurement and Monitoring	Recommend Appointment of Auditors for 2016-17	Aud										x		
101	Oversight of Management	2016-17 Work Plan Approval	Aud										x		Completed in March
102	Stakeholder Communication and Accountability	Financial Statements and Variance Report	FA				x								
103	Stakeholder Communication and Accountability	Operating Plan 2015-16	FA				x								
104	Stakeholder Communication and Accountability	Q2 2015-16 Financial Review	FA				x								
105	stakeholder Communication and Accountability	Work Plan 2015-16 Approval	FA				x								
106	Stakeholder Communication and Accountability	Financial Statements as at 2015-08-31	FA				x								
107	Stakeholder Communication and Accountability	Financial Statements and Variance Report	FA									x			
108	Stakeholder Communication and Accountability	Operating Budget 2016-17	FA									x			

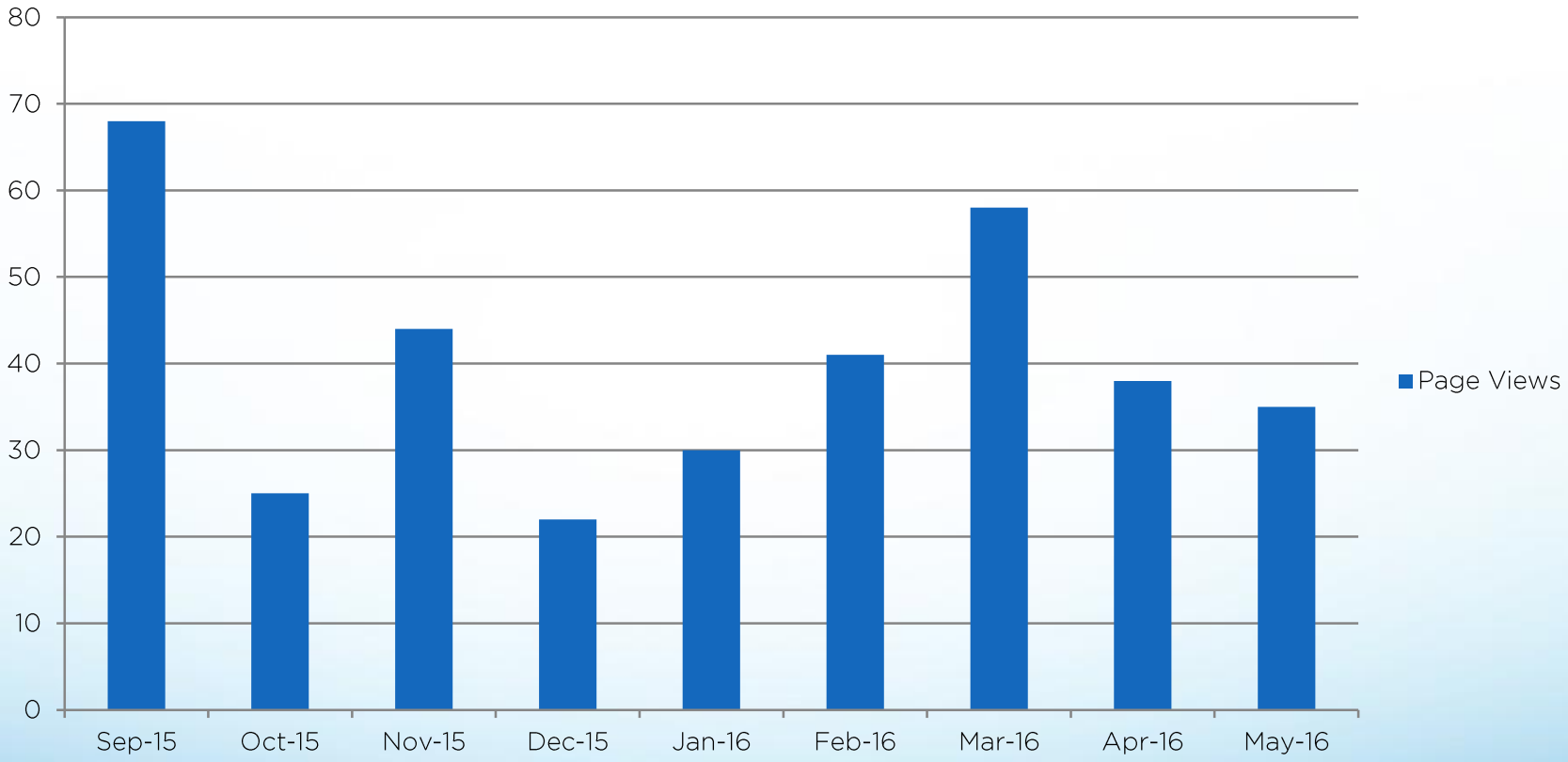
#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
109	Stakeholder Communication and Accountability	Q3 2015-16 Financial Review	FA									x			
110	Stakeholder Communication and Accountability	Financial Statements as at 2015-02-28	FA									x			
111	Stakeholder Communication and Accountability	Terms of Reference Annual Approval	FA									x			
112	Stakeholder Communication and Accountability	Work Plan 2015-16 Approval	FA									x			
113	Governance	Review Committee work plan	G		x										
114	Governance	Review Committee terms of reference	G		x										
115	Governance	Board members identify education needs for coming year	G		x										
116	Governance	Discuss annual Board retreat	G		x										
117	Governance	Review Board vacancies	G		x										
118	Oversight of Management	Review CEO/COS Performance Evaluation Process	G		x										
119	Governance	Review Board forms	G		x										
120	Governance	Review all Board policies - identify revisions required	G				x								
121	Governance	Plan annual Board retreat	G				x								Board Retreat deferred to September 2016
122	Governance	Review all Board Committees terms of reference and work plans	G				x						x		
123	Governance	Review meeting evaluations for the quarter	G				x			x			x		

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
124	Governance	Review Board and Board Committee attendance summary	G							x			x		
125	Governance	Review team effectiveness scale summary	G							x			x		
126	Governance	Board Chair to review self assessment questionnaire	G							x					
127	Governance	Appoint community member	N							x					
128	Governance	Review and approve nominating action plan	N							x					
129	Governance	Review Policy BD-45 Preferred Selection Criteria for Board Membership	N							x					
130	Governance	Review and approve skills matrix for Board of Directors applicants	N							x					
131	Governance	Review and approve application for membership form	N							x					
132	Governance	Review and approve ad	N							x					
133	Governance	Review of Board of Directors applications	N								x				
134	Governance	Review and approve letters to applicants	N								x				
135	Governance	Review and approve interview questions	N								x				
136	Governance	Review and approve interview schedule	N								x				
137	Governance	Interview candidates	N									x			
138	Governance	Review incumbents	N									x			
139	Governance	Review of applicant interviews	N									x			
140	Governance	Propose slate of nominees	N									x			

#	Accountability	Activity	Responsible Body	As Needed	September	October	November	December	January	February	March	April	May	June	Comments
141	Governance	Review By-Laws	B										X		Preliminary Review in May. A special meeting will be held in September with final approval deferred to 2017 AGM.
142	Governance	Review orientation program	G										x		
143	Governance	Review Board annual evaluation tool summary	G										x		
144	Governance	Review annual education session summary	G										x		

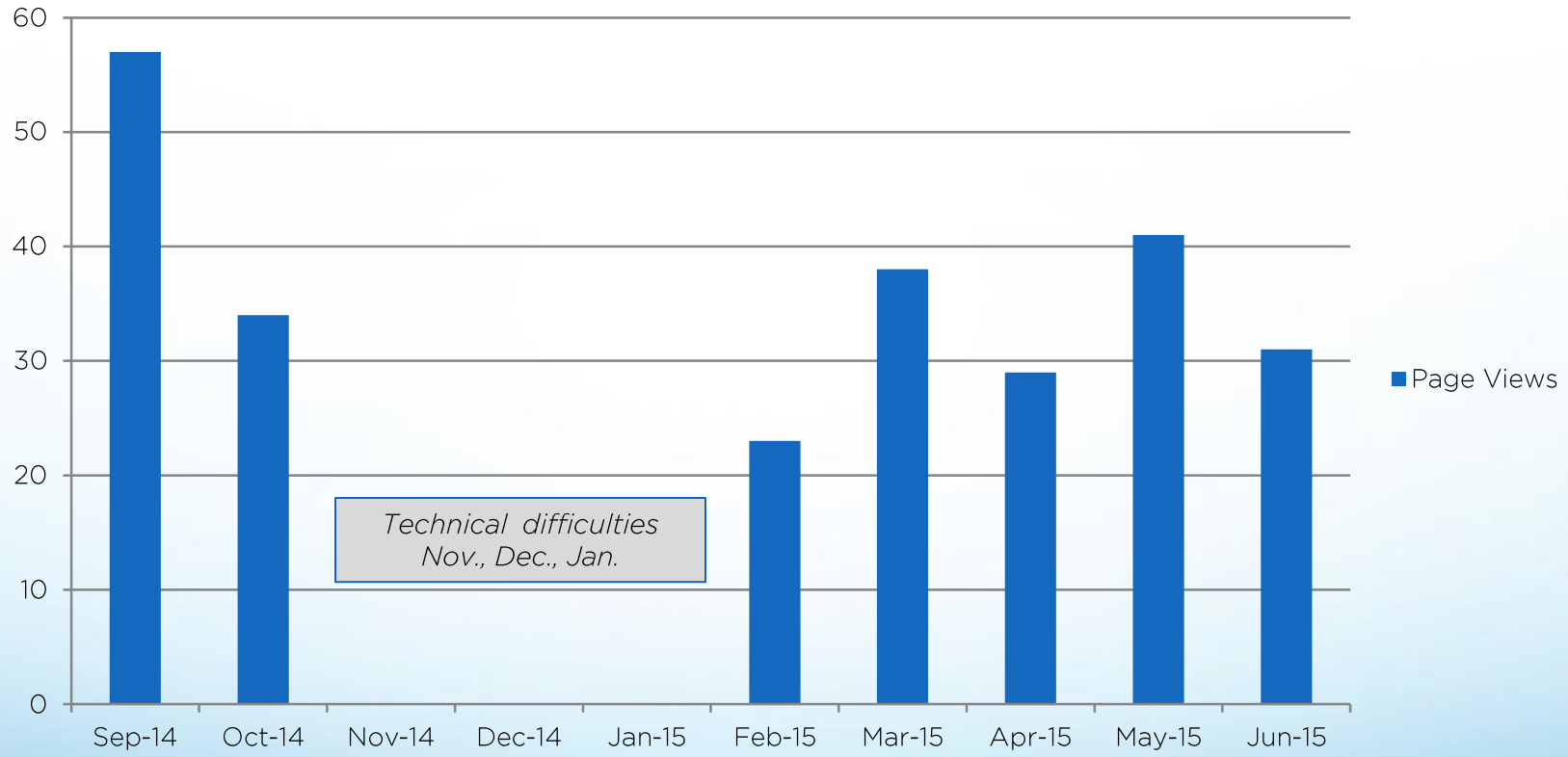
Page Views: Open Board Meeting Webcast

September 2015 – May 2016



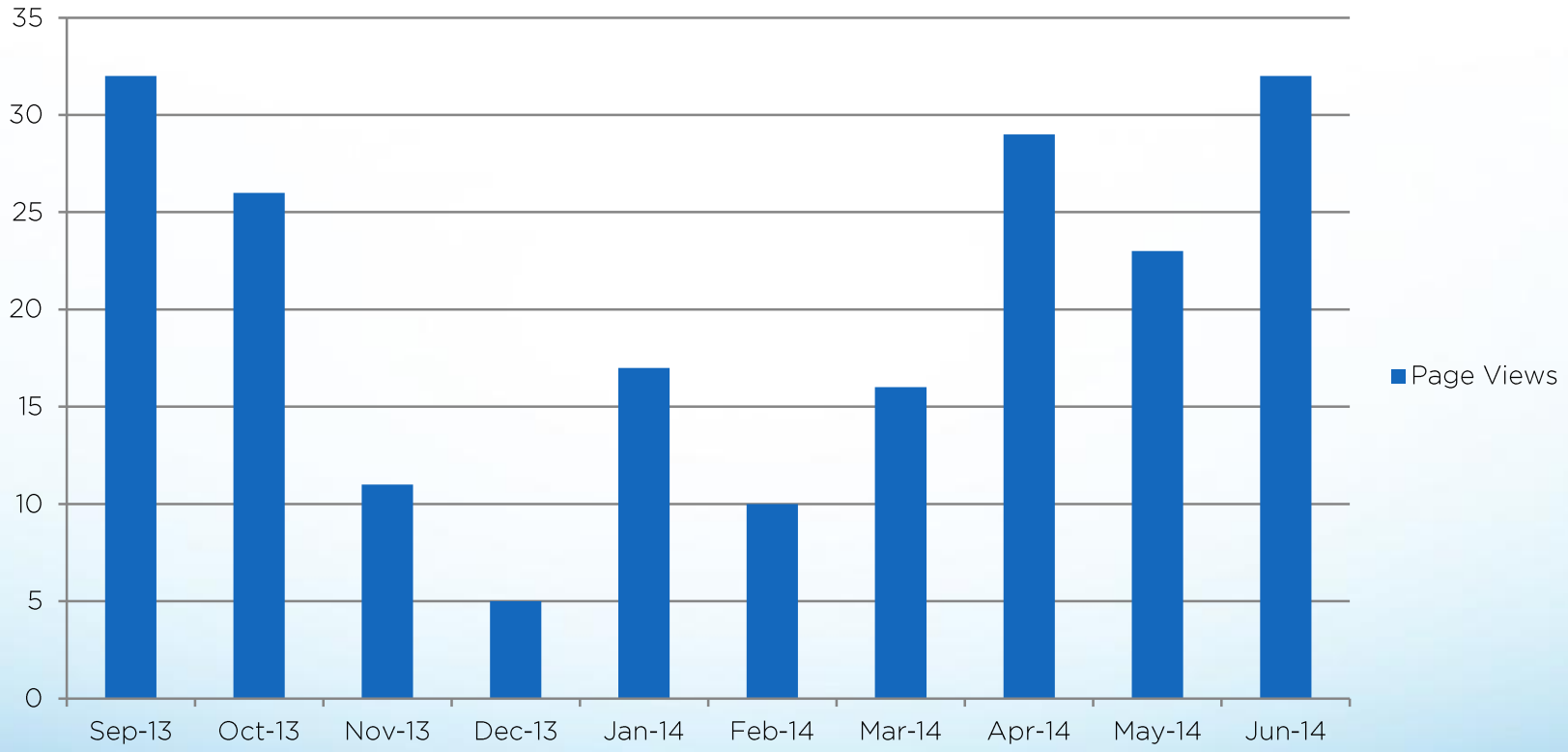
Page Views: Open Board Meeting Webcast

September 2014 – June 2015



Page Views: Open Board Meeting Webcast

September 2013 – June 2014



Page Views: Open Board Meeting Webcast

September 2013 – May 2016

Month	# of Page Views	Month	# of Page Views	Month	# of Page Views
September 2013	32	September 2014	57	September 2015	68
October 2013	26	October 2014	34	October 2015	25
November 2013	11	N/A	--	November 2015	44
December 2013	5	N/A	--	December 2015	22
January 2014	17	N/A	--	January 2016	30
February 2014	10	February 2015	23	February 2016	41
March 2014	16	March 2015	38	March 2016	58
April 2014	29	April 2015	29	April 2016	38
May 2014	23	May 2015	41	May 2016	35
June 2014	32	June 2015	31		

Thunder Bay Regional Research Institute

Translational Research Office
980 Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Pre-Clinical Research Office
290 Munro Street
Thunder Bay ON
P7A 7T1 Canada

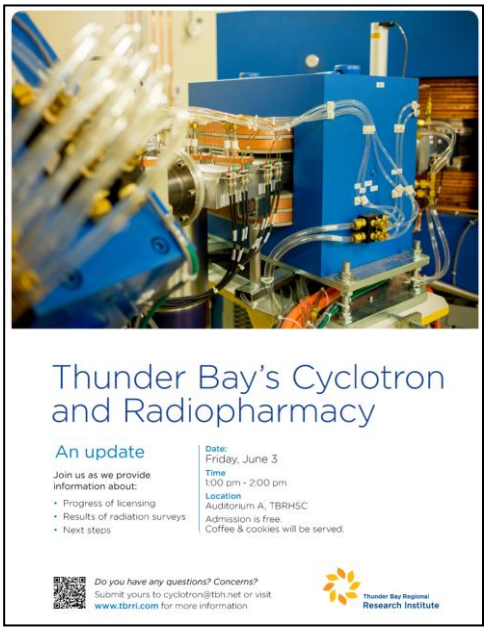
Tel: (807) 684-7223
Fax: (807) 684-5892
www.tbrri.com

Thunder Bay Regional Research Institute Report for TBRHSC Board – June, 2016

Submitted by: Jean Bartkowiak, CEO – TBRRI and President & CEO – TBRHSC – June 1, 2016

Cyclotron Update

Hiring has been completed and staff have been working on various initiatives including research and development; facility testing; safety training and Health Canada licensing. The facility is in compliance with all Canadian Nuclear Safety Commission environmental and other regulatory requirements. Staff are in the process of developing Standard Operating Procedures for various processes needed to secure a Drug Establishment License from Health Canada. If you are interested in hearing more about the Cyclotron and Radiopharmacy, a public information session will be held on **June 3rd from 1:00 – 2:00 in Auditorium A at the Hospital** or you can visit www.tbrri.com.



Clinical Research Services Department

The **Clinical Trials** team is rolling out the "ASK ME" campaign. During the month of May, the team and other Hospital staff wore buttons as part of a cross-Canada initiative to increase awareness about clinical trials. It is hoped that this will spark conversations between staff and patients about potential treatment options that may be available in Thunder Bay.

Thunder Bay recently partnered with Princess Margaret Hospital in a Pan-Canadian network collaboration initiative called the *Canadian Cancer Clinical Trials Network*. This coordinating centre is designed to strengthen academic sponsored cancer clinical trials capacity and to improve patient outcomes. The partnership has opened opportunities for sharing of resources, staff training and support of operations, activities, and methods to facilitate faster study start-up and increase recruitment to academic trials. This has resulted in increased trials activity in Thunder Bay and has created more opportunities for patients with cancer to receive treatments that would not otherwise be available to them in Thunder Bay. To learn more you can speak to the clinical trials team or visit one of the following websites: www.itstartswithme.ca, www.3ctn.ca or www.tbrhsc.net.

Thunder Bay Regional Research Institute

Translational Research Office
980 Oliver Road
Thunder Bay ON
P7B 6V4 Canada

Pre-Clinical Research Office
290 Munro Street
Thunder Bay ON
P7A 7T1 Canada

Tel: (807) 684-7223
Fax: (807) 684-5892
www.tbrri.com

Local Innovators Honoured at Award Ceremony

Congratulations to Shayna Parker for receiving a Young Innovator of the Year award at the 8th Annual Innovation Awards Ceremony held today by the Northwestern Ontario Innovation Centre (NOIC). Shayna received her award for creating BrainShift, a game to help stroke and brain-injury patients regain use of their hands. The app is in the development stages and we look forward to hearing more about this exciting project. Congratulations as well to Sasha Bubon for his nomination!

NOIC manager Judy Sander said innovation and entrepreneurship are increasingly becoming driving factors in the region's economy, which is why it's important to celebrate the success stories.

Summer School of Medical Imaging

TBRRI and Lakehead University recently launched the opening of the 6th Annual Summer School of Medical Imaging. The Summer School is a summer student research program jointly hosted by Lakehead University and the Research Institute which offers a unique research experience for undergraduate students and showcases the graduate environment in Medical Imaging as a prospective career path. Under the direction of Dr. Alla Reznik, the program provides topical tutorials and a seminar series, and hosts an end of summer research project competition. Every year the program grows in the number of participants and the depth of students' involvement and exposure to the field of medical imaging. As part of the program, TBRRI and Lakehead University Scientists present seminars to the students on a weekly basis about topics related to medical imaging as well as other areas of research. This year, 27 students are enrolled in the program which runs from May 9th to August 26th.

Staffing Updates

- After 15 years of hard work and dedication to TBRHSC and TBRRI, **Janet Northan,** Director Strategic Partner Relations and Special Projects, will be retiring on June 17th. We wish Janet well and happy travels!
- Interviews are being held for the **Manager of Business Development**.
- Recruitment will commence in June for a permanent **Vice-President Research**.

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	2015-16 Q4 Balanced Scorecard Results
PREPARED BY	Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO
PREPARED FOR: President &CEO ☒Board of Directors ☐ Other 2015-16 Q4 Planning & Performance Review	
DATE PREPARED	June 2, 2016

PURPOSE/ISSUE(S)

This briefing note accompanies the 2015-16 Q4 balance scorecard (BSC) results, and replaces the presentation that previously accompanied the BSC. The briefing note's purpose is to highlight indicator results which are falling short of target, reasons for same and to outline what actions are being undertaken to improve performance.

Note that the BSC content includes all indicators which have been reported to the Board during 2015-16, including those reported at Quality Committee of the Board and Resource Planning Committee. For 2016-17 onward, indicators will be separated and grouped in unique views for the Board (strategic indicators), Quality Committee of the Board (quality-focused indicators) and Resource Planning Committee (resource-focused indicators).

BACKGROUND

The BSC and related indicators are prepared, updated and published monthly by Decision Support. The format of the BSC was recently adjusted to more clearly present results and related trends.

Results were presented to Senior Leadership Council (SLC) on May 17, 2016, and to additional Hospital leadership at the 2015-16 Q4 quarterly Planning and Performance Review on May 25, 2016. BSC results at a more granular level are also reviewed monthly at various councils.

ANALYSIS/CURRENT STATUS

CDifficile infection

Reason: Results fluctuated somewhat during 15-16. Although above target, Hospital results are within the 25th percentile (.28) for Ontario teaching facilities, and the Hospital ranks 7th of 24 facilities reporting CDifficile infection results.

Action: Indicator is not included in BSC for 16-17, but results will be monitored and reported internally. No further action required at this point.

Hand hygiene – before & after contact

Reason: Results fluctuated considerably during 15-16 and declined substantially in Q4. Results by profession which vary considerably from average include physicians, physiotherapists, environmental services worker, and patient transporters. Results by unit which vary considerably from average include 1C Maternal Newborn, NICU, 3B Surgical and 3C Surgical.

Action: Infection Control e-mails hand hygiene compliance results to Hospital leadership monthly, and results are included on all BSCs for review at council meetings. At present, primary accountability for hand hygiene monitoring and compliance results rests with individual managers. Preliminary results for Apr 2016 show considerable improvement.

Medication reconciliation on admission

Reason: Consistent uptake and acceptance by RNs and physicians has proven challenging. The medication reconciliation process and related tools used at the Hospital are complicated, paper-based, and time-consuming to use, which contributes to resistance.

Action: During 15-16, re-education was conducted for RNs and physicians, and education materials (including frequently asked questions) were created and shared. However, results have not improved significantly. A new model for medication reconciliation is being researched and will be presented to SLC in 16-17.

TOPIC	2015-16 Q4 Balanced Scorecard Results
PREPARED BY	Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO

PREPARED FOR: President &CEO ☒Board of Directors ☐ Other 2015-16 Q4 Planning & Performance Review

Hospital standardized mortality ratio

Reason: Target for hospital standardized mortality ratio (HSMR) was established using old methodology. New methodology has resulted in higher rates and target has not been re-stated to reflect same. HSMR results remain relatively stable and considerably better than Ontario and Canadian peers.

Action: No action required at this time. HSMR is being replaced with two new indicators for 2016-17 onward (30-day in-hospital deaths following major surgery; Number of critical events).

Patient satisfaction: Overall rating of care - Inpatients and All Dimensions – Inpatients

Reason: Results fluctuated somewhat during 15-16 and have improved slightly since 14-15, but remain short of target. Results for medical units are considerably lower than surgical units. Lowest results are related to communications (i.e. discussed anxieties/fears, enough to say about treatment, when to resume normal activities), need for a care plan, and better coordination of care (consistent most responsible physician).

Action: Detailed improvement plans are being developed in consultation with Hospital leadership, and will be implemented during 16-17 Q1 & Q2.

Total margin

Reason: Results improved considerably in Q4, mainly due to addition of late one-time funding from the Northwest LHIN which helped offset over-expenditures. Significant contributors to over-expenditures include overcapacity, sick time, overtime, medical fees, medical & surgical supplies, sundry expenses, and equipment maintenance.

Action: Further investigation of benchmark savings is underway and will be reviewed with SLC in June 2016. As noted below, action plans are in development for sick and overtime. The planned operational review should assist in identifying additional improvement opportunities.

Paid sick hours

Reason: Results have improved considerably during 15-16 but still lag targets. The main causes are long term sick leaves due to critical illness, and an increased frequency in short term sick incidents.

Action: Hospital leadership was engaged 2015-16 Q4 quarterly Planning and Performance Review on May 25, 2016. Suggested actions are being compiled, and will be reviewed and implemented where appropriate.

Overtime hours

Reason: Results have improved somewhat over 15-16 but still lagging targets. Main causes are overcapacity combined with insufficient staffing levels and incorrect staff mix in Nursing Resource Team.

Action: Action plans in development to reduce overcapacity and adjust Nursing Resource Team staffing.

ALC days

Reason: Results improved in Q3 but regressed considerably in Q4. Note that target of 13.3% was as per HSAA agreement and not a stretch target based on trended actuals.

Action: To be determined

Staff Performance Appraisals

Reason: Results relatively unchanged throughout 15-16.

Action: During upcoming 2016 Hospital leadership performance appraisals, staff performance appraisal completion rates will be reviewed and discussed, which should lead to improvements. As well, various efforts are underway to free up time for Hospital leadership.

TOPIC	2015-16 Q4 Balanced Scorecard Results
PREPARED BY	Michael Del Nin, Manager, Decision Support
APPROVED BY	Jean Bartkowiak, President & CEO

PREPARED FOR: President &CEO ☒Board of Directors ☐ Other 2015-16 Q4 Planning & Performance Review

Patient accruals to clinical trials

Reason: Target was dramatically overestimated.

Action: 16-17 target has been adjusted to reflect 5 percent growth on 15-16 actuals.

Year-over-year growth in external research funding

Reason: Target was dramatically overestimated.

Action: 16-17 target will be corrected.

Number of staff and physicians activity involved in research

Definition has been refined to ensure consistency with Council of Academic Hospitals of Ontario. Results reported reflect new definition but target has been removed as it related to previous definition. 16-17 target reflects new definition and a stretch from 15-16 actual.

RECOMMENDATION

N/A

NEXT STEPS

N/A

STAKEHOLDER REACTION

N/A

COMMUNICATIONS

N/A

FINANCIAL IMPACTS

N/A

APPENDIX SECTION

Balanced Scorecard – Results for 15-16 Q4

TBRHSC is committed to ensuring decisions and practices are ethically responsible and align with our mission/vision/values. All leaders should consider decisions from an ethics perspective including their implications on patients, staff and the community. The following questions should be considered for each decision.

1. Does the course of action put '**Patients First'** by responding respectfully to needs, values, and expectations of our patients, families, and communities?
2. Does the course of action demonstrate '**Accountability**' by advancing a quality patient experience that is socially and fiscally accountable?
3. Does the course of action demonstrate '**Respect**' by honouring the uniqueness of each individual and his/her culture?
4. Does the course of action demonstrate '**Excellence**' by fostering an environment of innovation and learning to provide a quality patient experience?

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making

For more detailed questions to use on difficult decisions, please refer to TBRHSC's Framework for Ethical Decision Making on the iNtranet under **Quality and Risk Management > Quality > ECFAA (Excellent Care for All Act) > Presentations.**

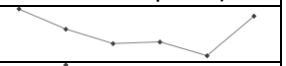
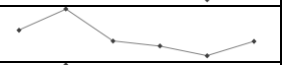
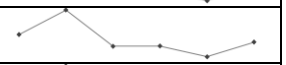
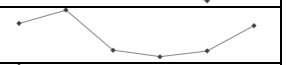
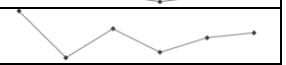
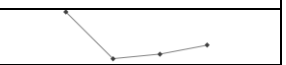
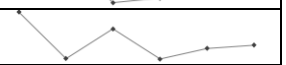
Thunder Bay Regional Health Sciences Centre

Balanced Scorecard
Indicators for: TBRHSC Board
Results for 15-16 Q4

Domain	Indicators	2015-16 Fiscal								
		Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Annual Target	YTD Target	YTD Actual	YTD Variance	Trending (last 6 or available quarters)
Customer	Rate of central line blood stream infection	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Customer	Rate of CDifficile infection	0.20	0.26	0.26	0.14	0.20	0.20	0.22	(0.02)	
Customer	Rate of ventilator-associated pneumonia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Customer	Rate of hand hygiene compliance before initial patient/environment contact	97.3%	93.1%	94.5%	82.6%	95.0%	95.0%	91.2%	(3.8%)	
Customer	Rate of hand hygiene compliance after patient/environment contact	96.5%	96.8%	98.1%	89.6%	97.0%	97.0%	95.0%	(2.0%)	
Customer	Rate of compliance for use of surgical safety checklist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	
Customer	5-day in-hospital mortality following major surgery	13.50	6.60	1.70		9.30	9.30	7.10	2.20	
Customer	Medication reconciliation on admission: Compliance re best possible medication history	65.8%	61.5%	62.9%	63.7%	67.3%	67.3%	63.6%	(3.7%)	
Customer	Hospital standardized mortality index	82	79	85		75	75	82	(7)	
Customer	Patient satisfaction: Overall rating of care - Inpatients	95.9%	89.6%	94.3%	92.3%	95.3%	95.3%	93.0%	(2.3%)	
Customer	Patient satisfaction: All Dimensions - Inpatients	77.0%	73.3%	72.4%	72.4%	76.2%	76.2%	73.8%	(2.4%)	
Customer	Patient satisfaction: Overall rating of care - Emergency Department patients	90.1%	86.0%	90.9%	83.8%	86.9%	86.9%	87.7%	0.8%	
Customer	Patient satisfaction: All Dimensions - Emergency Department patients	66.0%	68.1%	67.1%	67.8%	66.9%	66.9%	67.2%	0.3%	
Effectively Use Our Resources	Total Margin (year to date)	(2.40%)	(1.39%)	(2.05%)	(0.01%)	0.00%	0.00%	(0.01%)	(0.01%)	
Effectively Use Our Resources	Paid sick hours as a percentage of worked hours	3.96%	3.85%	3.53%	3.31%	2.94%	2.94%	3.78%	(0.84%)	
Effectively Use Our Resources	Overtime hours as a percentage of worked hours	2.43%	2.86%	1.52%	2.20%	1.99%	1.99%	2.27%	(0.28%)	
Effectively Use Our Resources	Percentage full time nurses	73.4%	72.9%	72.4%	72.2%	70.0%	70.0%	72.2%	2.2%	
Internal Processes	Percentage alternate level of care days	17.0%	18.0%	13.0%	20.0%	13.3%	13.3%	17.0%	(3.7%)	

Thunder Bay Regional Health Sciences Centre

Balanced Scorecard
Indicators for: TBRHSC Board
Results for 15-16 Q4

Domain	Indicators	2015-16 Fiscal								
		Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Annual Target	YTD Target	YTD Actual	YTD Variance	Trending (last 6 or available quarters)
Internal Processes	Length of stay (excluding alternate level of care days)	5.61	5.63	5.48	5.92	5.65	5.65	5.66	0.01	
Internal Processes	Occupancy - Overall	95.3%	94.5%	92.9%	95.3%	96.8%	96.8%	94.5%	2.3%	
Internal Processes	Occupancy - Select beds	102.3%	102.3%	100.2%	103.1%	104.7%	104.7%	101.9%	2.8%	
Internal Processes	90th Percentile ER length of stay (hours) for admitted patients	30.4	28.3	30.1	38.2	34.1	34.1	31.7	2.4	
Learning & Growth	Staff with up-to-date performance appraisals	75.2%	72.3%	74.1%	74.7%	85.0%	85.0%	74.1%	(10.9%)	
Learning & Growth	Number of staff and physicians actively engaged in research				295	n/a	n/a	295		
Learning & Growth	Patient accruals to clinical trials	92	128	202	244	517	517	244	(273)	
Learning & Growth	Year-over-year growth of external research funding	(6.1%)	(17.0%)	(13.1%)	(12.0%)	5.0%	5.0%	(12.0%)	(17.0%)	
Learning & Growth	Learner satisfaction				86.1%	N/A	N/A	86.1%		

At or better than target
Slightly (less than 5%) worse than target
Significantly (5% or more) worse than target

BRIEFING NOTE

Thunder Bay Regional Health Sciences Centre

TOPIC	2020 Strategic Indicators Summary Views
PREPARED BY	C. Freitag & M. Del Nin
APPROVED BY	J. Bartkowiak
PREPARED FOR: President &CEO ☐Board of Directors x ☐ Other	
DATE PREPARED	June 1, 2016

PURPOSE/ISSUE(S)

To provide the strategic monitoring indicator summary views for the Board, Quality Committee, Resource Planning Committee, and Senior Leadership Council.

BACKGROUND

The strategic monitoring indicators were presented and approved at the May 3rd Board meeting. The summary views for the Board, Quality Committee, Resource Planning Committee and Senior Leadership Council were developed to ensure that each forum monitored the relevant indicators.

ANALYSIS/CURRENT STATUS

RECOMMENDATION

NEXT STEPS

The Balanced Scorecard will be amended with the 2020 strategic indicators and related targets and include summary views for the Board, Quality Committee, Resource Planning Committee and Senior Leadership Council.

STAKEHOLDER REACTION

Accept the refreshed strategic monitoring indicators report and respective Board, related committees and Senior Leadership Council summary views.

COMMUNICATIONS

The 2020 strategic monitoring indicators views will be reported to the respective forums "quarterly" accompanied by a status update on the progress of activities in the form of a color-coded summary report.

FINANCIAL IMPACTS

None

APPENDIX SECTION
2020 Strategic Indicators Summary.

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1. Does the course of action put '**Patients First'** by responding respectfully to needs and values of our patients, families, and communities?
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Thunder Bay Regional Health Sciences Centre

Appendix A

Recommended Reporting Alignment for Strategic & Operational Indicators

As at Jun 1, 2016

2020 alignment	Traditional BSC domains	Indicator	Board - Strategic	Quality Committee of the Board	Resource Planning Committee	SLC - Strategic & Operational	SLC Indicator Lead
Patient Experience	Quality & safety	Hand hygiene compliance before contact	x	x		x	R. C. Ellacott; M. Henderson
Patient Experience	Quality & safety	Hand hygiene compliance after contact		x		x	R. C. Ellacott; M. Henderson
Patient Experience	Quality & safety	Medication reconciliation on admission		x - QIP process in 16-17		x	S. Kennedy
Patient Experience	Quality & safety	Medication reconciliation on discharge		x - QIP process in 16-17		x	S. Kennedy
Patient Experience	Quality & safety	Surgical safety checklist compliance		x		x	R. C. Ellacott
Patient Experience	Quality & safety	30-day in-hospital deaths following major surgery	x	x		x	R. C. Ellacott
Patient Experience	Quality & safety	Number of critical events	x	x		x	R. C. Ellacott; M. Henderson
Patient Experience	Customer	Patient satisfaction: Overall rating of care - Inpatients	x	x - QIP		x	R. C. Ellacott; M. Henderson
Patient Experience	Customer	Patient satisfaction: Overall rating of care - Emergency Department patients		x - QIP		x	R. C. Ellacott
Patient Experience	People	Percentage of staff with up-to-date performance appraisals			x	x	VP-HR
Patient Experience	People	Staff satisfaction - organizational engagement	x		x	x	VP-HR
Patient Experience	People	Staff turnover			x	x	VP-HR
Patient Experience	Financial	Paid sick hours as a percentage of worked hours	x		x	x	VP-HR
Patient Experience	People	Physician satisfaction - organizational engagement	x		x	x	S. Kennedy; Chief of Staff
Patient Experience	Academics	Learner satisfaction	x		x	x	S. Kennedy
Patient Experience	Academics	Total Researchers	x			x	A. M. Heron
Patient Experience	Academics	Total number of subjects enrolled in clinical trials			x	x	A. M. Heron
Patient Experience	Financial	Overtime hours as a percentage of worked hours			x	x	R. C. Ellacott
Comprehensive Clinical Care	Quality & safety	Percentage alternate level of care days			x	x	M. Henderson
Comprehensive Clinical Care	Quality & safety	Occupancy Percentage - Overall			x	x	M. Henderson
Comprehensive Clinical Care	Quality & safety	Average length of stay, excluding alternate level of care days		x - QIP		x	M. Henderson
Comprehensive Clinical Care	Quality & safety	Emergency Department length of stay (90th percentile in hours)	x	x - QIP		x	R. C. Ellacott

Thunder Bay Regional Health Sciences Centre

Appendix A

Recommended Reporting Alignment for Strategic & Operational Indicators

As at Jun 1, 2016

2020 alignment	Traditional BSC domains	Indicator	Board - Strategic	Quality Committee of the Board	Resource Planning Committee	SLC - Strategic & Operational	SLC Indicator Lead
Comprehensive Clinical Care	Quality & safety	Percentage of acute inpatient cases completed with Northwest Health Integration Network		x		x	J. Bartkowiak
Seniors' Health	Quality & safety	Fall rate per 1,000 patient days (excludes paediatric & newborn patients)		x		x	R. C. Ellacott; M. Henderson
Seniors' Health	Quality & safety	Pressure ulcer incidence	x	x		x	R. C. Ellacott
Seniors' Health	Customer	Results of staff survey on attitudes, knowledge and behaviours related to seniors health (65+)				x	VP-HR
Seniors' Health	Customer	Percentage of staff and physicians who have completed sensitivity training re seniors health				x	VP-HR
Indigenous Health	Quality & safety	Wait times for surgeries & diagnostic tests/procedures for patients from Indigenous communities		x		x	J. Bartkowiak
Indigenous Health	Quality & safety	No show rates for surgeries & diagnostic tests/procedures for patients from Indigenous communities				x	J. Bartkowiak
Indigenous Health	Quality & safety	Acute hospital admissions for patients from Indigenous communities	x			x	M. Henderson
Indigenous Health	Quality & safety	Screening rates for chronic health issues for Indigenous population of Northwest Local Health Integration Network				x	M. Henderson
Indigenous Health	Customer	Results of staff survey on attitudes, knowledge and behaviours related to Indigenous culture				x	VP-HR
Indigenous Health	Customer	Percentage of staff and physicians who have completed sensitivity education on Indigenous culture				x	VP-HR
Acute Mental Health	Quality & safety	Repeat unscheduled emergency visits within 30 days as a proportion of total mental health visits		x		x	M. Henderson
Acute Mental Health	Quality & safety	Psychiatrist full-time equivalent staffing as percentage of required full-time equivalent complement	x			x	M. Henderson
Acute Mental Health	Customer	Results of staff survey on attitudes, knowledge and behaviours related to mental health				x	VP-HR
Acute Mental Health	Customer	Percentage of staff and physicians who have completed sensitivity training on awareness and respect for mental health				x	VP-HR
	Financial	Total margin			x	x	P. Myllymaa
Indicator count			**13**	**16**	**11**	**38**	

Thunder Bay Regional Health Sciences Centre

Appendix B

Reporting Dates for Strategic & Operational Indicators

As at Jun 1, 2016

Audience	Type	Apr	May	Jun	Jul	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Current														
Senior Leadership Council	Strategic & Operational		Q4					Q1		Q2			Q3	
Hospital Leadership (quarterly Planning & Performance Group)	Strategic & Operational		Q4					Q1		Q2			Q3	
Board	Strategic & Operational			Q4					Q1		Q2			Q3
Quality Committee of the Board	Quality & Safety								Q1		Q2			Q3
Resource Planning Committee	Financial	Q3							Q1			Q2		
Proposed														
Senior Leadership Council	Strategic & Operational		Q4					Q1		Q2			Q3	
Hospital Leadership (quarterly Planning & Performance Group)	Strategic & Operational		Q4					Q1		Q2			Q3	
Board	Strategic			Q4					Q1		Q2			Q3
Quality Committee of the Board	Quality & Safety							Q4	Q1		Q2			Q3
Resource Planning Committee	People & Financial							Q4	Q1		Q2			Q3

Changes from Current reflected in RED

Thunder Bay Regional Health Sciences Centre

Research Ethics Board
2015 – 2016 Annual Report

Thunder Bay Regional
Health Sciences
Centre

Contents

Message from the Chair

The Research Ethics Board (REB) has had a great year of perfecting some of our processes and at the same time wading into some new territory where we are finding it important to consult with scientists and with ethics board members elsewhere because of some of the cutting-edge science that has been coming our way.

This is good news in that it means we have research happening here that is truly innovative. As a result we have been challenged to make sure we are always asking the right questions so as to ensure patient safety and truly ethical processes consistent with the Canadian standards for ethical research. It makes the work interesting, to be sure.

The numbers will support that we have had a busy year. I thank each member for having worked evenings and weekends in order to arrive prepared for our monthly meetings, as well as provide reviews and scrutinize researcher-responses many of the days between meetings, and I thank those in the Office (Jonathon, Katherine, Kathy) for helping make the work of Chair most enjoyable.

They really do run a very effective operation!

I will be finishing my term in June as I exit the building after 28 years with the Cancer Program and with the Health Sciences Centre. It's been a good run and I am looking forward to focusing exclusively on clinical practice and teaching.

Kind regards,

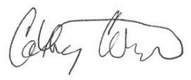
Dr. Scott M. Sellick, Ph.D., C.Psych.

Chair, TBRHSC REB

Message from the Director

It has been an exciting year! Far more collaboration is on our horizon! We continue to work on the Research Quality Oversight Program recommendations and to work collaboratively with Lakehead University (LU) and the Northern Ontario School of Medicine (NOSM) to ensure mirror policies and procedures. We will see a harmonized local ethics review process with Thunder Bay Regional Health Sciences Centre (TBRHSC) and LU in 2016. We will leverage this partnership to offer joint education for our members and we will explore a single streamlined review process for REB projects approved through a Clinical Trials Ontario (CTO) qualified REB.

As our Chair retires, we will seek a dynamic individual to continue moving us forward on our path to ethical research together!



Cathy Covino

Senior Director, Quality and Risk Management

About Us

Our Vision: Ethical research together

Our Mission: A harmonized and expert research ethics review process that upholds the interests of research participants to further cultivate an engaged and conscientious research community in Northwestern Ontario.

Our Core Principles: In accordance with Tri-Council Policy Statement, "Ethical Conduct for Research Involving Humans", our Core Principles are:

Respect for Persons – To respect autonomy and protect those with developing, impaired or diminished autonomy by recognizing the intrinsic value of human beings and the respect and consideration that they are due.

Concern for Welfare – To protect and promote the quality of all aspects of a participant's experience of life by taking into consideration factors determining and contributing to it when evaluating any foreseeable risks associated with the research.

Justice – To respect and show concern for participants by ensuring the benefits and burdens of research participation are fairly and equitably distributed.

Our Strategic Directions: Our journey to achieve our vision with REB members, researchers, research participants and other members of the research ethics community will be aligned by following two strategic directions:

Expertise: Advance knowledge and experience in research ethics

Harmonization: Enhance and foster the research ethics environment

Who we are

Research Ethics Office (REO):

Ms. Kathleen Shilliday
REB Secretary

Mr. Jonathon Scully
Research Ethics Officer

Ms. Katherine Bell
Manager, Quality and Research Ethics

Ms. Cathy Covino
Senior Director, Quality Risk Management

Dr. Scott Sellick
REB Chair

Ms. Michelle Allain
REB Vice Chair

It is through the commitment and hard work of each person who volunteers his or her time and effort that the TBRHSC REB is able to apply its core principles to achieve its mission, values and goals. Below is a list of the incredible people who make this possible.

Core Members

Dr. Scott Sellick

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB

Ms. Michelle Allain

Member knowledgeable in ethics

Dr. Chandar Rao

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB - Physician

Dr. Christopher Zanette

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB - Physician

Ms. Shelley Tees

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB

Dr. Mariette Brennan

Member knowledgeable in the relevant law and Member with a primary interest that is not in the area of research

Mr. Bill Gregorash

Community Member who has no affiliation with the institution

Substitute Members

Dr. Valentina Peeva

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB - Physician

Dr. Salima Oukachbi

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB -Physician

Ms. Nancy Fleming

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB

Ms. Lorella Piirik

Member knowledgeable in relevant research disciplines, fields and methodologies covered by the REB

Dr. Richard Matthews

Member knowledgeable in ethics

Dr. Karen Drake

Member knowledgeable in the relevant law and Member with a primary interest that is not in the area of research

Mr. Claude Camirand

Community member who has no affiliation with the institution

Advisors

Dr. Giles Santyr

Knowledgeable on magnetic resonance imaging using Xenon

Dr. Fredric Sarrazin

Knowledgeable on matters related to emergency and trauma medicine

Dr. Mitch Albert

Knowledgeable on matters related to Magnetic resonance imaging methods

Dr. Laura Curiel

Knowledgeable on matters related to medical engineering

Dr. Jane Lawrence-Dewar

Knowledgeable on matters related to behavioural sciences and neuro-imaging

Ms. Helen Cromarty

Knowledgeable on matters related First Nations, Inuit and Métis Peoples of Canada

TBRHSC Joint Pharmacy and Therapeutics Committee

Clinical trials involving the administration of drugs

TBRHSC Privacy Officer

Research involving personal health information or privacy issues

TBRHSC Credentialing

Committee Research projects that involve qualifications overseen by the credentialing committee

What researchers, research participants and REB members think about research ethics at TBRHSC

Annually, the REO puts out surveys online for researchers, REB members and research participants intended as quality improvement (QI) tools for human research protection. They are designed to gather information to promote better communication amongst and between researchers, research administrators, research participants and our REB. Results of the 2014 and 2015 survey were summarized and presented at the 2nd Annual Research Ethics Board Meet and Greet held at 5 Forks South on Tuesday, April 5, 2016. The data showed that:

- When asked to score how often a list of factors contribute to delays in approvals, in 2014 and 2015 REB members scored the following 5 factors the highest: consent form issues, slow response from researchers, missing information, poorly written protocol and privacy concerns. All were rated as contributing "a little" or "occasionally" to delays. In 2015, a larger fraction of REB members recognize issues associated with multi-site review as frequently contributing to the delays. **Results from the survey will help guide strategies to reduce approval delays including consent guidance and a streamlined research ethics review process.**
- When asked to rank the quality of submissions received in terms of science and ethics, a larger fraction of REB members scored the quality of science as above average or excellent in 2015 when compared with 2014, whereas, a smaller fraction of REB members scored the quality of ethics above average or excellent. **Early REB consultation will continue to be promoted and training opportunities focused on research ethics will be developed for researchers.**
- Trends suggest that a growing number of REB members and researchers feel the REB needs additional support in risk estimation. **Opportunities for REB members to be educated on research procedures the researcher's and patient's perspectives will be explored to help inform risk estimation.**
- Trends suggest that a growing number of REB members feel the protocols reviewed are occasionally beyond their expertise and that a growing number of researchers somewhat agree with the statement, "The REB fails to understand their research protocols or methodology". **Our REB's expertise, training and experience will become better focused as we implement the reciprocal review arrangement with LU's REB.**
- No research participants completed the 2015 online survey. **We look will work with the Clinical Research Services Department, principal investigators and Patient and Family Advisors on ways to increase research participant survey participation.**

The Numbers between April 1, 2015 and March 31, 2016

10 Full board REB meetings held

153 Annual renewal applications submitted and approved

49 Study completion reports submitted and approved

78 Amendments submitted and approved

12 New applications reviewed on average per quarter

3 Full board approval letters issued on average per quarter taking on average 68 days from submission to approval letter

48 New initial research applications reviewed

- **10** More than minimal risk studies (went through Full Board)
- **34** Minimal risk studies (went through delegated review)
- **4** Approved through the Ontario Cancer Research Ethics Board

146 Projects are actively overseen on average per quarter, of which on average by quarter:

- **93** Projects where the principal investigator is primarily affiliated with TBRHSC
- **7** Projects where the principal investigator is primarily affiliated with TBRRI
- **47** Projects where the principal investigator is primarily affiliated with another organization

8 Delegated review approval letters issued on average per quarter taking on average 54 days from submission to approval letter

For full board review, the longest bottleneck in the approval process is consistently following the full board meeting when the REO has sent the REB clarifications to the researcher and the researcher has yet to submit a final and sufficient response

For delegated review, the longest bottleneck in the approval process is consistently following the initial submission when the REO has sent the prescreening clarifications to the researcher and the researcher has yet to submit a final and sufficient response

Our Goals and Accomplishments:

The 2015 fiscal year has been a busy year for the REB and REO. Below is a summary of our goals, where we want to be, what we have done well to get us there and opportunities we will take advantage of in the 2016 fiscal year to get us even closer.

Goal 1:
Enable expertise in research ethics

1.3 Recruit and develop excellent REB members

What we have done well

- Maintained a TCPS2-compliant board membership.
- 2 REB members attended the 2015 CAREB conference in Vancouver.
- REO educated members on potential changes to the US Common Rule.
- Utilized our ad hoc advisors.

Where we want to be

- Continue to maintain a TCPS2 Compliant board membership
- REB members are experts in clinical trials.
- REB members are knowledgeable in the research that matters to our researchers
- REB decisions are informed by the patient experience.

Opportunities to get us closer to where we want to be

- Recruiting a core member knowledgeable in research to replace a member who retired.
- Recruiting a member to act as the Chair to replace the retired Chair.
- REB members attending CAREB 2016 and bring back lessons learned for the group.
- Develop REB member curriculum for clinical trials
- Education sessions for REB members led by researchers.
- Education sessions for REB members led by patient advocates.

1.2 Focus our review on research ethics

What we have done well

- REB Chair and office administrators met with the Credentialing committee to discuss gaps in the current process for research requiring credentialing.
- REO staff members worked with the Chair of JPTC to pilot a process to ensure JPTC oversight during ongoing review of research.
- Through the quality and research oversight project and working with the Clinical Research Services Department, policies and procedures have been established to ensure local implementation plans are in place before projects are reviewed by the REB.
- Joint presentation on the Authorization process by Clinical Research Services and the REO at TBRRI's research and innovation week.

Where we want to be

- Comfortably rely on the credentialing committee for matters associated with credentialing
- Comfortably rely on the Joint Pharmacy and Therapeutics committee for matters associated with drugs.
- Comfortably rely on the Clinical Research Authorization Process for logistical matters associated with a study's local implementation plan.

Opportunities to get us closer to where we want to be

- TBRHSC Policy & procedures for research requiring credentialing.
- TBRHSC Policy & procedures for submitting research projects to JPTC.
- Continuing to work with Clinical Research Support Services to implement the authorization policy.

1.3 Encourage the emergence of champions in research ethics

What we have done well

- A REO staff member attended the 2015 CAREB conference in Vancouver.
- REO staff members provided a voice for research ethics at TBRHSC and TBRRI Strategic Planning engagement sessions and the TBRRI's annual general meeting.
- Research ethics awareness was raised through a presentation at the annual patient and family-centred care event.

Where we want to be

- The research ethics office, REB members and researchers are leaders in research ethics.
- Researchers are engaged in the research ethics community.
- Research participants are engaged in the research ethics community

Opportunities to get us closer to where we want to be

- Researchers, REB members and administrators continuing to work together to tackle research ethics hot topics at the annual meet and greet.
- Education sessions for researchers led by REB members.
- Research ethics lectures and events in collaboration with NOSM and LU.

Goal 2:
Impact through harmonization

2.1 Harmonize the local ethics review process

What did well in 2015-2016

- Drafted a reciprocity agreement with LU

Where we want to be

- A single streamlined review process for REB projects normally going through LU and TBRHSC REB.
- Researchers and TBHRSC staff adhere to a research ethics review process that meets their needs.

Opportunities to get us closer to where we want to be

- Executing the reciprocity agreement.
- Using national standard operating procedures to harmonize REB policies and procedures.
- Exploring the use of shared REB application forms and information systems.
- Developing shared training and education for LU and TBRHSC REB members.
- Engagement and education sessions for researchers.

2.2 Harmonize ethics review process for projects reviewed by provincial boards

What did well in 2015-2016

- Explored and prioritized opportunities to get involved with Clinical Trials Ontario.

Where we want to be

- A single streamlined review process for REB projects approved through a CTO qualified board REB.

Opportunities to get us closer to where we want to be

- CTO qualification of the TBRHSC REB.

2.3 A harmonized perspective when indigenous people and indigenous communities participate in research

What did well in 2015-2016

- A REB ad hoc advisor presented at TBRRI's Research and Innovation week: Engaging the First Nations community to address invasive Haemophilus influenza type A disease".
- REB members and REO staff participated in the LU Workshop, "Working Outside of Traditional Boundaries: Engaging in Research with Aboriginal Peoples in Urban Settings".

Where we want to be

- Urban indigenous populations participate in research
- Indigenous people acting as investigators on studies
- Indigenous communities are research participants

Opportunities to get us closer to where we want to be

- Engagement sessions with relevant stakeholders to identify gaps and opportunities related to research and indigenous populations.

Conclusions

As we move forward with new leadership and initiatives focused on driving expertise and harmonization we will renew and strengthen our commitment to ethical research together.

Thunder Bay Regional
Health Sciences
Centre

Thunder Bay Regional Health Sciences Centre is a leader in Patient and Family Centred Care and a research and teaching hospital proudly affiliated with **Lakehead University and the Northern Ontario School of Medicine**.

Le Centre régional des sciences de la santé de Thunder Bay, un hôpital d'enseignement et de recherche, est reconnu comme un leader dans la prestation de soins et de services aux patients et aux familles et est fier de son affiliation à **l'université Lakehead et à l'École de médecine du Nord de l'Ontario**.

healthy together

En santé ensemble

Compliance with Excellent Care for All Act - Critical Incident Process

June 8, 2016

Cathy Covino, Senior Director, Quality and Risk Management

Critical Incident Defined

A critical incident is defined in Regulation 965 under the *Public Hospitals Act,* as, "any unintended event that occurs when a patient receives treatment in the hospital that results in death, or serious disability, injury or harm to the patient, and does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment."

TBRHSC's definition- Canadian Patient Safety Dictionary

Critical- An incident resulting in serious harm (loss of limb, life or vital organ) to the patient or the significant risk thereof. Incidents are considered critical when there is an evident need for immediate investigation and response1,2.

Aggregated Critical Incident Data

- Section 4 of the Excellent Care for All Act (ECFAA) provides that the Quality Committee must oversee the preparation of the quality improvement plan, which must be developed having regard to its aggregated critical incident data (Jan. 2011)
- Board ensure the Administrator provided aggregate date of critical incidents to the Quality Committee twice a year
- Includes data of incidents occurring at the hospital since previous report - does not stipulate how to aggregate data - hospitals develop their own template for consistent reporting
- The Quality Committee should consider the recommendations of the MAC that relate to systemic or recurring quality of care issues
- The MAC is now required to make recommendations directly to the Quality Committee which in turn, must take these into consideration when reporting to the Board

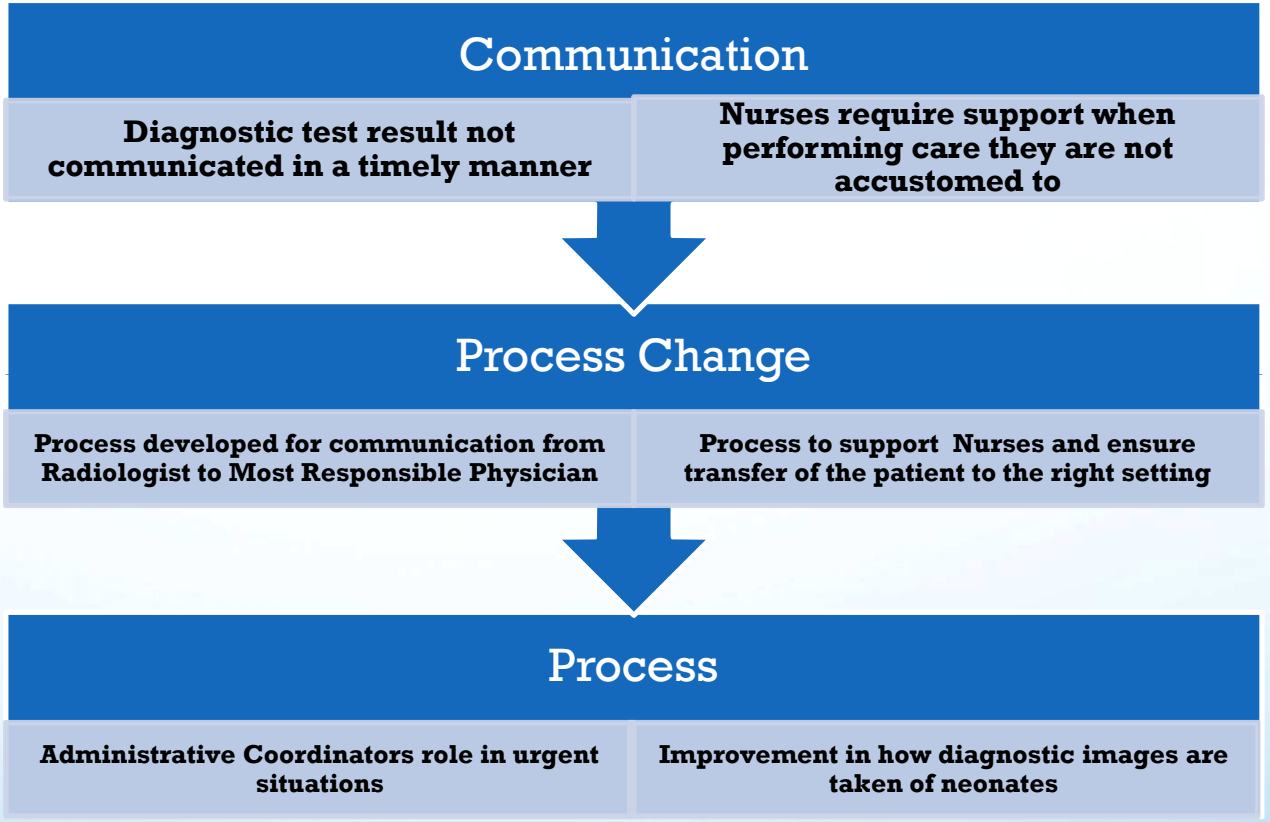
Aggregate Reporting to the Board and Quality Committee of the Board November 2015 –March 2016

Critical Incidents Summary

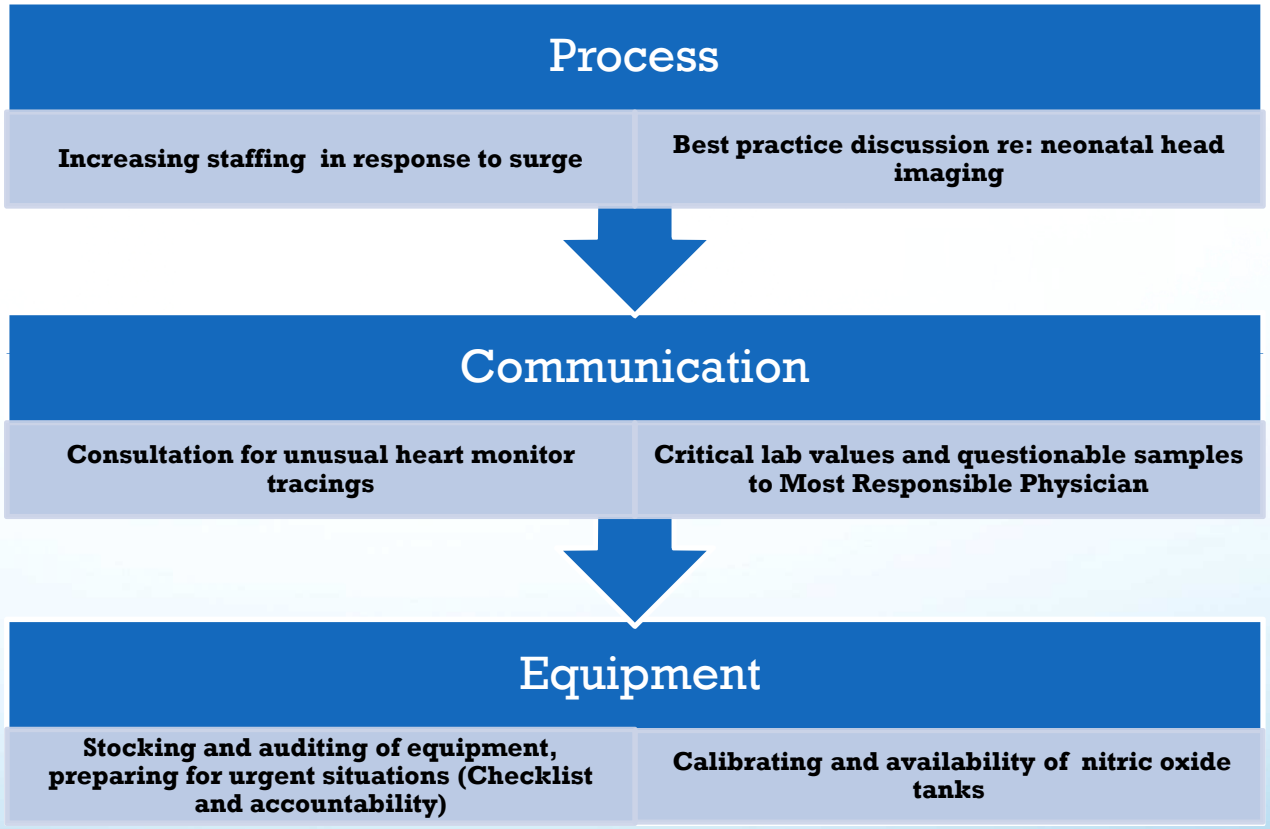
Classification

Recommendations

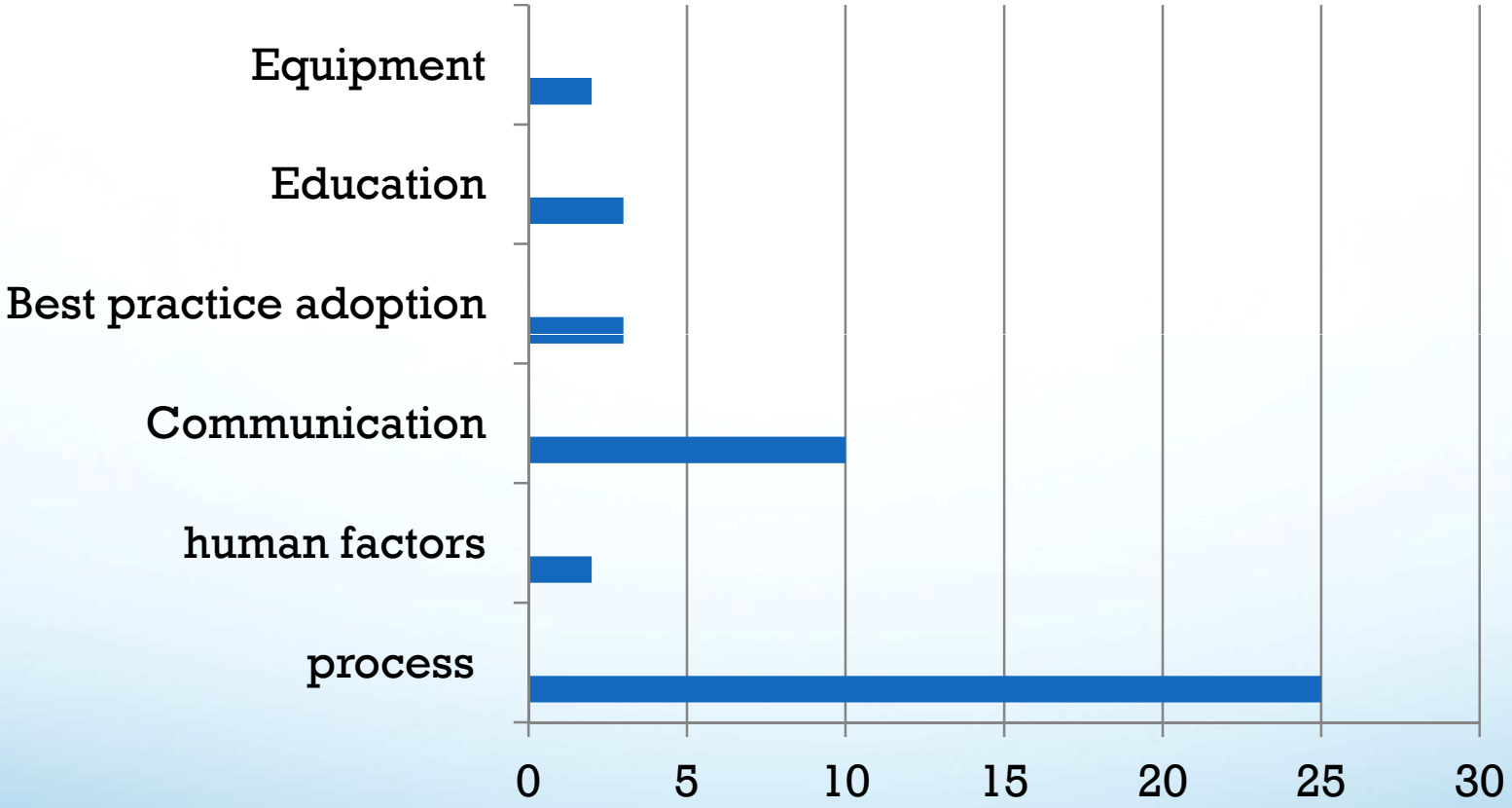
Summary of Critical Incidents and Recommendations Aggregate



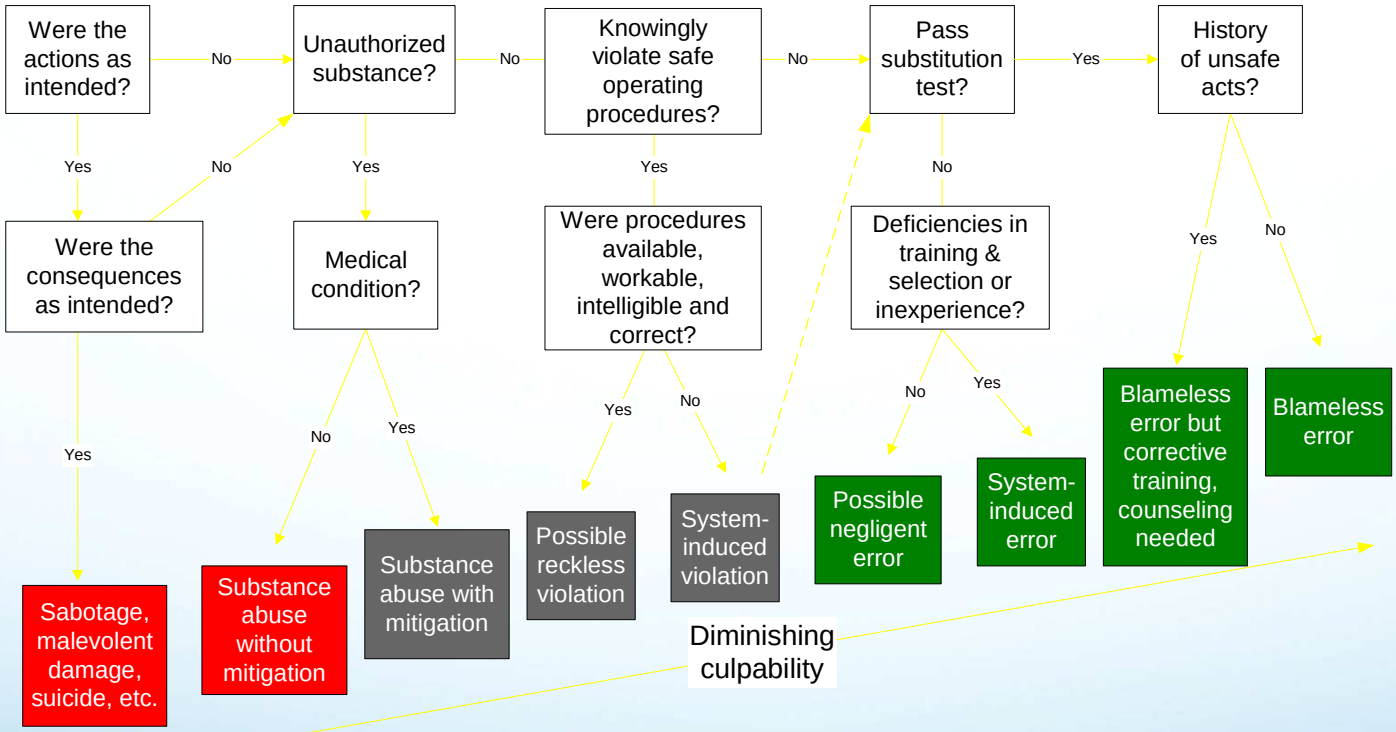
Incident Classification and Recommendations Aggregate



Incident Root Cause Classification November 2010-2016



James Reason's Decision Tree – Performance vs. Process



Decision Tree for Determining Culpability of Unsafe Acts

Excellent Care for All Act

- Incidents must be shared with the Administrator as soon as possible
- A review is conducted
- Improvements are shared with the families as soon as we are able to
- The Chief of Staff (Chief of Department), Manager, Director and Senior Director of Quality and Risk Management meet with patients and families when a critical event occurs
- A letter is written including the recommendations and provided to the patient/family
- The trust and rapport we develop is very important
- Open and honest discussion of the facts
- Reviews must be brought to the Medical Quality Assurance Committee of the Medical Advisory Committee and then to the Quality of Care Committee (QOCC) – Leaders in having a Patient Family Advisor on our QOCC - October 2015 Keith Taylor joined our committee
- Reviewing QCIPA review recommendations, await legislation and implement

Never Events for hospital care in Canada

- **In January 2014, the Canadian Patient Safety Institute brought together health sector partners to form a National Patient Safety Consortium. Working together, the consortium identified a list of *15 never events* for hospital care in Canada.**

- **In September 2015 Canada released its first *Never Event* report, a joint effort between Health Quality Ontario and the Canadian Patient Safety Institute.**

- **Never events are defined as:**

"Patient safety incidents that result in serious patient harm or death, and that can be prevented by using organizational checks and balances[1]"

- **Never events are not intended to reflect judgment, blame or provide a guarantee; rather, they represent a call-to-action to prevent their occurrence.**

[1]Never Events for Hospital Care in Canada: Safer Care for Patients. Toronto, ON: Health Quality Ontario and the Canadian Patient Safety Institute; September 2015.

Never Events for Hospital Care in Canada

1. **Surgery on the wrong body part or the wrong patient, or conducting the wrong procedure.**
2. **Wrong tissue, biological implant or blood product given to a patient.**
3. **Unintended foreign object left in a patient following a procedure.**
4. **Patient death or serious harm arising from the use of improperly sterilized instruments or equipment provided by the hospital.**
5. **Patient death or serious harm due to a failure to inquire whether a patient has a known allergy to medication, or due to the administration of a medication where a patient's allergy had been identified.**

6. **Patient death or serious harm due to the administration of the wrong inhalation or insufflation gas.**

7. **Patient death or serious harm as a result of a pharmaceutical event including:**
   - **wrong-route administration of chemotherapy agents;**
   - **intravenous administration of a concentrated potassium solution;**
   - **inadvertent injection of epinephrine intended for topical use;**
   - **overdose of hydromorphone by administration of a higher-concentration solution than intended;**
   - **neuromuscular blockage without sedation, airway control and ventilation capability.**

8. **Patient death or serious harm as a result of failure to identify and treat metabolic disturbances (eg. hypoglycaemia in an admitted patient, hyperbilirubinemia in neonates).**

9. **Any stage III or stage IV pressure ulcer acquired after admission to hospital.**

10. **Patient death or serious harm due to uncontrolled movement of a ferromagnetic object in an MRI area**

11. **Patient death or serious harm due to an accidental burn (eg. oxygen fires, heat or cold burns from assisted bathing, the use of hot or cold packs during wound care).**

12. **Patient under the highest level of observation leaves a secured facility or ward without the knowledge of staff (eg. patient with dementia, psychosis, or at risk of suicide).**

13. **Patient suicide or attempted suicide that resulted in serious harm, in instances where suicide-prevention protocols were to be applied to patients under the highest level of observation.**

14. **Infant abducted or discharged to the wrong person.**

15. **Patient death or serious harm as a result of transport of a frail patient, or patient with dementia, where protocols were not followed to ensure the patient was left in a safe environment.**

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- 2 JCAHO. Joint Commission on Accreditation of Healthcare Organizations. *Sentinel Event Policy. 2015. Retrieved from*
- the Internet on 24 Novembe 2015 at: *http://www.jointcommission.org/sentinel_event_policy_and_procedures*

Questions or Comments?