OMBUDSMAN FOR BERMUDA

REVIEW

of the

CLINICAL AND CORPORATE GOVERNANCE REVIEW

of the Bermuda Hospitals Board

by Howard Associates

May 2013

May 17, 2013

The Speaker, The House of Assembly
The Hon. K. H. Randolph Horton, JP, MP
Sessions House
21 Parliament Street
Hamilton HM 12

Dear Honourable Speaker,

I have the honour to present a Special Report of my Review of the Clinical and Corporate Governance Review of the Bermuda Hospitals Board. Uniquely, my review was requested by the Bermuda Hospitals Board.

This Report is submitted in accordance with section 5(2)(b) read with section 12(5) of the Ombudsman Act 2004.

> 5(2) Subject to this Act, the Ombudsman may investigate any administrative action taken by or on behalf of an authority
>
> (b) on his own motion, notwithstanding that no complaint has been made to him, where he is satisfied that there are reasonable grounds to carry out an investigation in the public interest.
>
> 12(5) Subject to the provisions of this Act, the Ombudsman may regulate investigations and proceedings under this Act in such manner as he sees fit.

Yours sincerely,

Arlene Brock
Ombudsman for Bermuda

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May 17, 2013

Ombudsman's Review of the Clinical and Corporate Governance Review ("CCG Review") by Howard Associates ("HA")

EXECUTIVE SUMMARY

It was commendable of the Bermuda Hospitals Board ("BHB") to requisition a CCG Review late last year (see BHB Terms of Reference *Appendix I*). Another sensible step was to ask me to review that review on behalf of the public. The BHB knew that there would be some skepticism about a CCG Review that they paid for – *"he who pays the piper plays the tune"*, especially if the piper hopes for further opportunities to play. Accordingly, the BHB understood fully that my oversight of the consultant's process and report would be frank, not subject to the BHB's preapproval or timelines, and that all of my statutory powers would remain intact. I would not be a rubber stamp (see Ombudsman Terms of Engagement *Appendix III*).

I participated in the interview of the short-listed consultants and agreed that HA had presented themselves best – as humble, serious and inclined to ask questions rather than razzle-dazzle with "consultant-speak". Their proposed methodology was particularly impressive. They would embed themselves into the BHB (in the same way that journalists embed themselves with troops at war). This is an ideal way of obtaining both formal and informal information about the real dynamics and operations of an organization. The "Embed" method tends to uncover untold amounts of extremely useful information.

From such an auspicious beginning through an excellent methodology, I am sorry to have to report to the Legislature and the public that I am exceedingly disappointed with the HA report. The report simply does not reflect the wealth of information and insight that ought to have been obtained from embedding.

After thorough review and opportunity for HA to explain their report (indeed, I asked 134 specific questions of which only half were adequately responded to), my conclusion is that the report is full of statements, conclusions and recommendations without evidence, examples, best practices or rationales.

Throughout the course of my review, I explained to the BHB and HA what I expected and required both in substance and in process. Despite my clear instructions and deadlines (sometimes repeated several times) and agreements made by all parties, it appears that at certain points there was disregard for and backtracking from such agreements.

There are three HA reports that must be noted:

I. **March 18 Report**
By an email dated March 2, HA agreed to a deadline of March 18 to submit to me a final report for my review (subject only to potential minor subsequent revisions). HA did submit a report on March 18 but did not copy this report to the BHB.

II. **March 22 Report**
Instead, HA submitted a report to the BHB dated March 22. However, HA did not copy that report to me. I found out! The two reports were different and the differences warranted critique (see pages 21 and 22 of my following report).

III. **April 12 Report**
Largely as a result of my critique, HA produced a Rectification Report – in accordance with its contractual agreement with the BHB. I was not told until 1st April (quite informally) that the BHB had required a Rectification Report. Had I known from the outset that there was an intention to use our considerable resources, thinking, insight, time and efforts to improve upon what the HA review would produce, I probably would not have agreed to this in the first instance.

Logically, I cannot critique the Rectification Report. It would be improper for me to applaud the improvements that I had suggested. Essentially, I cannot review my own work.[1] Accordingly, my following report is based on HA's March 18 and 22 reports. The March 22 report is on my website www.ombudsman.bm.

[1] In any event, a few of the improvements in the Rectification Report relate to clinical governance and procurement best practices which are relatively boiler plate and easily googleable (i.e. similar information can be found in, e.g., Procurement Practices in the Health Sector Oct. 2011 Report of the Victoria Government, Australia).

INTRODUCTION

Context and Genesis of the Corporate and Clinical Review ("CCG Review")

Public interest in King Edward VII Memorial Hospital ("KEMH"), Mid-Atlantic Wellness Institute ("MAWI") and the overall operation of the Bermuda Hospitals Board (collectively, "BHB" or "the Hospital") is not just a matter of curiosity. Ultimately we all must rely on and have confidence in a properly functioning hospital and healthcare system. We, the public, fund the cost of hospital services through: (a) government payments (called subsidies) for services rendered by the hospital for seniors, children and the indigent; and (b) our insurance premiums.

According to accreditation reports, the hospital meets or even exceeds international standards in the delivery of services for diabetes, dialysis and diagnostic imaging. Notwithstanding even stellar patient survey feedback, public perceptions about the hospital often veers into very negative territory.

The new CEO's tenure officially started in April 2012. She was Acting CEO from April to October 2006 and Deputy CEO from November 2006 to April 2012. Since 2009 she was responsible for leading the Redevelopment Project (the new hospital). Accordingly she and her team needed to spend certain periods of time abroad to conduct arms-length meetings with legal, design, business, and other BHB partners and advisors. Upon taking the reins in April 2012, the CEO was of the view that she had not been privy to the agendas and reasoning underlying a number of decisions such as significant bonus contracts for doctors (for which she would now be responsible). In addition, she was not clear about the reasons behind skyrocketing costs despite a relatively stable population. Essentially, is the hospital getting its money's worth? In the best of circumstances, this would be an obvious moment to commission a full clinical and corporate governance review.

The summer of 2012 was not the best of times. Within five months of the CEO assuming her role, she suspended the Chief of Staff. For at least two years, concerns had circulated amongst both internal and external publics. As is the case in small hospitals elsewhere, the former Chief of Staff was widely considered to be the real, actual and sometimes single power base of the hospital. It appeared that he had been given carte blanche to run the hospital. Eventually, several people (both staff and families of patients) expressed a lack of confidence about his actions and alleged personal agendas.

It must not go unsaid that the former Chief of Staff and the former CEO were often viewed as an indelible pair. There was discomfort, even amongst some members of the Board, about the extent to which the Board was receiving all appropriate information and/or was expected to rubber-stamp executive decisions. For more than half of 2012 the Board was at approximately half capacity and seemed to be in slow motion pending an inevitable general election. This did not augur well for a Government, Board and Executive in the middle of a capital campaign for the new facility. The generosity of donors depends to a very large extent on their trust in the hospital's governance.

Whether things go well or wrong in our hospitals depends in large part on the quality of governance. The role of both corporate and clinical governance of a hospital is to deliver quality patient care aligned with prudent management of resources and talents. Corporate governance generally entails the policies and practices required by the Board and executive staff to ensure accountability and transparency in administering an entity and its relationship with stakeholders. In the context of a hospital, Clinical Governance refers to the

systemic approach of decision-making, rules and processes for ensuring proper medical practices (such as tests and infection control) and patient management.

‘Good Governance’ not only sets policies but also leads the institutional culture. An institution that is accountable, transparent, and engages its constituencies in driving performance and learning can shield itself against negativity based on rumours and one-off experiences. Governance is about:

- vision, policies and strategies aimed at empowering staff to deliver high quality care
- evidence-based policy-making that builds in accountability and capacity to rethink should decisions prove unsustainable
- operational intelligence that engages persons tasked with implementing policies to give reasonable input into decisions
- monitoring adherence to policies.

An honest and clear snapshot of the state of governance would not merely be opportune, but indeed critical for the new CEO. Howard Associates (“HA”) set out their Terms of Reference for the comprehensive CCG Review that was to include assessing:

- the effectiveness of existing governance structures, authority and accountability
- concerns raised by the Auditor General, patients and other stakeholders
- financial challenges, efficiency tools, controls and risk management
- transparency, conflicts of interest, benchmarks and performance management
- the incorporation of Healthcare Partners Limited (“HPL”) [Note: This is a new type of business venture for the BHB. This is of considerable interest because the BHB had not previously engaged in business partnerships that would sell back services to the BHB. Therefore the business model, shareholders, decision-makers and contractual arrangements should be scrutinized adequately.]
- transition to new management and preparedness for the new facility.

Involvement of the Ombudsman

The public is not monolithic – there are many audiences who hold a stake in the hospital, including:

- patients and their families
- residents generally and visitors – who may need hospital services
- providers – staff at all levels, senior management, the Board itself
- primary care physicians, social agencies and other professional users and healthcare providers’ specialists and other doctors offering competitive services (e.g. diagnostic tests)
- insurers and the Health Insurance Department
- Bermuda Hospitals Charitable Trust seeking to raise funds
- The Government – people expect the government to shoulder the blame when things go wrong as ultimately, the Minister of Health appoints the Board.

Given the criticism from internal and external audiences, and a growing climate of distrust and uncertainty about the direction of the hospital, the CEO was acutely aware that a CCG Review conducted by consultants engaged and paid for by the BHB would be open to the suspicion that *“he who pays the piper plays the tune”*.

There is a further issue of 'consultant fatigue'. The BHB has commissioned at least twelve reports in as many years since 2000. None entailed a full, wide ranging review of decision-making and policies. As is the norm for internal reviews there was little ongoing public communication or accounting for the BHB's responses to the recommendations. Many members of the public had come to believe that BHB-initiated reports would not lay bare the true problems that they perceive to be plaguing the hospital.

Our 2007 report *A Tale of Two Hospitals* was not initiated by the BHB and was frank about the issues uncovered. Although narrowly focused on allegations of discrimination involving medical practitioners, certain recommendations aimed at improving patient care overall. For example, the recommendation that clinical affiliations with overseas hospitals should be expanded would likely enhance the BHB's objective diagnostic capacity and patient management – whether or not relationships improve amongst the local doctors.

Given that investigation and report, the CEO sought my involvement to oversee the CCG Review on behalf of the public. She was adamant that the CCG Review be honest and forthcoming – warts and all. Further, she expected that my "review of the review" would be the same. A "review of the review" is very different from our usual investigations. When we launch our own investigations we have absolute control over the process, substance, direction and intensity. Overseeing someone else's work requires meticulous monitoring and testing of their methodology, diligence, assumptions and reasoning. Moreover, given my prior experience in the consultant world, I am attuned to the natural business development impulse of consultants to look ahead to the next "gig". Therefore, my task was to watch out for any temptation to pander to the client or otherwise compromise full disclosure and robust analysis (however, see page 21 of this report!).

I have undertaken to review the work of the reviewers in the public interest. However, I cannot take any responsibility for their insight into substantive matters. Notwithstanding such caveats, most Ombudsman are thrilled when government departments and quangos initiate transparency measures. Therefore, we are happy to lend the lens of our resources, skills and experience. In several jurisdictions Ombudsman invoke their "own motion" authority to review draft legislation relevant to governance. Therefore, it was not a stretch for me to agree to this oversight function.

This task is within my statutory authority under s.5(2)(b) of the Ombudsman Act 2004 ("Act") to conduct own motion investigations in the public interest, read with s.12(5) of the Act that empowers me to conduct proceedings as I see fit. I agreed to the oversight function on the condition that, not only must the reviewers have full access to information for their report, but also that my statutory powers would not be fettered or diminished in any way. In particular:

- I could speak directly with witnesses and review documents as I deem necessary
- my report will be forthright and would not be subject to pre-approval by the BHB prior to tabling in the Legislature.

Attached as *Appendix III* is my November 5, 2012 media statement setting out my terms of engagement.

Ombudsman Oversight Process

My process entailed: participation in the last stage of the recruitment process; periodic contact with HA; our own due diligence; and assessment of HA's report.

Recruitment

While not involved in determining the short list of four applicants, I participated in the October 2012 interviews of the short list and selection of the successful candidate. Interviews were all conducted on the same day by *skype* and telephone. The interview panel comprised of the Chair and another member of the Governance Committee of the Board, the CEO, Acting Chief of Staff and Interim Chief Performance Officer. I participated actively, fully free to ask questions.

The two persons representing HA (Jim Langstaff and Philip Hassan) distinguished themselves by not having a cookie cutter approach or overloading their proposal with standard jargon. They asked thoughtful questions and did not seem to be focused only on selling themselves. I was persuaded by their apparent humility in recognizing the need to learn from us before making recommendations. HA was selected by an unanimous decision.

HA proposed embedding themselves into the BHB in order to generate the information they needed to conduct the CCG Review. The "Embed Method" (in a similar way that journalists embed themselves into military units during wars) is compelling. From my prior experience in the consultant world, the Embed Method was always the ideal. It is a rare client who can afford the time, costs and inconvenience of having strangers on site, attending meetings, walking the halls and physically present almost 24/7. The Embed Method is one of the best ways to collect insight on the institutional culture and the dynamics of daily work and relationships. Embedding typically yields a veritable gold mine of informal information that adds context, texture and substance above and beyond the more formal interviews and other information gathering that consultants who are not embedded must settle with. (I employed the Embed Method years ago when teachers at Cedarbridge Academy challenged me to live their reality before concluding my report on labour relations there.) The Embed Method usually results in reports and recommendations that are formidably insightful, nuanced yet realistic.

By mid-January I had heard excellent feedback from KEMH staff that the HA Embed Method felt genuine – in contrast to the high-handed, combative approach they had experienced with previous consultants. They had very positive comments about the way that HA seemed to fit in almost seamlessly. The HA presence at meetings was unobtrusive and their approach was humble and inoffensive. The promise from the recruitment interview of the value of the Embed Method was fully met in this regard.

However, I was also hearing discontent that HA and the CEO seemed to be having far more frequent contact than would be desirable to maintain their independence. I strongly cautioned that HA should not be situated in the CEO's office wing. I also expressed concern about the temptation during embedding to step outside of the review remit and to give strategic and/or operational advice. Neither HA nor the BHB informed me that HA was doing so. Nor did they double-check on the propriety of doing so. It was not until late in February – after my insistent questioning – that HA admitted to having given advice to the BHB on at least seven occasions.

The potential downfall of the Embed Method, if great care is not taken, includes:

- over-identification with the client to the point of involvement beyond remit of a review
- over-sympathy with the client to the point of bias.

Indeed, if concerns about independence were so important as to involve the Ombudsman in the first place, then surely this is a clear signal that care should be taken to maintain independence and therefore distance between the consultants and the BHB. It can be done – even with the Embed Method.

Periodic contact with HA

We initiated all meetings starting with the very first official day of the review on November 5, 2012. We set out our oversight role and warned in the very first meeting against the temptation of consultants to tailor their work with an eye on future consulting contracts. We prepared for the first meeting by reviewing media reports, our 2007 Report as well as several pieces of evidence from that investigation.

We suggested that HA review reports conducted during the past decade about the BHB to determine if and why prior recommendations were not implemented. We provided a written list of some 33 issues that HA could pay attention to. We highlighted that they should review: the concerns of the Auditor General; the establishment and operation of HPL; and, the tenure of the former Chief of Staff.

We also analyzed and copied five outstanding individual complaints that had been made to us in order to provide HA with underlying issues that we also wanted incorporated into their review. Essentially, we asked our complainants to be patient and wait for the results of the HA review.

Between November 5, 2012 and February 25, 2013 we held a total of eight meetings in person. We also conducted three extended telephone calls and several email exchanges as needed. The last (2.5-hr) meeting on February 25 plowed through our concerns about the 1st draft (after broad written feed-back on February 20, 2013).

In December I asked twice for a list of interviewees – just to ensure that various audiences would be interviewed. We received the list on December 20 and I was satisfied that it was expansive and representative of a full range of hospital, government and community audiences. I requested outline information on December 12 and again on December 20 which was submitted on January 9, 2013. I returned substantial feedback five days later on structure and priorities.

The meetings and other contact with HA are summarized in more detail in *Appendix IV*.

Ombudsman's Due Diligence

Parallel to our contact with HA, we also conducted our own due diligence interviews and documentary review. The purpose was not to conduct an investigation of our own. The purpose was to test whether HA had gleaned necessary information from their interviewees and documentary review.

Interviews: We conducted fourteen interviews representing a range of constituencies – Board, staff, insurers, unions and doctors – including persons that HA would need to speak with to capture an informed view of health care in Bermuda. I asked:

- what would 'success' look like for the reviewers
- are they asking the right questions and looking at pertinent issues
- what would 'success' look like for my "review of the review"
- what omission would undermine the credibility of either review.

HA Success – Interviewees responded that HA should:

- air and clear up suspicions and concerns regarding HPL and the former Chief of Staff
- specify proper governance structure, credentials and training for the Board
- clarify the proper role of the Board to make policy rather than operational decisions
- address financial issues such as salaries, hiring, billing and over-utilization of tests.

I shared a rough written summary of these responses with HA on February 13, 2013 to assist their understanding of what the public might expect of them (see *Appendix V*).

My Success – Interviewees said I should ensure that HA:

- had done enough
- honestly told the story of the problems at BHB, especially regarding the former Chief of Staff
- made credible, realistic and operational recommendations.

Documentary Review – We looked at:

- Compensation Committee Minutes from June 2007 to September 2012
- a number of contracts and human resources documentation, including those relating to the Interim Chief Performance Officer, Former Chief of Staff and the former Chief Executive Officer
- Clinical Affiliation Agreements
- incorporation documents and one contract for HPL
- timeline of key events since 2007.

ASSESSMENT OF HA'S REPORT

Process of Review

HA agreed by email of February 15, 2013 that we would see their best draft before presenting to any other person, including the BHB itself. The purpose was for me to check-off that they were generally on the right track substantively and had adhered to their terms of reference and to the "success" parameters that we had given them. HA did not comply with this agreement and instead circulated the first draft to the Minister, Chairman of the Board, CEO and Chief of Staff at the same time that it was given to me. At the end of this report, one example makes it abundantly clear why the procedure that I had set out should have been followed. In any event, the BHB has promised to write a letter of apology to me for HA's deviation from the agreed plan.

The deviation is unfortunate as my substantive review below must now also reflect on HA's first draft, so widely circulated. It would be to the detriment of the credibility of our office if the audience of the first draft is not aware of my extreme concerns about it.

Agreed Report Deadlines

Twice on December 7, 2012 and again in our meeting of January 10, 2013, I questioned whether HA would be able to complete the CCG Review by their original deadline of mid-February. HA insisted that they were

on target to meet their deadline. Finally, I offered to contact the BHB to endorse an extension. HA agreed and indicated that they needed just a couple more weeks to complete their report. Accordingly, the BHB agreed and my media release of January 21 stated that I had recommended an extension to the end of February.

By email of March 1, 2013 I asked HA: *"please inform me by Tuesday March 5 of your target deadlines for submission of your* ***final*** *report"* (emphasis in original email).

That same day, HA proposed the following deadlines: *"Tuesday April 2nd. Final Okay by Ombudsman. Wednesday April 3rd. final Okay by BHB chairman. Anticipated release date of report to the public between April 8th or 9th."*

My response a few hours later was that: in order to meet HA's desire to release their report on April 8 or 9, I would need their final report by March 18 – *"no wiggle room"*. I explained the time constraints required by our statutory due process (ensuring that persons affected have an opportunity to respond to adverse comments) and printing schedules. In addition to narrative, I set out a grid of deadlines and respective tasks of HA and our office, clearly specifying that their final report was due to me for my review on March 18.

The next day, March 2, 2013, HA responded: *"yes, we are* (sic) *Howard Associates can adhere and meet this plan and timeline as shown in your table. In your text you mean of course March 18th for final report to ombudsman."* (My text incorrectly stated February instead of March.)

We did receive the report on March 18, 2013.

Substance of Report

Our process steps had to navigate a thin line. We cannot give input into a report and then turn around and purport to neutrally review it. Accordingly, we could not give HA substantive suggestions for how to improve the report. Instead we asked very specific questions (134 questions over 53 pages of the 1st draft) to:

- obtain information that the report did not readily reveal. I did not want to be in the position of not being able to respond to questions about whether HA uncovered or considered this or that point
- alert HA to deficits in the report in the hope that HA would address them.

As it turns out, the next and final draft for the purposes of my review deadlines was not significantly or substantially changed from the first. HA answered the questions by March 8, 2013 as required by the deadlines grid. Unfortunately, only half of the answers to my 134 questions were somewhat more illuminating than the original draft. (68 of the answers were responsive; 37 were not responsive; 29 were partially responsive.) Accordingly, many of my concerns remain alive in the 2nd draft. Many of the issues underlying even the 68 responsive questions were not changed or otherwise addressed in the 2nd draft.

Here are three examples of unresponsive answers:

- *Question 13:* "Is there literature to support this statement?"
  - *Answer:* "We made this statement based on our viewpoint, however, I think a review of the literature, in the future, will show this to be true. We may well be ahead of the literature at the moment."

- *Question 56:* "What are the existing committees that you reviewed and why are you recommending others?"
  - *Answer:* "We are ahead of the curve in this regard. This concept is just really starting to show its huge value – therefore there are not really best practices here only leading consultants and leading institutions doing this – soon we expect it to be best practices and eventually, it will be the norm in the industry – is our prediction."

- *Question 84:* "Did the doctors explain why there was resistance to morbidity and mortality rounds?"
  - *Answer:* "Yes they need a very savvy marketing person to get everyone to think outside the box. Traditional methods have failed to move the needle. We think other tactics are required at this point."

From the auspicious beginning of a superior interview and a thorough Embed Method (and seemingly successful implementation of this method), I cannot fully convey my consternation with the final report. By January 21, 2013 I had heard such good feedback about the Embed Method that I was prepared to state in a media release that the review was *"turning out to be a robust, comprehensive review"*, and that I was satisfied that HA are *"thorough, and getting a good grip on the issues"*. Unfortunately, the actual report negates this positive assessment.

Overall, in my considered opinion, the report does not fairly reflect the value of embedding and the wealth of information that HA must surely have gleaned. Sometimes it is not even always clear that HA is making a recommendation. By and large, I find the report to be relatively vague, recommendations unreasoned, and conclusions unfounded. Rather than go through the HA report paragraph by paragraph and issue by issue, I set out a very few illustrations of my concerns in this narrative. Additional examples of glaring gaps of substance are set out in Grid B (see *Appendix II*).

Grid A (see *Appendix II*) sets out issues addressed or sections of the report that are adequately or well done by HA. A couple of recommendations that are reasonably drawn out are included in this grid despite insufficient description of the problem being addressed or lack of best practices. The grid shows, to the best of our ability to discern, that HA has set out:

- the problems that the BHB is having or has had
- best practices supporting the recommendations
- the evidence supporting the statement of the problems
- HA's recommendations.

Grid B sets out those recommendations for which there are significant gaps – either too vague, unfounded generalizations or few specifics. HA does not adequately or clearly set out:

- the problems that the recommendations are intended to fix
- best practices supporting the recommendations
- the evidence or information relied upon to clarify the problems or support the recommendations
- HA's recommendations.

Neither grid is exhaustive. Between this narrative and Grid A, approximately 75% of the issues or sections that I evaluated as handled well are set out. Grid B and narrative in this report set out approximately 50% of the issues or sections that were not done well.

What Was Done Well

Generally the language is simple and easy to read. I will not comment on structure and style. Grid A shows that the section on the Board's role and committee structure was well done. (This section could have benefitted from thinking in the field of governance that goes beyond the traditional list of fiduciary duties. For example, see *Appendix VI*). The rationales for the new hospital facility and review of the Clinical Affiliation Agreements were helpful by describing the current problems and evidence to support HA's recommendations or conclusions.

The section on Long-Term Care was one of the most substantive in the report. Instead of summarizing in Grid A, I commend it here. Long-term care is a major challenge for Bermuda as our population ages. There is a debate about whether KEMH should be an acute care only hospital (serving only the very sick) or a community hospital (serving long-term care patients). There are arguments for and against keeping long-term care within the hospital. Arguments for include easy proximity to acute care services which can be required by long-term care patients. Arguments against include an aversion to the indignity that institutionalized long-term care can sometimes imply. While HA did not delve into this debate, they presented the problem with adequate data and comparisons with other jurisdictions. The reasons for HA's recommendations were clear. If HA's entire report had been written like this, it would be far more palatable.

Note: a separate recent study has been done on long-term care. HA should have set out what the study concludes or if it addressed the increase in recent years of overutilization of tests which is thought by many to be the driver of the high costs of long-term care.

What Was Not Done Well

- Corporate and clinical review of MAWI is absent altogether. BHB governance obviously include both KEMH and MAWI. The Board and the CEO are the Board and the CEO of both facilities. The Terms of Reference noted that there are two hospitals. MAWI is our only mental health institution in Bermuda. Our feedback on HA's outline in mid-January and our February 20, 2013 preliminary comments on the 1st draft pointed out that MAWI was missing and must be included. I raised this point again in the February 25 meeting. It appears that our concern was simply ignored

- There was no assessment of the progress of or barriers to implementation of recommendations in the many prior reports done in the past decade (we indicated in our very first meeting that prior reports should be reviewed)

- HA was or should have become aware (as I became in just 14 interviews) of allegations regarding hiring practices yet mentions none in the report. In particular, was there evidence of:
  - ∗ allegations of nepotism hiring or retaliatory firing by the former Chief of Staff? If so, what controls should be in place to guard against this
  - ∗ whether persons for whom work permit applications were made were hired, notwithstanding that their resumes were contrary to job descriptions given to the Department of Immigration in work permit applications? If so, what controls should be in place going forward?

Former Chief of Staff

HA knew at least from our very first meeting that one of the primary reasons for their review entails the tenures of and decisions made by the former CEO and Chief of Staff. There were questions about what key

decisions had been made, by whom and by what authority – especially decisions with financial implications for the BHB.

The former Chief of Staff, far more than the former CEO, became a lightening rod attracting criticism from the media, political quarters, the new patient advocacy group, staff and others. By all accounts these men worked closely with and supported each other. With respect to their work and decision-making, it is unclear what information was passed on to the whole Board and to relevant sub-committees (in particular the Compensation Committee) and which decisions were rubber-stamped or challenged.

Decisions in question included:

- the establishment of HPL and the proper vetting of proposals and contracts for projects with HPL. At least two projects that did not succeed may be litigated with possible financial costs to BHB. The governance around HPL is clearly quite important.
  - I stressed this at least ten times in the first three meetings with HA. On February 5, 2013 the Auditor General announced an investigation into the BHB, including HPL.
  - Accordingly, I was most alarmed when HA's 1st draft stated that *"HPL is both a problem area as well as an overblown area of curiosity and scrutiny"*. In the 2nd draft, HA removed the word "overblown", detailed some of the projects and concluded: *"From our initial observations, HPL has not been well managed by BHB since its inception"*. This restated finding is consistent with the information that we obtained in our due diligence interviews.

- contracts with medical staff – in particular bonus structure, criteria and payments. It is unclear who made decisions, on what basis, and how ratified.
  - HA reports that the former Chief of Staff *"was responsible for hiring and increasing the salaried physician complement at BHB to its current complement of 65 doctors...at very high compensation…* (with) *many of the contracts containing very unusual terms, heavily in favour of certain doctors. There were not enough management 'checks and balances' and controls on these contracts...and this represents a failure of governance at BHB."* This finding is consistent with the information that we obtained in our due diligence interviews.

In its 2nd draft, HA has acknowledged that such concerns informed the decision to suspend the former Chief of Staff – rather than solely the allegation that the former Chief of Staff single-handedly destroyed relationships with primary care physicians outside of the hospital (in our February 25, 2013 meeting, HA was adamant that this was the primary and indeed a sufficient reason to suspend the former Chief of Staff).

There are other reasons for the suspension of the Chief of Staff. HA has admitted to not having read the critical documents. We did and, as a consequence, have an understanding of some of the key reasons for the suspension. Some information, for example license issues, is already in the public arena. Other matters are subject to confidentiality provisions.

To be fair, several of our interviewees credited the former Chief of Staff with good crisis management and with enticing Bermudian doctors to work back home early in his tenure. After his first year or two, his authority and influence seem to have grown beyond the bounds of good governance with the cooperation of the former CEO and, it appears, the acquiescence of the then Board.

There are still unanswered questions which one would have expected a comprehensive CCG Review to unearth and disclose. The public has a right to know about the head doctor in our single hospital.

Generalizations / Recommendations Without Foundation

HA's report is full of statements, conclusions and recommendations without evidence, examples, best practices or rationales. I had hoped that my 134 Questions would have alerted HA to the kinds of information that could have been addressed in order to improve the final draft. However, this was not to be.

The challenge going forward is that in too many instances, HA's report leaves the BHB with recommendations but without the benefit of clarity about the problems that the recommendations are intended to fix. In some cases, it almost seems that the BHB would have to re-engage HA in order to follow through and implement the recommendations because only HA has the aggregate information needed to do so.

I will comment here on four examples of recommendations made without sufficient foundation or explanation. Other examples are set out in Grid B.

Recommendation to Disband the Governance Committee of the Board

This recommendation stands out because the CCG Review is a report ultimately about how to improve governance. Therefore it seems odd and somewhat counterintuitive that there is a recommendation to disband a committee that – in so many organizations and businesses – is designed and dedicated to improving governance.

The problem articulated by HA was "*we believe the old Governance Committee was doing too many things*". This is just too vague. It is truly difficult for me to assess the recommendation without better information about the problem, best practices and evidence in support of the recommendation.

A more effective analysis would: describe what the "things" are; explain why the Governance Committee had taken on too many; and canvass whether it was more appropriate for some of these "things" to be the responsibility of other committees. Then consideration might have been given to the idea of carving off some tasks to more appropriate committees thus leaving the Governance Committee intact to focus on governance. On the other hand, perhaps the recommendation to disband the Governance Committee is correct – there just is not enough information for me to judge.

Morbidity and Mortality Rounds

Morbidity and Mortality ("M&M") rounds are one of the most important tools for clinical governance. HA's single sentence recommendation that medical staff should hold regular M&M rounds *"for learning and making improvement"* does not explain to readers who are not hospital insiders what this is and why this is so critical. HA's treatment of this issue misses an opportunity to delve into why such an important practice – which is found in practically all hospitals in North America – is still not routine or robust in Bermuda. HA seems mollified that *"everyone agrees that this should be done"*. Well, everyone also all agreed back in 2006/7 when I made the same recommendation in *A Tale of Two Hospitals* (see *Appendix VII* which sets out the value of M&M as a sub-set of clinical incident reporting). I had hoped for HA to assess the barriers to implementation – why was this not yet done despite the agreement of all?

Downsizing

HA's treatment of the issue of downsizing is curious. "Downsizing" typically means job losses. Such an important strategy that could impact people throughout the BHB should be presented with more clarity, even within a dedicated sub-heading.

HA first hints at downsizing in an early comment regarding the proposed work by the Board Audit and Finance Committee to address the BHB's $60 million shortfall: *"At the end of the process of **resizing** the hospital, the Board and CEO will need to achieve a balanced organization, one that provides outstanding care and one where the staff are proud to work"* (emphasis added).

Another hint – HA states elsewhere in the report: *"There are too many physicians on salary – period – at the hospital...This problem can very easily be corrected as part of the clinical services review which we are proposing."*

This first clear indication in the report that job cuts are being considered or recommended is in a section titled "Financial Overview":

"The hospital is currently undergoing a major cost reduction and zero based budget exercise. We fully support this initiative. Some good ideas have been developed and savings have been identified. For example, the hospital has identified lowering its salary expense from 65% to 60% of total spending… we propose caution, however, with job cuts to front line staff. As we know, with the aging population, the Western world, including Bermuda, is rapidly heading into an unprecedented event. For the next 20 years, the need for services for the growing elderly population will be massive in requirement. In this regard, we are against making redundant any front line staff member who treats or counsels patients either through suggestion from this review or through the necessary cost cutting requirement. Through attrition, some jobs cuts may occur and some jobs in non-core areas may be transferred to community based programs and to growing requirements such as diabetes education and long-term care. Each and every person who has committed their careers to the healthcare service provision at front line staff level, must not only be retained but encouraged to grow their skills. The need for committed health care workers will be underestimated by most world countries."

Finally, in Step 1 of an *"action-oriented strategy"* for *(a)* a revised strategic plan and *(b)* funding method by the Ministry of Health and the insurers, HA proposes *"downsizing necessary for the hospital to meet its financial plan and coordinated service plan with the community"*. However, there is no clear statement of whether the BHB already has a plan to cut jobs.

There are no explorations or recommendations for other ways of cutting salary expense and finding workforce efficiencies before consideration of job cuts. For example, one would expect this section of the report to outline what percentage of the salary expense is from bonuses for medical and executive staff. One would also expect clarification about what is meant that there are "too many physicians on staff" and how would overall patient care be impacted if some of these positions are cut.

I am informed that apparently, HA believes that in the future it can assist the BHB to find savings – but there is no explanation for why such recommendations are not set out in the current report. Even in our brief interviews, people had a lot to suggest: tackling overutilization of tests and medical / executive bonuses,

electronic record-keeping and reducing top-heavy layers of senior jobs (one of our interviewees quipped: *"There's a chief directing a chief directing a director"*).

It appears that the BHB is on its own to explore such options. In the meantime, this report will raise alarm about potential, as yet undefined, job cuts. If downsizing is to happen – this is serious and deserves more than passing references in a Corporate and Clinical Review. If downsizing is to happen through attrition – then certain strategic thinking around aligning resources with projected needs is required. If downsizing means job cuts, then there will be an additional and complex set of strategies and negotiations around fairness, 21st century hospital management, the economics of job cuts during recessionary times, and, consultations with the unions.

In any event, HA would have to reconcile endorsement of job cuts with its recommendation to remunerate the Board. Bermuda is a highly volunteerist society. We give community service in the sure knowledge that 'what goes around comes around'. While the running of a hospital clearly takes more time and diligence than most volunteers might have to do (and likely warrants healthier meeting fees) there is no compelling argument that Board remuneration should be considered even after a turnaround in the financial crisis – especially if job cuts throughout the hospital are simultaneously on the table.

Recommendation About the Auditor General

During the course of our meetings November 2012 through January 2013, I asked HA at least seven times to be cognizant of the concerns of the Auditor General and to clarify directly with her that they were not stepping on her toes or otherwise compromising her work. However, HA held only one meeting with her. In fairness, they did seek another meeting in March but she was unable to meet. HA has provided no explanation for why they did not attempt a second meeting with her before March.

In my view, the most disturbing and unfounded recommendation in HA's report is that the sub-contractor audit firm should also sign the Auditor General's financial reports of the BHB in order to *"add a great deal more community confidence in the financial results"*. Under section 3 of the Audit Act 1990, it is the Auditor General's statutory duty – and hers alone – to sign off on the audits she conducts. Even when she sub-contracts whole or pieces of her audits, the private audit companies work under her absolute direction and control. The Auditor General has final review, approval and accountability.

HA's recommendation does not align with the reality of the Auditor General's contractual arrangements and represents a fundamental misunderstanding of her work. HA failed to learn from the Auditor General that she does not always use the same sub-contractor and therefore inappropriately named one. Indeed, there may well be serious legal consequences for HA's naming one of the agents of the Auditor General – even in a draft report.

The recommendation does not set out evidence of a problem that it is intended to fix. That is, there is no evidence of: community questioning or lack at any level of confidence in the Auditor General's financial statements and reports; or of a need for *"a great deal more community confidence"*.

Accordingly, I find HA's recommendation to be intemperate, ill-advised and even offensive. I quite forcefully, indeed stridently, said so in our February 25 meeting. In a Bermuda that privileges external expertise, recommendations that cast even a scintilla of doubt on our Auditor General should have been based on solid evidence of a problem.

In the meeting of February 25, 2013, I urged HA *"don't put this in your report"*. They agreed to set up a meeting with her and even said: *"it may be wise for us to check with the Auditor General and see if she is okay with this statement"*. The meeting did not happen. Lamentably, HA ignored my concerns. They did not change a word in the report's next draft.

Most egregious is the fact that HA made this recommendation – and even circulated it to the Board – without the courtesy of alerting the Auditor General and the due process of giving her an opportunity to comment. I am compelled to ask – how can any consultant purport to give advice on governance without themselves following one of the fundamental principles? That is, the Auditor General should have been afforded the due process of seeing, commenting, and rebutting the comments made by HA.

It is not a sufficient answer to say that these were drafts sent to a limited number of people only. People anchor in the information they read in a first draft and do not always distinguish what has been changed in a final. The doubt has already been aired and the damage done. It was precisely to prevent such a travesty that I requested to see HA's 1st draft before circulation to anyone else.

It is also not a sufficient answer that double-signatures by Auditors General and their sub-contractors are done elsewhere. HA responded to my concerns: *"At Foothills Hospital, for example, a provincial government owned facility, the hospital Auditor also conducted the audit and signed the statements, however the local accounting firm contracted also signs the statement as well. This can only add another layer of confidence for the public."*

Best practices are very important and useful guides – but guides only. I am a fervent proponent of best practices. Indeed my 134 Questions to HA (and the Grids attached to this report) point out that there is a dearth of best practices in the report. Best practices must always be deployed to solve problems that actually exist and in ways that are sensitive to local conditions. The humility that I had been so impressed by in HA's recruitment interview – that foreign practices cannot be imported without regard to local context – was wholly abrogated by this recommendation.

The notion that the signature of a sub-contractor would enhance the community credibility of our Auditor General's signature implies that her signature alone does not earn full and absolute community confidence. If HA has evidence of this, then this should have been set out fully. As HA patently has no such evidence, they should have refrained from impugning the professionalism of the Auditor General.

Clearly I am not persuaded by the disclaimer in the report: *"although this may seem to some as though we are showing a loss of confidence in the Auditor General, this is not true"*. My skepticism is informed by two other statements made by HA. I did not criticize those statements at the time, but now, aggregated with the recommendation, I am of the view that indeed there was an implicit questioning of the Auditor General:

- in response to our question 77 – with zero reasoning, evidence or understanding of the Auditor General's processes – HA asserted: *"We believe that the internal review by the Auditor General will cost over 750,000 dollars and will take nine months to complete."* This seems to come out of thin air. This projection is far off the mark in any event. The point is – HA did not conduct the due diligence and courtesy of checking their theory with the Auditor General

- with respect to a concern that the Auditor General had raised with the BHB, HA stated it is *"Important for me to learn why this is a 10 out of 10 problem for the Auditor. Our experience is that this type of issue is a 3 out of 10...but she has seen a lot in Bermuda so maybe that's why it's important to her"*.

- my response? It is important to her because she is not merely a chartered accountant, an Officer of the Bermuda Constitution, the expert in auditing public entities – she is in fact the Supreme Audit Institution of all government entities and quangos. I cannot fathom the hubris that puts her assessment of the gravity of any issue even in question. One possible explanation is HA's blatant push to usurp the work of the Auditor General (see page 22 of this report).

The implications of the above for the report as a whole is that – if HA is so blithely willing to dismiss strong advice and draw potentially damaging conclusions without the due diligence and due process of checking the facts, then how can I endorse the credibility of the rest of the report?

CONCLUSION

The interview was impressive. The methodology was excellent. The report is disappointing. The report suffers in lack of evidence, best practices, analytic rigour, reasoned recommendations and most critically, breezes over the key concerns that led to the report in the first place.

The notion that the BHB's primary and fundamental problem is community and public relations was not supported by evidence. Better PR will not overcome public distrust that the BHB is not forthcoming – unless accompanied by evidence that the BHB had turned a corner on *"past problems with transparency"*. Community meetings may be necessary but, in my view, are not sufficient to point the way forward for the BHB. In the past, despite report after report, the BHB may have changed at the edges but then often defaulted to how things have always been done – even with new people, roles and committee names.

There is a delicate balance that any report about any hospital must observe – between transparency about overall themes and confidentiality about specific circumstances. This is a particularly sensitive balance when reporting about the single hospital for a small captive population in the middle of the Atlantic Ocean. There are at least two approaches:

- take great caution not to disclose difficult or embarrassing information – such that the public continues to distrust the BHB and is cynical about whatever is disclosed
- thoroughly air all issues; shoulder public criticism and risk distrust even for years – until the BHB's consistent transparency convinces the public that it has become a learning organization.

Each approach is persuasive in part, neither are persuasive in whole. My critique of the HA report is based in part on my own view – not set in stone – but generally:

- err on the side of transparency if there are steps that have and can be taken to fix the problem
- err on the side of non-disclosure if this would imperil operations and especially if there are other mechanisms (such as investigation by the Auditor General) that are better suited to addressing the problems. Under no circumstances should non-disclosure be based solely on possible public embarrassment of *"he who pays the piper"*.

At the end of the day, a lot of people know a little about what is going on anyway. They often do not have the full or accurate story. But where there's smoke, most people believe that there's fire – even if the smoke is thick, dark and impenetrable. The sparks that do manage to fly off and pass from mouth to ear are enough to damage the credibility of the hospital. So, with a new CEO, new facility, new Board, what better time than now for a new approach – a time to err on the side of transparency?

There is much to say that is stellar about hospital services, especially in emergency care. Almost everyone who works at both KEMH and MAWI is dedicated and professional. We do not hear much about their daily successes. Better PR can help. However, the fundamental issues that led to this review are not about PR. Staff need to be supported by good governance – the policies, structures and measurements – that clarifies their responsibilities, regulates their work environment and inspires their service.

The hospital needs to proceed bravely to disclose what it must to win back the public trust and to pick out what it can from the HA's and prior reports in order to devise a plan to move forward. Until we do this, we will not fundamentally penetrate the all too common impulse of those people who can afford it to vote with their wings – to catch a plane when they need to be in the hospital. Those people who cannot afford to go away cannot be left to languish in the fear that they will not get the very best care possible.

POST SCRIPT

Further Tasks – HA noted:

- *"Our final report on our financial audit for BHB still requires one month to complete properly given the complexity of the hospital and its affairs"*. Financial audit of the BHB is the responsibility of the Auditor General and was not in the Terms of Reference for HA. Bermuda should not be paying HA to conduct a financial audit

- *"We are half way through our audit of HPL Limited and we recommend that we complete this audit which will take another 1 month to complete. From our initial observations, HPL has not been well managed by BHB since inception."* On February 5, 2013, the Auditor General announced an investigation of HPL. As this is fully within her expertise, there is no need for the BHB to fund HA to duplicate her work. Accordingly, HA should be required to turn over its evidence, notes and any other information about HPL to the Auditor General.

Due Process – Final Step for Ombudsman's Review
From our very first meeting on November 5, 2012 I informed HA of the statutory process that I must abide by in accordance with s.17 of the Ombudsman Act 2004. That is:

- after reviewing HA's final report, I write my report
- I then show HA and the BHB any adverse comments that I make about them. (In this case, I did not bother to extract the adverse comments. Instead, I allowed them to see my entire report to clarify the contexts in which I had made adverse comments.)
- HA and the BHB are then entitled to a hearing – an opportunity to be heard, comment on or object to my adverse comments – and may be represented by a lawyer. This is called the "Due Process (or "natural justice") Hearing" (scheduled for April 1, 2013)
- In addition, I offered them an opportunity to give me their concerns in writing prior to the Due Process Hearing
- After considering their concerns, I may decide to amend my report or otherwise acknowledge their concerns.

As HA's deadline to complete their work was extended to the end of February, I began an email exchange on March 1, 2013:

- I asked HA when they would complete their report and related timelines
- HA responded the same day that they wanted their report to be made public on April 8 or 9
- I responded a few hours later with a memo and a Deadlines / Task Grid
- The memo clarified:
  - that if their report is made public by April 9, then my report must be tabled in the House of Assembly on April 12 – the first Friday after their report becomes public
  - Prior to that, I must meet certain deadlines for printing, proof-reading and submission of my report to the Speaker of the House of Assembly
  - Therefore, I would need a minimum of 10 business days after the Due Process Hearing in order to submit my report to the Speaker.

- The Deadlines / Task Grid set out respective actions and deadlines for both HA and me to adhere to in order to accommodate HA's April 9 deadline, in particular:
  - ∗ March 18 – HA submits their final report to me (see Agreed Report Deadlines above pp. 8 & 9)
  - ∗ March 25 – Ombudsman gives adverse comments to HA and the BHB (I gave my Report on March 25 and added an Appendix on March 27. While this Appendix set out concerns in grid format, there was nothing new substantively as I had already detailed the concerns in the grids in my memo of February 20 and in an extensive meeting of February 25.)
  - ∗ April 1 – due process hearing.

- HA agreed to these deadlines on March 2, 2013

On Sunday March 31:

- As I had not received written due process concerns from HA, I emailed to confirm that they would be attending the Due Process Hearing on April 1.
- HA did not respond in a forthright way
- By several emails, both the BHB and I tried to confirm their intentions
- Further, both the BHB and I clarified and warned that by not attending the Due Process Hearing, HA was essentially waiving the opportunity to object to my report
- Eventually, HA requested a two week delay so that they could redraft their report to address the criticisms of their work in my report.

As had been explained to them several times throughout February and March, I cannot "contribute to", "give input" or otherwise have a hand in their report. If I did so, I would be compromising my review – because essentially, I would be evaluating my very own suggestions!

Therefore it is not appropriate for HA to scramble to re-write their report in response to mine. In any event, this would delay the process even longer as I would then have to evaluate their revised report, re-write mine, then have yet another Due Process Hearing. This could go on and on in a never-ending loop as long as I continued to have adverse comments.

HA had ample opportunity since February 20 and 25 to know what my concerns were and should have addressed them before submitting their final report to me on March 18. Further, HA had ample time to request an extension and should have asked well before the last minute.

The BHB attended the Due Process Hearing. HA did not. Accordingly, having been duly warned, HA has waived their statutory opportunity to rebut, object to or otherwise comment on my report.

HA'S FOCUS ON THE NEXT 'GIG'

In our very first meeting on November 5, 2013, I strongly counselled HA to beware of the impulse to focus on the "next gig" or the urge to market their future services. Such a focus would fully compromise their process and report. Indeed – this would verge on the unethical.

Therefore, their first draft of February 18, 2013 with four obvious marketing hints for future contracts raised serious red flags. I stated in my memo of February 20, 2013:

> "Most troubling is the comment on p.35 / 4th paragraph: *"With the information that we have collected... we could assist the excellent teams at BHB"*. By itself, this comment will be the death knell of this report. I was crystal clear in our first meeting that Bermuda is used to consultants who are always looking for "the next gig". In fact, I indicated that I was once in the consultant world and understand this business impulse – however that would not be acceptable in this case. So, it frankly astounds me that you have made this statement or even have the thought in mind."

The final March 18, 2013 report that was submitted to me by HA for the purposes of my review did not include such blatant marketing efforts. However, I have learned that HA did not copy the March 18, 2013 report to the BHB. Instead, HA gave a different report to the BHB on March 22, 2013. Tellingly, HA did not copy this report to me.

There are minor substantive differences between the two reports with respect to HA's analysis of the BHB. The five non-marketing additional sentences or paragraphs sprinkled throughout the report neither change my evaluation of it nor make significant improvements overall.

However, given the prior cautions that I had made to HA, it is now clear why they did not copy the March 22, 2013 report to me. There are at least seven marketing statements missing from the March 18, 2013 report – both subtle and blatant:

> p.19 – re HA's recommendation for a coordinated services plan to be completed within three months: *"We believe this is critical to the success for Bermuda's healthcare system and we do not believe that Bermuda has the manpower available who have the time and skillset to accomplish this important task within a reasonable time frame."*
>
> p.38 – re planning for new facility and need for more external consultation: *"We do not believe that the island has the current people with the time and the talent to deal with this problem in the rushed time frame required."*
>
> p.38 – re recommendation for a top priority within the next three months to revise modalities for quality care: *"we believe this can be accomplished much faster and with much higher outcome if the BHB works with outside experts who understand quality and health care."*
>
> p.48 – re recommendation to redesign the funding model for hospital health care: *"We do not believe that the time and specialized skills are available within the island to accomplish this critical task of developing a new funding model for Bermuda and yet this is one of the island's top and urgent priorities."*

p.55 – re Medical Tourism: *"We recommend exploring this opportunity in more detail and we do not believe that the talent and time is available on island to do this properly."*

p.57: *"The hospital needs to undergo an external operational review to maximize efficiency and effectiveness of its resources once its plan has been determined."*

A particularly undisguised ploy in the March 22, 2013 report to create a further contract for HA proves my earlier scepticism (see page 16) that HA intended to cast aspersions on the work of the Auditor General. The March 18, 2013 version that I received stated:

"These audits have made numerous valuable recommendations, and none have found as of yet any areas of fraud so far.

Despite this, the Auditor General's office has requested a more detailed internal audit of operations at BHB as well as for HPL. HPL is a complex entity that we will address later in the report. We support this audit being done, and feel it should be part of normal practice to conduct a more extensive review every ten years. It adds an additional bar of trust for the public to know that accounts are reviewed and scrutinized by several parties and that a very thorough review is undertaken every ten years."

(Notwithstanding that the annual audits thoroughly scrutinize the BHB; I did not criticize these statements.) However, the March 22, 2013 version given to BHB casts a very different light on those seemingly innocuous statements. This version adds the following:

p.46 – *"We caution, however, we believe this type of extensive audit unless narrowed significantly, will take up to one year to accomplish and will cost over one million dollars. A smarter and much faster strategy might be after receiving word of the inevitable narrowing of the scope of the Auditor General's review would be to add another month to our review at our end – resulting in the same overall objective and much cheaper and faster. "*

This is the proverbial nail in the coffin. What I had suspected were snide attempts to denigrate the work of the Auditor General appear to have been in service of a further – potentially lucrative – contract for HA (none of whom working on this job are even accredited public sector auditors).

In an email of March 11, 2013, HA commended me: *"Both Phil and I think you are doing superb oversight"*. Sadly, this means that I have had to point out the many flaws in their report. Poor structure, unfounded recommendations and lack of analytical rigour amount to a wasteful and expensive lesson for us. Their deliberate and repetitive devaluing of Bermudian skills and insight – all for the blinding glint of gold – takes cynicism to another level and is wholly unacceptable.

Bermuda needs the BHB to succeed. We need to develop solutions that both tap our vast insight into our own problems and still harvest the best from the rest of the world. Most important, we need all of the people in this critical endeavour to be focused on **our** common good.

APPENDIX I

BERMUDA HOSPITALS BOARD TERMS OF REFERENCE

(Key Extracts)

The Bermuda Hospitals Board regularly receives reports on a range of Governance issues to provide assurance on the effective delivery of services in line with key strategies. Over recent years there have been a number of significant changes for the BHB and Bermuda, which provide an opportune time to consider the continued fitness of purpose in light of:

- Concerns highlighted by the Auditor General on the need for robust corporate Governance standards in public service
- Growth in the number of employed physicians within the BHB, providing significant opportunities, but also obligations and liabilities
- Incorporation of Healthcare Partners Limited ("HPL") a wholly owned subsidiary of the BHB, to develop new services and revenue opportunities through joint venture projects ("JVPs")
- Concerns expressed by stakeholders, including patient representatives and key donors, on the quality of care they or their relatives have received
- Preparations for the operational readiness of the new hospital facility on the King Edward VII Memorial site planned for opening April 2014
- Agreement of a National Health Plan for Bermuda, with the BHB taking lead responsibility for the development of Island-wide Electronic Health Records (EHR) and enabling medical tourism
- Financial challenges in funding services developments and planned commitments as the BHB gets closer to 2014
- Transition to a new Chief Executive and a new corporate Management structure in 2012

The anticipation is that the future is likely to become more turbulent for the BHB, with growing service demands and expectations for delivering more care at reduced costs. If the organization is to remain financially viable, the BHB must develop new revenue opportunities whilst managing costs and meeting rising patient expectations over the quality of care.

APPENDIX II

GRID A
WHAT WAS DONE WELL?

GRID B
WHAT WAS NOT DONE WELL?

ASSESSMENT OF HOWARD ASSOCIATES REPORT: WHAT WAS DONE WELL?

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
10	Bermuda's hospital is out of date physically for multiple reasons.	–	For example: *"The rooms are far too small to handle modern equipment"* • *"Bathrooms are too small"* • *"There is a lack of space for infection control"* • *"The flooring is poor"* • *"The electrical wiring in places is against modern code and could represent a fire hazard in some parts."*	*"...we believe a new design is a good idea."*	***Answers questions about why new facility has been undertaken in current economic climate***
14	Lack of continuity amongst directors due to policy of re/appointing directors annually and having new Chairs who are new to the Board. .	–	*"we found* (frequent changes in Board members) *to be a regular pattern for the BHB and one that we believe can lead to problems."*	Revise policy for re/appointing directors: A director's term should be three years, and no more than three directors should be replaced in any given year.	***Reasonable, although could have given examples of problems resulting from small Board numbers***
14	Need to strengthen community relationship, improve quality of information getting to the Board Committees and need to assess potential Board members.	–	Ensure necessary knowledge is available to the committee; Orient and assess potential future Directors to the Board; and Strengthen the hospital's relationship with the community.	Appoint non-Board members to Board Committees. A member of the Bermuda Health Advocacy Group should join the (proposed new) Community Relations Committee.	***Could have addressed how satisfied patients and families could be identified and represented?***
15 **16**	–	–	Need to widen the net of those to whom the Board holds itself to account, to entire community and *"not unique groups or special interest groups."*	Lists Board responsibilities; prescribes community relations role and need for Board to be *"knowledgeable of and take into account the interest of the entire community to which the hospital is accountable."*	***Reasonable – consistent with normal Board practice***

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
17	Past Board deficient in *"clinical, medical and healthcare expertise...This is a major area to correct"*	–	There are *"serious problems the hospital is experiencing with the community physicians."*	Two to three physicians should join the Board, with at least *"two physicians being from the community, preferably one specialist and one primary care physician."* *"...one member of the Board having a nursing background."*	***Problem stated elsewhere in CCG Report: hospitalist system introduced without adequate consultation with primary care physicians***
17	No more than half the Board has a background that is mainly in hospital or healthcare areas	–	Directors with business background *"would have been much more effective if* (their) *expertise was supplemented with physician and clinical leadership at the table. Similarly, strong clinical leadership requires the presence of capable business and community talent to complement them."*	Balanced Board in terms of experience and expertise.	***Good recommendation: medical and business expertise should be about equal***
17	In the past management presented to the Board requests for action *"without proper background information or time for the Board to prepare."*	–	Present issues and material for the Board long before discussions are required, this enables Board to make comments, ask questions and make informed decisions.	No recommendation as V. Symonds is already implementing improvements.	***Specifics of problem and resolution through current practice with new CEO are set out clearly***

ASSESSMENT OF HOWARD ASSOCIATES REPORT: WHAT WAS DONE WELL?

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
18	*"All stakeholders told us the BHB's Board has had serious problems in the past with transparency."*	–	–	Board *"must commit to improved, transparent processes and decisions and demonstrate how they are going to be more accountable to the public."* Board and chief of staff to hold quarterly news conferences for the public and press to address questions/concerns raised about BHB. Board should have at least one annual meeting open to the public. *"Board must disclose information important to the community within the limits of the law and on a timely basis."* This (CGG) review should be released to the public *"within three weeks of the presentation to the Board."*	***Best practices would have been useful to judge whether quarterly press conferences are advisable and effective; would have been helpful to know comparative practices regarding effectiveness of emerging community outreach practices using social media***
20	No office in BHB for Board Chair	–	*"The Board Chairman is the key link between the Board and Minister and one of several key links between the community and the Board."*	*"...the Board chairman should have an office at the hospital."*	***Best practices would have been helpful***
26	Need for Board Training	–	*"There are also courses for the Board members available in Canada and the United States."*	*"...the CEO and Board of Directors need to advance themselves at all times through personal development. "*	***Why personal rather than (soft) professional development courses?***

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
31	*"The hospital is not providing adequate staff recognition and staff rewards."*	*"Having said that, the morale is above average by comparison to other institutions that we visit."*	*"Morale in hospital is lower then it ought to be."* *"The stress on staff at hospitals is very high."* *"As one of the largest employers on the island, and in the health care business, the hospital should show leadership in providing this type of facility (gymnasium) for staff."*	• Continue town hall sessions with CEO and staff; • *"More staff education and skills advancing and earning opportunities must be developed."*; • *"More front line staff participation into decisions must be implemented."*; • Patients and staff should have more parking available on site.; • *"Food services should be improved for both patients and staff."*; • *"A gymnasium of 5,000 sq. feet should be planned and completed in the next 5 years."*; • *"The policy on free coffee twice a day should be reinstated for staff."*; and • *"The Christmas party of old should be returned."*	***Good specific recommendations; references to data on staff morale elsewhere in CCG report but vague here – hard to know exactly what "very high" and "above average" actually means***
35	There are many problems in the medical and surgical part of the hospital.	–	An over reliance on junior house officers for patient care High degree of variability of medical staff compensation... Some medical specialties are over compensated at BHB relative to industry norms and averages and a few are under compensated. There are too many physicians on salary – period – at the hospital. There is a striking lack of peer review for physicians at the hospital or in the Bermuda medical community generally	Reducing the number of junior house officers and supplementing/replacing them with more experienced community physicians Review physicians compensation, noting V. Symonds commissioned a review of BHB compensation Suggests BHB evaluate certain key areas to cut down the number of physicians Surgeons and other specialists should undergo peer review at least every year.	***"many problems" too vague. Point of the CCG Review was precisely to be transparent and specific about the problems – but sufficient specifics in the Evidence and Recommendation columns to warrant inclusion here.*** ***See Appendix 5***

ASSESSMENT OF HOWARD ASSOCIATES REPORT: WHAT WAS NOT DONE WELL?

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
13	Board did not always have a full number of directors, due to resignations and relocations.	–	–	Board should always have an adequate number of Directors in place.	***Vague***
13	*"We believe the Board is too small in number."*	–	*"Having a few more directors will help to provide Board with broader skills, will increase the depth on the Board, and will make the large workload easier to accomplish."*	Board should be composed of 12-13 directors in addition to the 3 *ex-officio* members.	***No explanation or best practices for numbers recommended***
14	*"Simply put, the Board governs and Management manages… where blurring of roles is too much and too frequent, there are always problems."*	–	–	Board Directors must understand their roles and duties while differentiating them from management and medical staff. Board must *"set goal of no deviation."* Board must be transparent about roles/responsibilities and manner in which they assure quality care.	***Examples should have been given to clarify how roles were blurred***
15	–	–	–	In addition to profit/loss reporting, "hospitals must include additional metrics to determine the status and performance of the institution" e.g. patient outcomes, quality and safety measures.	***Problem, best practices and metrics not specified***

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
20	–	–	–	*"The Board should have an in-camera session at the end of each meeting."* *"The first part being with the CEO to discuss any issues the Board may have with the manner in which the agenda was handled..."* *"...without the CEO to discuss how they functioned as a group"*	***Common Board practice: but CCG report should explain for readers who are not familiar with Board self-assessment***
20	–	–	*"As much as hospitals can be considered non-profit, charitable institutions, they no longer function in this manner."*	*"...the time may have come to make the Board Positions 'paid' positions."* *"The Board Chairman...would receive the highest compensation and the Chairman of Committees, the second highest compensation."*	***Why? How much? How determined? More thinking required about ramifications for all other Boards in Bermuda. Consistent with our volunteerism culture?***
21	–	–	–	*"...each* (Committee) *Director must bring a set of skills and competencies to ensure the business of each Committee, and thus the Board, is successfully conducted."*	***Specifics about what skills and competencies?***
21	–	–	–	*"...the Board should appoint the necessary additional members, non-Board members, to complement these Committees and to increase the skill sets required at a Board Committee level."*	–

ASSESSMENT OF HOWARD ASSOCIATES REPORT: WHAT WAS NOT DONE WELL?

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
21 **22**	–	*"Leading international hospital Boards spend as much or more time on their 'principal products' – patient/client care and community and stakeholder relations – as they do financial concerns."*	–	*"At each meeting, the Board should devote significant time and focus to these three Committees'* (GPS, CRSC, AFC) *reports and recommendations."*	***What were prior problems in this regard?***
23	*"We believe the old Governance Committee was doing too many things..."* (See note in Ombudsman Report)	–	–	*"It is our recommendation that the roles of the previous Governance be transferred to the other key hospital committees and that the Governance committee be disband."*	***Unpersuasive – see note in Ombusman's Report***
27	*"Over the past 8 years, the Board sometimes entered into operational issues and a few years later, certain senior staff decided to usurp some of the Board's responsibility."*	–	*"From our interviews, it is clear to us that there has been some confusion at the BHB in this regard."*	*"The Board of the Bermuda Hospitals, in consultation with Management, must from time to time review these lines and either affirm that they are appropriate or make modifications."*	***Repetitive of page 14 – similarly no specifics*** *(There are other instances that I have not highlighted where CCG report rambles)*
28	*"Better rationalization of services will be much more easily obtained if key relationships have been well formulated."*	–	–	*"It is recommended that the CEO join with the Board and senior administrative and medical staff to provide leadership for health care, hospital care and care of seniors in Bermuda."*	***No explanation of what is meant by "rationalization" or "join"***
30	*"Quality needs to be improved at the BHB."*	–	–	*"As a key leader, the CEO must spearhead significant cultural change within the organization."*	***No specifics of what is meant by "quality" to be improved; there is a good section on culture***

PG	PROBLEM	BEST PRACTICE	EVIDENCE SUPPORTING	RECOMMENDATION	*OMBUDSMAN COMMENT*
34	–	–	–	*"We recommend that the physicians plug medical input into existing hospital multidisciplinary committees where possible."*	***What is done now? Best practices?***
37	*"We also believe that patient and staff complaints are not properly addressed by the current BHB system."*	–	–	*"We recommend that the Community Stakeholder Relations Committee of the Board make this as one of the top priorities to address."*	***Detail existing problems with examples.*** ***(Redundant: entire community is stakeholder)***
48	HPL has not been managed well by BHB from its inception.	–	–	HPL's concierge service can become profitable. BHB should continue HPL's physician billing service.	***Vague: HPL review launched by Auditor General – HA must turn over information to the Auditor General***
56	$60 million shortfall	–	–	Steps: Clinical services coordination plan; Medical manpower plan; Revised financial strategy plan; Medical record automation; Medical tourism review. Revised funding method to be used by the Ministry of Health and the insurers.	***Foundations/rationales for these steps? Best practices?*** ***Unclear exactly what recommendation is – appears to be a radical departure from how Ministry and insurers currently fund hospital. If so, recommendation should be clear, well-reasoned, thoroughly double-checked/vetted by Ministry, insurers and Health Council.***

APPENDIX III

MEDIA RELEASE: OMBUDSMAN TERMS OF ENGAGEMENT

November 5, 2012

November 5, 2012

To: All Media

Ombudsman involvement in BHB Review

Hamilton, BERMUDA: Arlene Brock, Ombudsman for Bermuda, commends the Bermuda Hospitals Board for initiating a full review of its Clinical and Corporate Governance: *"This comprehensive review is timely given the BHB's transition to a new CEO and new facility"*.

Ms. Brock states: *"It is to the BHB's credit that they have asked me to be involved as well – in the public interest. I will be updated on a weekly basis, will give input and will comment publicly on the reviewer's report. I have agreed to this involvement under the following terms:*

- *my involvement is in accordance with the authority under the Ombudsman Act to conduct own motion inquiries and regulate proceedings as I see fit (sections 5(2)(b) and 12(5))*
- *none of the powers conferred by the Ombudsman Act may be fettered in any way, including the power to question any person and to request copies of documentation*
- *I may identify issues to be referred to more appropriate authorities for further review*
- *periodically and upon my request, the reviewers will update me on their progress*
- *my report on the process and final report will not be subject to BHB timelines or preview."*

The BHB has just completed a rigorous search and selection of the reviewer. Ms. Brock notes: *"I was involved in the vetting and selection process of the short-listed candidates. I can confirm that this was a thorough process and that, to date, I have confidence in the competence and objectivity of the successful candidate, Howard Associates"*.

Anyone who wishes to provide information directly to the Ombudsman for forwarding to the reviewers may do so at: complaint@ombudsman.bm; tel: 441-296-6541; or 14 Dundonald St., Hamilton HM 09.

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Notes to Editor

- The Ombudsman is an independent, non-government official who makes inquiries and investigates complaints from the public about maladministration in the delivery of public services.

- Although requested by the Bermuda Hospitals Board to review their Clinical and Corporate Governance Review, the Ombudsman's decision to do so is based on her authority under s.5(2)(b) of the Ombudsman Act 2004: *"on her own motion, notwithstanding that no complaint has been made to her, where she is satisfied that there are reasonable grounds to carry out an investigation in the public interest."*

- For more information, contact Arlene Brock, Ombudsman for Bermuda, tel: 441-296-6541.

OMBUDSMAN FOR BERMUDA
Suite 102 • 14 Dundonald Street West • Hamilton HM 09 • Bermuda
TEL 441-296-6541 • FAX 441-296-7734 • www.ombudsman.bm • complaint@ombudsman.bm

APPENDIX IV

BRIEF SYNOPSIS OF MEETINGS

Between the Ombudsman and Howard Associates

(From November 5, 2012 through February 4, 2013
Note: February 25, 2013 meeting is referred to in this report)

1. November 5, 2012

Ombudsman:

a. provided a written list of 33 possible issues to be reviewed, including the Bermuda Hospitals Board ("BHB"): composition, criteria and meetings; hiring practices and morale of Hospitalists and Medical Officers; costs and waste • noted that public suspicions about Healthcare Partners Ltd. ("HPL") and Dr. Thomas were the two key concerns precipitating the review;
b. suggested a documentary review to determine what previous recommendations were not implemented and why;
c. explained her process and warned that she: may ask them to double and triple check data; would need to know who they were dealing with and what the substance of the relationship was; and, what governance issues they were reviewing as she may need to add comments;
d. explained the reason for her review was mainly due to a lack of public trust • the public's perception is that if the BHB is paying for the review it would not be credible;
e. gave copies of the five complaints received to date and explained that our office was informing complainants that their matters would be sent to the reviewers for review and if the complaints were not dealt with during the review we would then investigate.

2. November 19, 2012

Ombudsman:

described the additional complaints received since the November 5 meeting (email summarizing three complaints was sent to Howard Associates ("HA") on November 20).

HA explained:

a. that they were getting a sense of what is good and bad and that they will attend the quality control meetings • they had not spoken to all Board members however they had identified areas that could be improved • the examples would be included in the report;
b. the one issue he would expand upon was the difference between King Edward VII Memorial Hospital ("KEMH") and teaching hospitals • people sometimes come back after receiving treatment abroad and give glowing reports about the quality of service and facilities at those teaching hospitals and compare them (unfavourably) to KEMH.

3. December 7, 2012

Ombudsman:

a. suggested that HA speak with the former CEO and the Auditor General to ascertain whether she has any outstanding concerns;
b. asked about the progress of HPL • HA replied that they had not begun investigating HPL at this time
c. explained that if HA did not focus on this matter then the review was useless;
d. asked their leanings about the clinical governance • HA explained that the common scenario was that GP's have to go to hospital to see 3-4 patients at a time, which was not an efficient use of their time • using hospitalists was a more modern model but the decision was made abruptly • a major part of the problem was the way the scheme was communicated to the GPs.

HA explained:

a. met a wide range of people and received good cooperation;

b. forty-three percent of money goes to KEMH • this is acceptable because KEMH gives senior citizens nursing care;
c. they were well along in their review of the former Chief of Staff • it is a priority and will take the major portion of the three months.

4. December 12, 2012

Ombudsman:

a questioned the hiring practices used by Human Resources • for example, the Chief Performance Officer did not have the required academic qualifications as advertised;
b. requested HA to submit a note of how well he did;
c. requested HA to submit a summary of the scope of their investigation to include what should be a parking lot issue and, if they had the money and time what would they investigate • this would assist in understanding need of additional funds and time;
d. asked how they intended on dealing with the individual complaints,

HA:

a. stated that they needed to look at how the decision was made regarding the remuneration package for the anaesthetists and make sure it does not happen again (does final draft do this?);
b. stated that current CEO was on the "right track" • when asked for examples to support the claim he replied that it will be in the report;
c. explained they were looking at some of the joint ventures the former Chief of Staff may have been party to;
d. explained that for at least one overseas hospital it goes out of its way to build relationships with patients and their families but there are mixed messages about its quality of care;
e. stated that they would provide an analysis in their report of why costs have increased when the level of service / care has not changed.

5. December 20, 2012

Ombudsman:

a. gave outline of her report;
b. questioned the status of HPL and who the final decision makers were. For example, was it Dr Thomas and / or Mr. Hill;
c. strongly encouraged HA to look at the specific issues the Auditor may want them to investigate ;
d. reminded HA of the issues she would look at, for example, HPL, former Chief of Staff, anaesthetists and finder's fees for referrals to certain hospitals.

HA:

a. stated that they were asked to make some recommendations and felt comfortable doing so:
    i. include clinical affiliations in December board agenda;
    ii. Chief Executive Officer and Chief of Staff should go to medical staff party;
b. replied that they were "three-quarters of the way there" regarding the hiring process of the Chief Performance Officer.

6. January 10, 2013

Ombudsman:

a. requested the names of the principals of HPL;

b. requested a list of the areas of investigation and an outline by tomorrow;

c. asked how HA was doing about the medevac issue • the response given was that they were 80% done • the final 35% is making an assessment on whether Bermuda needs this service;

d. explained that part of her due diligence process was talking to key people about what success of the report would look like;

e. expressed her concern that HA created a briefing for the new board • she explained that it is the executive's responsibility and should not be included with review;

f. requested HA's evidence for how cap and collar payments are successful.

HA:

a. responded that 75% of each area of the report is finished

b. explained that KEMH was way behind in its electronic capability therefore you cannot have confidence in governance if access to the proper information is not there. KEMH could do so much more if hospital had electronic capabilities • this would be one of HA's top 10 recommendations;

c. stated that not all of the former Chief of Staff's background checks came through clean • there was more than enough information to justify his removal • they were 100% convinced that the decision to suspend him was good • the Ombudsman questioned what evidence supported HA's conviction;

d. explained that they were making individual assessments • when asked who requested this HA explained that it was the Chief Executive Officer, former sub-committee chair and a couple of board members • they noted that if anything was said it would be separate from the public document.

7. February 4, 2013

Ombudsman:

a. asked whether HA spoke to the Minister about the composition of the Board and was informed that HA recommended more doctors, a young person and someone from the patient advocacy group;

b. asked whether they had a view on political persons being appointed to the BHB and whether they could intimidate the non-political members • the response was that they did not think that was out of line...Bermuda is small, there are two main parties therefore political appointees would be possible;

c. explained that she wanted to see HA's report at least six days before he showed it to the key people because she would then be able to give comments beforehand;

d. requested a list of the "interesting things" HA found about HP • in reply HA stated "it is an odd thing that is going on and would prefer to do a little more research before speaking on it."

APPENDIX V

SUCCESS PARAMETERS

From Persons Interviewed by the Ombudsman

(Shared with Howard Associates
February 13, 2013)

Howard Associates Report should address the following:

1. Bermuda Hospitals Board Governance

Training

- Terms of Reference ("TOR") capture what Howard Associates should focus on.
- What is the extent to which the Bermuda Hospitals Board ("BHB") can genuinely exercise the oversight of running a hospital?
- The BHB knows little about running a hospital. Does the BHB need training / orientation from stakeholders?
- Does the BHB have an understanding of what questions to ask? Does the BHB need to be trained to ask the right questions.
- Since 2006 the BHB has not been thinking from the lens of Bermuda's entire health system. They are thinking only about the financial health of King Edward VII Memorial Hospital ("KEMH").
- Governance should not be interpreted in a limited way.
- The BHB needs to be very aware of what happens It must act with due diligence to address health care costs and IT systems.
- The BHB needs help to better align resources and justify its capabilities.

Roles / Responsibilities

- Previously the Board was too involved in operational matters – should be policy only (this is a common disconnect around the world between hospital boards and executives).
- Relationship between the Senior Executives and the BHB is one where the BHB gets the information it needs to make decisions. Board should not be 'managed' by the Executive
- Guidelines were previously put into place for board governance. For example the Balanced Scorecard, which covered the BHB's responsibilities, including the role of *ex-officios* was introduced by a former CEO. Were these standards implemented, maintained or eroded? If implemented how effective were they?
- There is always concern about politics (Ministerial interference) being so close to operations. The BHB should be independent.
- There should be clarity on what the BHB cannot do.

Implementation

- The Chief Medical Officer and Chief of Staff are already on the BHB. Is there a need for additional physician insight in addition to the Chief of Staff?
- What are international best practices for sub-committees? Are the sub-committees adhering to their remit? For example, number of meetings, being accountable either through reports or other means of follow-up.
- What is the relationship between corporate and clinical governance?
- Is there a succession plan?

2. Performance Indicators

- What outcomes should the BHB be looking at to ensure what is needed for success. For example, what are performance targets / metrics? Are they appropriate for a hospital of our size and location e.g. readmission rates / mortality rates.
- What is the picture of the desired outcome?
- The BHB should be tracking key performance indicators. Is there a tracking mechanism? Is the Hospital meeting international benchmarks?

- Is there a concerted effort to tell the Board what is being done?
- Complaints about the Hospital are the same as before but the prior BHB was able to answer. Concerns from patients ought to be addressed.
- The Hospital needs to communicate better, perhaps create a digest to tell their story.
- The care is infinitely superior to 2005 but very costly.
- The Hospital has come a long way in terms of quality. There are real clinical improvements in terms of mortality (most useful metric for health insurance).

3. Role of KEMH / Relationship with Community

Acute vs Community Hospital

- A clear decision must be made regarding KEMH as an acute care facility or a community hospital. If the former, then where will we facilitate long-term care? If the latter, then some services can be triaged for less expensive delivery of services.
- There are different views of whether the Hospital should offer long-term or residential care.
- Long-term care should be a lower-cost setting, on a brownfield site away from the Hospital.
- Residential care should not be institutional.
- The Hospital has expanded beyond acute care therefore more revenue is generated but the Hospital is a higher cost centre.
- The National Health Plan is shifting to primary care. What is the BHB's role?
- Makes sense to have residential nursing care but must carve out lower cost wards and separate subsidiary for nursing care. Should be a part of the Hospital's plan.

GP / Hospitalists / Community

- The way Hospitalists were introduced was bad. Were GPs pushed out?
- Hospitalists are treated badly. Seems there was discrimination based on lack of seniority.
- Repair relationships between community and the Hospital.
- Recommend how to communicate accurately with all stakeholders.
- The report should drive KEMH in the direction of being guardians of the community's health.

National Impact

- Is there a systemic risk in the health care system? What KEMH does has ripple effects throughout the country with unintended consequences.
- Reform – efficiency and quality of care starts from the Hospital.
- The BHB needs to be proactively engaged as the leader of Bermuda's health care system rather than being defensive.
- The Hospital has the know-how and facilities. There are huge synergies and efficiencies.
- There are serious questions about whether or not Bermuda really needed a new hospital given the recession. Is this the time to have a new hospital?
- Will there be an excess of beds / capacity? May need to reconfigure / redeploy existing KEMH facility towards (a) step-down units (intermediate facility for people who cannot go home) and (b) residential nursing care. Both are less expensive as specialists and doctors do not need to be on wards constantly ordering tests.

4. Former Chief of Staff

- There are too many rumours about the former Chief of Staff. The TOR would answer these questions.
- His first set of responsibilities were necessary because there was a clear need for someone without baggage to tackle the recommendations of *A Tale of Two Hospitals*.
- However, once that was done, his responsibilities morphed from fighting fires to managing the BHB and outside entities. This may not have been his expertise
- His companies should be investigated.
- His compensation should be made public.

5. Costs

- There are questions about the way in which Hospitalists are practicing medicine. There are claims of defensive over-testing.
- There should be guidelines to guard against over-testing.
- Testing should not just be guided by algorithms but also by age / commodity. Recommendation should be that guidelines are adhered to.
- Need to determine what percentage of increases in costs is due to overutilization of testing.
- The Hospital has moved to Diagnostic Related Group ("DRG") billing – a form of bundling care. This means charges are for global care, which is good.
- What needs to happen is expansion and upgrade of software plus include all in-patient services. Specialist physician services are not included in DRG.

6. Billing

Fees

- There are questions about the way that the BHB sets fees.
- BHB is required to consult but invariably they leave too little time for external input. The Health Council has not been consulted since 2009.
- BHB often adds codes. The Hospital's billing practices should be more transparent about codes.
- There is currently a fee-for-service health care system but the controls are not in place for meeting industry standards e.g. billing for in-patient services.

Regulations

- There is nothing in the regulations or agreements with insurers about how to treat incidents where they have not done everything in the DRG. For example if the DRG is to cover four days there is no mechanism for bills to be discounted to a single day. Therefore if the patient dies on the first day the insurer is still billed for four full days.
- We have elements of the US system but not the accompanying regulations.
- Insurers in the US can audit whether all procedures were really necessary and can negotiate the bills.

Financial Controls

- What is the robustness of financial controls? We have significant challenges reconciling claims paid: general accounting and hospital reports based on date claims submitted rather than incurred. Sometimes claims are submitted months later.
- More attention needs to be paid to the National Health Plan's impact / integration on the Hospital as fundamental changes are needed on how reimbursement / funding takes place.

Relationships

- More collaboration is needed between the Hospital doctors and insurance companies.
- The Hospital is not used to being questioned about billing.
- There are more questions now that information is electronic and insurers are able to catch duplicate billings. For example, billing for the same test done twice on the same day.
- The Hospital is the "elephant in the room" regarding any discussion of healthcare in Bermuda. It is the main provider and main consumer of health funds (is this a perception of the truth?).

7. Compensation

- Physician compensation is a big drain on the system.
- Bonus pay incentivizes practitioners to generate more procedures.
- Costs are primarily due to physician compensation.
- Much of the costs result by not following clinical guidelines.
- What are the Executives compensated?
- There should be appropriate compensation and contracts.
- Recommendations re waste of money for senior executive jobs / functions
- What percentage of increases in costs is due to compensation?
- Top-heavy. Still retaining former salaried people as consultants. Seems that the BHB is creating new roles to retain people.
- Long-term care study already done at the Ministry. Why did the BHB need a second person at the Hospital doing this?
- An interim human resource position was created to assist the Director, Organizational Development.

8. Recommendations

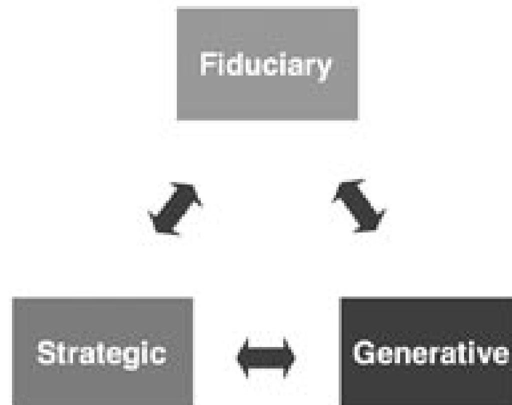
- Despite the wide scope of the review they should be brief rather than a sprawling set of concrete recommendations.
- Recommendations should be operational and practical and based on our own situation and resources.
- Must be presented in a way that will help us to implement.

APPENDIX VI

QUANTUM GOVERNANCE SCHEMATIC

From The Science and Art of Exceptional Governance, Michael G. Daigneault

Quantum Governance, L3C
The Science and Art of Exceptional Governance



"Governance As Leadership"
Three Vital Modes of Thought At the Board & Senior Management Leadership Level

Source: "Governance As Leadership: Reframing the Work of Nonprofit Boards", Chait, Ryan & Taylor (2005)

The Fiduciary Mode

Board's core work:

- Ensure legal & regulatory compliance.
- Ensure financial controls & overall accountability.
- Conserve organization's resources, public stewardship for assets of the organization.
- Regularly evaluate CEO & set "success" criteria.
- Oversee operations & critical risk areas.
- Monitor quality of care & performance.
- Evaluate results.

Source: "Governance As Leadership: Reframing the Work of Nonprofit Boards", Chait, Ryan & Taylor (2005)

The Strategic Mode

Board's core work:

- Scan internal & external environments.
- Review, modify & assist strategic plan/vision.
- Assess strategy performance via needs assessment, critical success factors, benchmarks, and competitive position.
- If necessary, recruit new leadership to help with strategy formation & execution.

Source: "Governance As Leadership: Reframing the Work of Nonprofit Boards", Chait, Ryan & Taylor (2005)

The Generative Mode

Board's core work:

- Sees current challenges in new light.
- Perceives and frames "better" problems and opportunities. Asks key questions!
- Acknowledges organizations are not always logical or linear.
- Discovers strategies, priorities, & "realities."
- Suspends the rules of logic to tap intuition and intellectual playfulness.
- Encourages robust discourse & learning, not just quick consensus.

Source: "Governance As Leadership: Reframing the Work of Nonprofit Boards", Chait, Ryan & Taylor (2005)

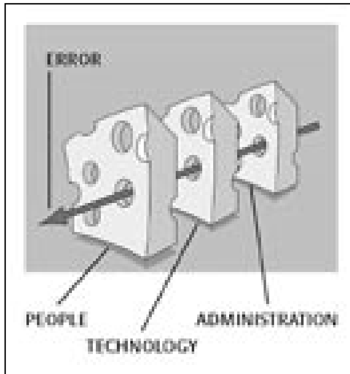
APPENDIX VII

MORBIDITY AND MORTALITY ROUNDS

From "A Tale of Two Hospitals"

(The Ombudsman's November 2007 Report into Allegations of Discrimination Involving Medical Professionals)

Critical Incident Reports



Professor James Reason, arguably the world's leading thinker on managing institutional risk, notes that errors occur when three layers of an organization's defences align and falter: people, technology and administration. His "Swiss Cheese Model" of human error posits that an institution improves only by simultaneously tackling all three layers.

Many organizations respond to human error by focusing on the people layer only: *"blaming individuals is emotionally more satisfying than targeting institutions"*. However, there must be a focus also on the context and conditions within which people make errors. That requires "a reporting culture" and a system of rigorous analysis of mishaps, incidents and near misses by the institution.

Reason continues that *"trust is the key element of a reporting culture and this, in turn, requires the existence of a just culture – one possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions."* [1]

The problem at KEMH is that there is no trust. Many blacks would add – there is no justice.

Contrary to the conclusion of the 2005 Canadian Council On Health Services Accreditation Survey, I find that KEMH does not have an effective reporting system for sentinel incidents involving physicians. The Major Clinical Incident Policy is not clear and not followed consistently. Further, the hospital has no mechanism to capture the incidents that are not now reported.

According to the policy, Occurrence Reports should be made to the CEO, Chief of Staff ("COS") and the Office of Quality and Risk Management ("OQRM"). The relevant physician leader and OQRM must initiate an inquiry within 24 hours. Sometimes reports are made to physician leaders who may decide to address complaints directly and not forward them to the CEO, COS or OQRM. Forms are not always properly filled in either initially or for follow-up actions and notations.

As a consequence, the files held by the Chief of Staff may not be complete. Our perusal of KEMH physician files revealed incomplete, almost ad hoc data – making it difficult to analyze individual performance and patterns of physicians over time. Even the hospital's records of its own out of court settlements are not adequate.

A further problem with the review of critical incidents is that when incidents involve both a doctor and a nurse, it may be reviewed by two separate silos (nursing administration and physician leaders) without adequate communication between the two.

Moreover, several medical practitioners – doctors, nurses and others concurred: they do not get any feedback or see obvious consequences for the incidents or doctors that are reported. They feel discouraged and conclude that there is no point in filling out incident reports. The June 2003 Critical Care Morale Survey quotes staff: *"When we submit incident forms, they seem to 'disappear' and the issues don't get addressed"*.

The value of effective critical incident reporting and analysis is several-fold. 1. the practice of an individual doctor can be remediated. 2. systemic improvements (to the administration and technology layers of defense) can be made in clinical practice as a whole. 3. the institution's overall credibility is strengthened (both from within and without). As noted by Dr. Lucian Leape of the Harvard School of Public Health: *"if error analysis leads to systems correction, then internal reporting will skyrocket."* Patient care is affected by the fact that, beyond a basic continuing education requirement, KEMH has not yet instituted formal processes to share and foster learning from critical incidents.

[1] Reason, J., *Human Error: Models and Management*, British Medical Journal 2000; 320 18 March

Recommendation X: The hospital should augment its Major Clinical Incident Policy to ensure a clear, accessible and confidential procedure in a separate complaints department to identify, report, review and respond to sentinel events. There should also be a policy, based on best practices, for disclosing incidents to patients.

The key recommendation which almost all interviewees recognized is needed – but few could figure out how to implement – is the introduction of systematic, ongoing, in-depth Morbidity and Mortality Rounds ("M&M"). In other jurisdictions, this is considered a basic and critical component for maintaining high standards. It is one of the most useful ways for physicians to improve.

M&M Rounds are structured discussions within each clinical department. Doctors take turns presenting current cases to colleagues. The presentation includes clinical details of interest or concern, how the doctor handled the patient, comparisons with current articles or research on the issue and, as a consequence, options for improving care in the future.

In the current climate of medical practice in Bermuda, doctors (black and white) fear being targeted and counter-targeted, given:

- prior leaks to the media
- the seeming eagerness of doctors to critique each other
- the intense competition chasing a low amount of business
- racialized attacks on each other's competence.

Doctors do not trust that M&M discussions will be kept confidential and fear that cases will be twisted and exaggerated in order to prove each other incompetent. Likewise, there has been some reticence in Bermuda about performance appraisals for the purpose of renewing privileges.

According to the Medical Protection Society ("MPS", UK based insurer/advocate formerly used by many physicians in Bermuda), there is evidence of a positive association between effective appraisal and better outcomes for patients. Appraisals are primarily an educational process that focus on the development of the practitioner. It is a process that facilitates self-reflection and should allow individuals to review their professional activities comprehensively and to identify areas of strength and areas needing development.

In the US, the evolving scholarship that promotes a culture that examines errors was spurred on by the insurance industry. In the UK, recent professional introspection has been prompted by the ground-breaking Bristol Infirmary and Shipman inquiries. In a recent annual report, the Chief Medical Officer for England noted that the reason why poor performance was not dealt with satisfactorily within the world of medicine was because of three main themes:

- the high tolerance of deviant behaviour amongst doctors
- the fact that whistle blowing could be seen as disloyal
- the ambiguity of where to draw the line between acceptable and unacceptable practice.

I hope that this report on discrimination in Bermuda will be the catalyst for the kinds of changes that will lift the layer of race out of the equation. KEMH is in desperate need of change in the institutional culture – in order to break the cycle of blame and attack and to ensure rational practices focused on patient care.

Recommendation XI: The hospital must phase in mandatory, methodical, and regular reviews of adverse events, including Morbidity and Mortality Rounds and analytical tools such as Root Cause Analysis and Evidence Based Practice.

Some Critical Incidents

Complication: An additional problem that arises following a procedure, treatment of illness and is secondary to it, that may result from the illness or from independent causes. Postoperative complication may (or may not) be directly related to the disease for which the surgery was done or to the surgery itself.

Error: There is little consistency in definitions for what constitutes "medical error". Some countries use a wider definition that encompasses action and potential harm to patients, whilst others consider only errors that cause actual harm:

- From Australian General Practice: *"An unintended event, no matter how seemingly trivial or commonplace, that could have harmed or did harm a patient"*.
- From US Family Physicians: *"An act or omission for which the physician felt responsible and which had serious or potentially serious consequences for the patient"*.
- The Department of Health (UK): *"The failure to complete a planned action as intended, or the use of an incorrect plan of action to achieve a given aim"*.

Sentinel Event: *"As defined by JCAHO (US), a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The term 'sentinel' reflects an event that requires immediate investigation and response"*.
Smith, D., Brennan, PJ, Fleisher, L., *Approaches to Quality Improvement in Anaesthesia Care*.

Near Miss: A "Process Variation" that did not affect the outcome, but for which recurrence carries a significant chance of a serious adverse outcome. Should be reviewed and changes made to decrease the risk of the event happening again.

- The Department of Health (UK): *"a healthcare near-miss" is a "situation in which an event, or omission...arising during clinical care fails to develop further, whether or not as...a result of compensating action thus preventing injury to the patient"*.

Substandard Care UK: *"The totality of care – not only failure of clinical care, but also some of the underlying factors which may have produced a low standard of care for the patients. This includes situations produced by the action of the patient or relatives which may be outside of the control of the clinicians. It also takes into account shortage of resources, administrative failures in services and back up facilities such as anaesthetic, radiological and pathology services."*

APPENDIX VIII

SCHEMATIC OF STAKEHOLDERS

STAKEHOLDERS OF THE KING EDWARD VII MEMORIAL HOSPITAL AND THE MID-ATLANTIC WELLNESS INSTITUTE

Patients

Government
Ministry of Health
Health Insurance Department

Providers
Primary Care Physicians
Specialists
Overseas Hospitals

Insurers

Unions
Bermuda Public Service Union
Bermuda Industrial Union

Bermuda Hospitals Board
- Board
- Executive – CEO & Senior Management
- Medical – Chief of Staff & Medical Staff
- All Staff
- Volunteers

Bermuda Health Council

Bermuda Health Advocacy Group

Auditor General

Bermuda Hospital Charitable Trust

Redevelopment Project
New Hospital

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