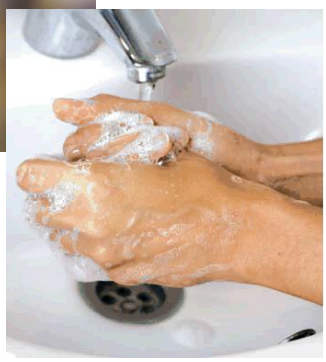
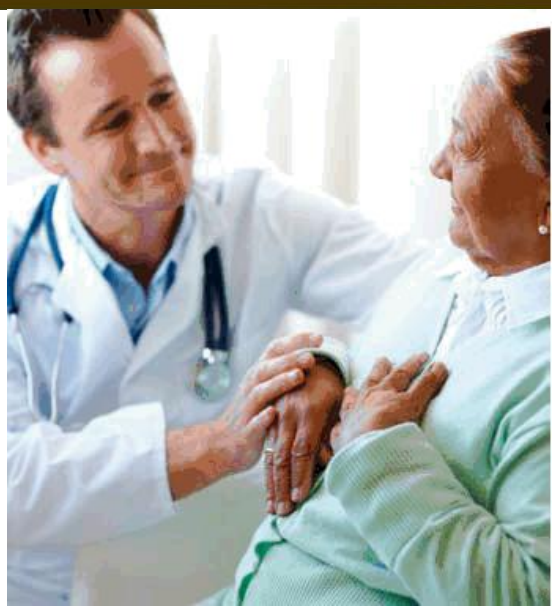
Business Process Design:
A Framework for Change
Final Report

Prepared for:

Government of Northwest Territories





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Submitted On: Version 3.0 March 18, 2011

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MNP MEYERS NORRIS PENNY LLP

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Glossary

DHSS – Department of Health and Social Services
GLE – Government Letter of Expectation (BC)
GNWT – Government of Northwest Territories
HA – Health Authority (BC)
HSSA – Health and Social Service Authority
ISDM – Integrated Service Delivery Model
MNP – Meyers Norris Penny
PHSA – Provincial Health Services Authority (BC)
RHA – Regional Health Authority (MB)

Executive Summary

Meyers Norris Penny (MNP) was engaged by the Government of the Northwest Territories, Department of Health and Social Services (GNWT DHSS) to conduct a business process design review with the intent of making recommendations for improvement that will help ensure the effective and efficient delivery of health and social services to the people of the Northwest Territories (NWT).

Four key areas: Accountability; Financial Management; System Resourcing; and Governance Structure guided MNP's review efforts. The scope of the Business Process Design Project was to examine the following components:

1. Board capacity to manage risk, achieve efficiencies, develop linkages and provide opportunity for community input
2. Role clarity between the DHSS and the HSSAs
3. Governance model that ensures balance between integrated service delivery and community input and feedback
4. Service delivery options that allow shared services and ensure performance monitoring and reporting on accountabilities

Rationale for Change

Meyers Norris Penny interviewed the project steering committee, HSSA CEOs and DHSS Directors in August 2011 to determine the rationale for change. As part of this process we explored what was working well and what could be improved in regard to governance, accountability, financial management and system resourcing. We also reviewed Legislation, HSSA budgets, HSSA annual reports, HSSA audited financial statements, DHSS strategic plans, DHSS annual reports, and many other background documents and reports. The message we heard was consistent: that the current model and structure was not sustainable, presented a number of risks and required change. One key informant stated that the "system was at a tipping point."
The table below summarizes the rationale for change and articulates a problem definition, solution design constraints and solution performance criteria. In addition, a March 2011 report from the Office of the Auditor General presented findings that were aligned with our conclusions and accordingly has been presented in the table as well.

Defining the Problem – What has led to a need to change

1. **Structural Design and Funding** – The current structure and funding model for eight Health and Social Service Authorities does not facilitate the delivery of an integrated service delivery model where patients flow between HSSAs to access various levels of programs and services.
2. **Legislation and Policies** – Multiple instruments are used to define authority and performance expectations ranging from legislation and formal policies, to ministerial direction, bulletins, and statements in legislature.
3. **Process** – A reactive system operating in silos means there are limited system-wide processes and protocol that ensure consistent implementation, coordination of efforts, clear decision making, and system-wide knowledge.
4. **Capacity and Capability** – The same skills and capabilities are required to administer a health system regardless of population size. In addition administrative capability and capacity need to be duplicated within each HSSA.
5. **Environmental** – Population and geographic dispersion, cultural differences, language, infrastructure, and demographics can significantly impact the ability to deliver relevant and effective health and social services.
6. **Measurement and Communication** – Poor quality of and limited access to data and information means it is difficult to make informed decisions

Design Constraints – What would limit solution design

1. **Capacity** – The solution will need to consider the Department and HSSAs capacity to design and implement change.
2. **Political Environment** – A consensus government system, like that of the NWT requires increased levels of agreement to implement change than that required in a party government system. There can be a higher level of turnover at the Ministerial and Premier levels, which in turn can result in inconsistencies that may impact the government's ability to drive and sustain significant change.
3. **Geographic Isolation** – Solution design and implementation will need to consider the geographic isolation of communities in NWT.
4. **Self Government and Land Negotiations** Solution design and implementation will need to consider current situation and future impact of self government and land negotiations.
5. **Fiscal Restraint** – Solution design and implementation will need to accommodate the requirement for fiscal restraint.
6. **Infrastructure, Tools and Information** – Solution design and implementation will need to consider current infrastructure and requirements for changes to tools and information.

Performance Criteria – What the solution needs to achieve

1. **Accountability** – provides clearly understood roles, responsibilities, accountabilities, performance expectations, performance measurement and compliance. The solution should recognize that accountability for health system performance rests with the minister, but acknowledge the requirement for separation between government and service delivery.
2. **Risk management** – provides capacity to appropriately mitigate and manage risks including patient safety and quality services to ensure a sustainable health system.
3. **System linkage** – system wide planning and coordination of service delivery results in consistent levels of service and program delivery.
4. **Efficient** – facilitates coordination, reduces duplication of efforts, and fosters accurate and appropriate communication for good decision making.
5. **Flexible** – allows for ongoing review, revisions and adaptations as required.
6. **Sustainable** (Relevant and realistic) – DHSS and HSSA resource requirements for implementation and ongoing sustainability are understood and available with an opportunity for community and stakeholder input and feedback.
7. **Feasibility** – cost, required capacity, required timeline, degree of change.

Office of the Auditor General

In a March 2011 report, the Office of the Auditor General presented findings and recommendations that support our observations. Reported concerns include: performance agreements with HSSAs, current funding model given patient flow, territorial management of physician services, service agreement with GNWT Department of Human Resources, system-wide performance indicators and corresponding program evaluation, definition of and compliance with program standards, consistent program implementation across NWT, flow of patient health records, and measurement and communication of program outputs and outcomes.

A summary of our findings and their corresponding symptoms are presented in the table below.

Summary Findings	Symptoms
Integrated service delivery model funded and operating in geographic silos	• Blurred roles and responsibilities
	• Territory wide services like physicians and medical travel are not well coordinated
	• Poor case management and limited continuity of care
	• Inconsistent service delivery standards and policies for core services
	• Inconsistent access to territorial and regional level services
	• Challenged to coordinate and control shared administrative services, for example eHealth, medical travel, third party billing, and procurement
	• Inability to move funds between HSSAs based on where services were accessed
Unclear performance expectations, program planning process and inconsistent adherence to policies and program standards	• Limited accountability to Minister of Health and Social Services
	• Inconsistent definition of and funding for core primary, secondary and tertiary level services and programs
	• Inconsistent definition of and funding for additional services and programs through contribution agreements
	• Inconsistent services and programs across the territory
Limited capacity within communities and recruitment and retention challenges	• Current Boards of Management are not always able to fulfill their mandated role
	• Health and Social Service Authority gaps in MIS/IT, finance and administration management are being filled by department
	• Health and Social Service Authority gaps in funded health professional positions are being filled by other HSSAs
	• Some Health and Social Service Authorities are not able to provide regional level services at all or without the support of other HSSAs
	• Some HSSAs are challenged to do required planning and reporting
	• Inconsistent quality and content in financial and performance reporting between the HSSAs

To address the problems outlined and to improve performance of the system against the performance criteria, recommendations were developed and categorized into the following four areas:

1. Financial Management
2. Resourcing
3. Consolidation and Collaboration
4. Accountability

Recommendations – Financial Management

Financial Management Recommendations
• Ensure financial management roles are well defined and understood (see section 3.1.1) • Ensure financial instruments are well defined and understood (see section 3.1.2) • Ensure financial protocols are well defined and understood (see section 3.1.3) • Ensure financial systems are compatible and able to present information in the required categories and format

Recommendations – Resourcing

System Resourcing Recommendations
• Formally sanction ISDM and use ISDM categories for funded core programs and services to budget and report spending at territorial level (see section 3.2.2) • Ensure reporting can easily be transferred to required categories for Public Accounts • Ensure all costs for service delivery, administration and leadership are funded • Should approved budgets not meet all costs, it is the responsibility of the GNWT and the Minister (under advisement from the HSSA) to make decisions regarding funding cuts • Capital funding should remain within government control • Financial protocol and compliance mechanisms to ensure operating surplus retention, reporting and variance analysis requirements are clearly defined and enforced • All core programs and services should be defined in the Accountability Agreement • Additional special projects should be funded through separate Contribution Agreements and summarized in the Accountability Agreement. Contribution Agreements should outline goals and objectives, inputs, outputs/activities, expected outcomes, end dates and reporting requirements • Use of funds at primary level should have more discretion than those at secondary or tertiary levels

Recommendations – Consolidation and Collaboration

	System Collaboration Recommendations	Clinical Support Consolidation Recommendations	Back Office Consolidation Recommendations
Purpose	Develop system goals and priorities that are relevant and can be realistically implemented	Remove duplication of effort and ensure "right service, right place right time" - Successful Integrated Service Delivery Model Implementation	Remove duplication of efforts and address capacity, recruitment and retention issues
Potential Benefits	• Improved leadership • Improved direction • Improved planning and reporting • Improved standards and policies	• Improved quality assurance and risk management • Improved equity in system resourcing • Improved accountability and sustainability • Improved ability to provide seamless service delivery	• Improved consistency through a standardized approach • Improved quality through use of best practices in process and technology • Improved efficiency through reduced duplication of efforts and reassignment of resources to value add activities • Improved sustainability through reduced requirement for functional expertise capacity
Potential Concern	• The ability to ensure required communication, cooperation, trust and accountability to truly collaborate	• Having appropriate structure, authority, accountability and capacity to achieve system coordination and collaboration	• Previous bad experience with design and implementation process – change management • Loss of positions in communities • Loss of control in communities • Increased time to process requests
Opportunity Examples	• Ongoing ISDM development and implementation • Service delivery policies • Program standards • System needs analysis • Community input and feedback • Strategic and business planning • Measurement and reporting • Quality assurance • Risk management	• Physician services • Pharmaceuticals • Labs and diagnostic services • Continuity of care: case management, bed management, wait lists, territorial admissions and placements • Medical travel administration, medivac and escorts	• Fleet management • Human Resources • Financial processing • MIS, IT and IM • System and technical support – eHealth – Telehealth • Procurement and equipment purchasing • Legal support

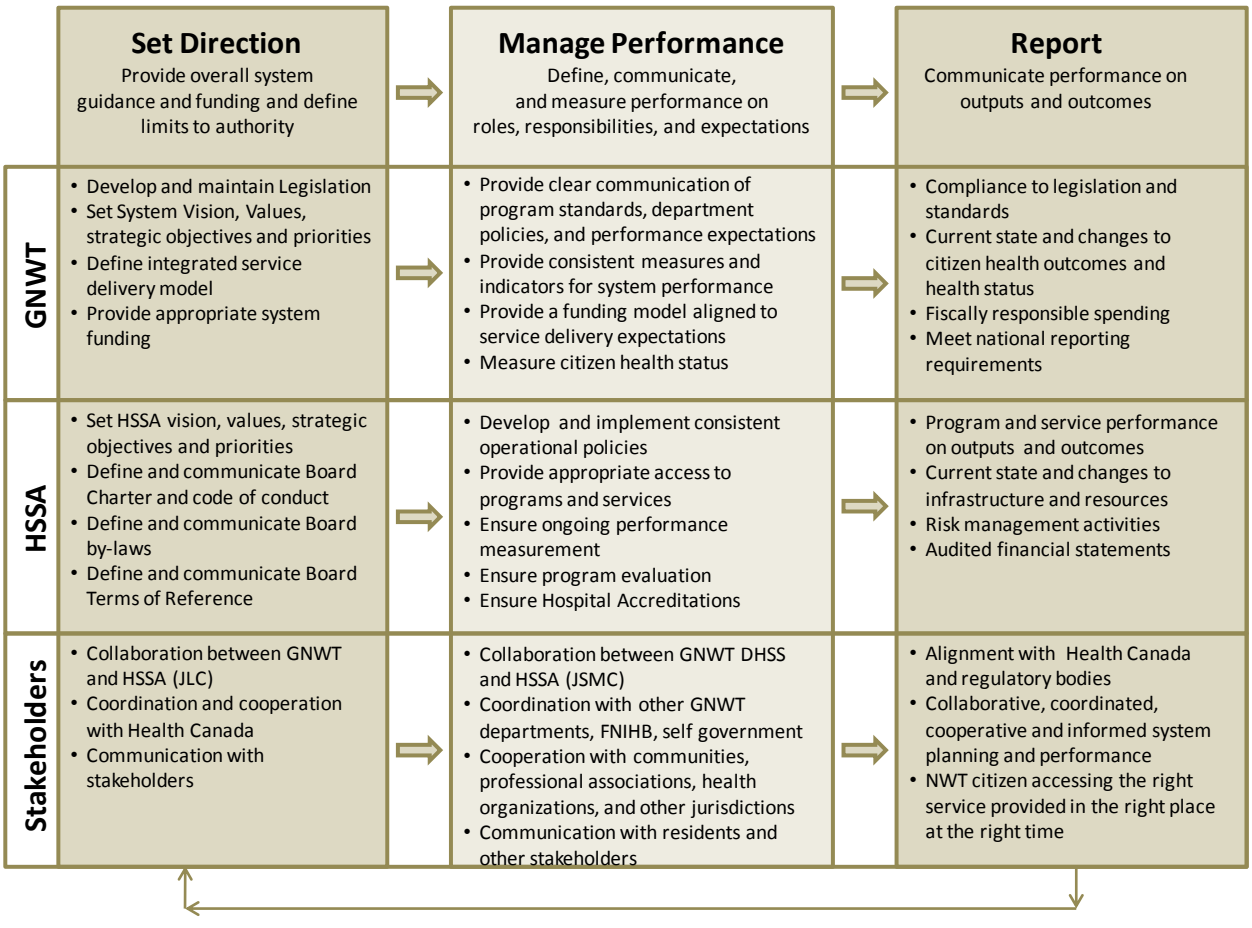
Recommendations - Accountability

Accountability Recommendations

- Define program and service delivery levels for each HSSA once service delivery review is complete
- Ensure roles and responsibilities are well defined and understood (see section 3.4.3)
- Define program standards and associated performance indicators
- Use Accountability Instruments to define and communicate roles, responsibilities and expectations as well as communicate performance and variance from expectations (see section 3.4.6)
- Develop an Accountability Agreement to reinforce and communicate accountability structure and update as standards and performance indicators are developed (see section 3.4.9)

Accountability Framework

An accountability framework provides a visual representation of health system management roles, responsibilities, performance expectations, and reporting measures. A recommended framework was developed and is presented below.



The ability to implement the framework depicted above depends on the ability to further implement the ISDM, define program standards and define associated program and system performance indicators. To more clearly communicate accountability to HSSAs we are recommending the development of an Accountability Agreement. The purpose of this agreement is to ensure mutual understanding of roles, responsibilities, associated performance expectations, required resources, and reporting requirements to ensure accountability. An outline for this agreement is presented below.

Agreement Sections		Agreement Schedules	
Section 1.0	Purpose of Agreement	**Schedule 1**	General
Section 2.0	Definitions	**Schedule 2**	System Integration and Planning
Section 3.0	Term	**Schedule 3**	Performance Requirements
Section 4.0	Financial Contribution and Related Provisions	**Schedule 4**	Special Projects
Section 5.0	Accountability	**Schedule 5**	eHealth
Section 6.0	Audits and Inspections	**Schedule 6**	Financial Policies and Protocol
Section 7.0	Confidentiality	**Schedule 7**	Compliance
Section 8.0	Liability and Indemnity	**Schedule 8**	Budget
Section 9.0	Insurance	**Schedule 9**	Insurance Requirements
Section 10.0	Termination		
Section 11.0	Dispute Resolution		
Section 12.0	General		

Recommendations – Governance

While the recommendations detailed in regard to financial management, resourcing, consolidation and collaboration, and accountability provide guidance to address many of the identified problems, their implementation will not address all of them. In particular, key problems identified that would remain unaddressed with implementation of the articulated recommendations include:

- The capacity of the DHSS to provide support and monitor compliance for eight HSSAs.
- The capacity and capability within the eight Boards and HSSAs to govern and manage health and social service delivery.
- The ability to integrate service planning and delivery as a result of segmentation into eight separately funded and managed HSSAs.

Accordingly, it becomes apparent that further change is warranted to realize the full benefits of implementing the aforementioned recommendations. Specifically, it became clear that we must look at the manner in which the health system is governed to provide the best opportunity to:

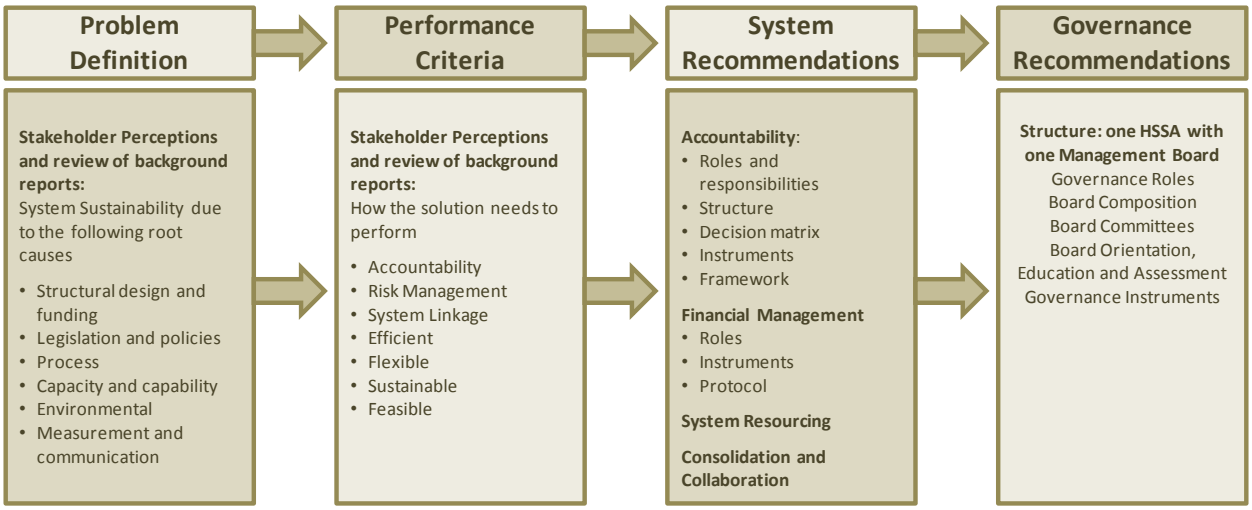
- Enhance the delivery of services in NWT;
- Manage risk;
- Make the optimum use of Government resources;
- Ensure clear and appropriate accountabilities; and
- Balance the benefits of community involvement.

We investigated health system governance options for the GNWT with a goal of recommending an option that supports and optimizes the recommendations on financial management, resourcing, consolidation and collaboration, and accountability. Six design concepts were developed, three of these were chosen

for assessment and each of these three options were assessed against the established performance criteria.

To develop the governance recommendation we employed a structured logic process whereby we:

- Firstly, revisited the core problems that any new structure must address;
- Secondly, reviewed the performance criteria against which the structure would be measured;
- Thirdly, assessed the requirements for change and developed recommendation in the four areas of accountability, financial management, system resourcing, and consolidation and collaboration; and
- Lastly, assessed governance models that could optimize health system performance.



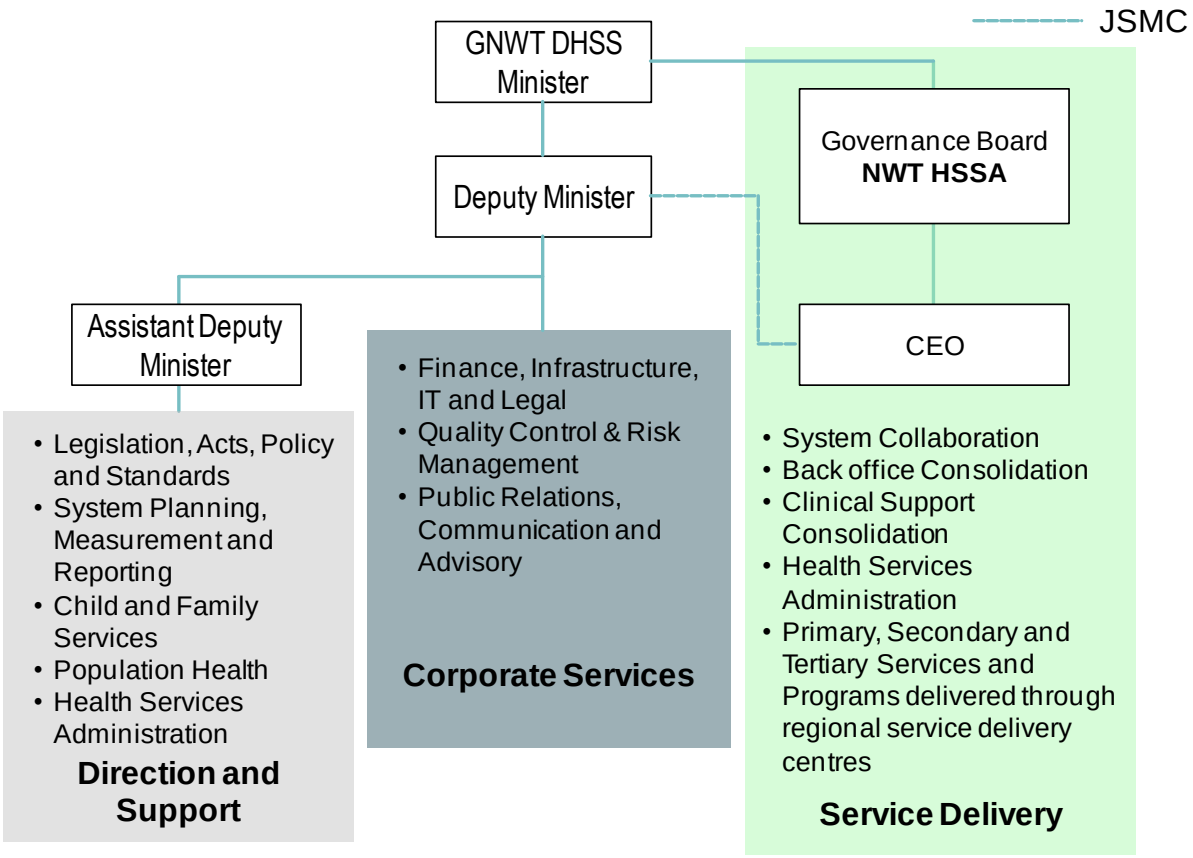
A summary of the analysis for the three options is included in the table below.

Option Analysis Summary

Criteria	Option A	Option B	Option C
Accountability	Does not provide arms' length management of health and social service delivery	One organization and board provides greater clarity of governance role and the capacity to fulfill that role	Four separate HSSAs with boards reporting to GNWT DHSS
Risk Management	Government has responsibility for entire risk management process but is accountable only to itself	Government delegates responsibility to one accountable HSSA	Government delegates responsibility to three separately accountable HSSAs who manage risk independently
System Linkage	Service delivery and system resourcing will be internal to the department allowing system linkage	Service delivery and system resourcing will be coordinated by one HSSA	No authority or accountability to ensure system collaboration between three HSSAs
Efficient	Allows for consolidation of back office and clinical support but as a bureaucratic organization will likely not be efficient due to the inability to delegate decision making	Back office and clinical support consolidation managed by one HSSA reduces duplication, frees up resources, ensures consistency, and allows for best practices	Back office consolidation and clinical support collaboration in a separate organization provides opportunity for greater efficiency but organization has no control over HSSAs to ensure collaboration
Flexible	Structure does not encourage initiative or innovation	Service Delivery Authority is delegated to regional centres, which allows for relevant services and programs at territorial and community level	Delegation of control over service delivery to three regional HSSA boards with limited ability to coordinate at the territorial level
Sustainable	Would only be viable as a short term solution due primarily to the advantages of an arms' length health system	Improved sustainability through reduced requirement for functional expertise capacity	Reduces but does not eliminate root causes
Feasible	Going from 8 to 0 HSSAs – significant governance change required	Going from 8 to 1 HSSA – moderate governance change required	Going from 8 to 3 HSSAs – no significant governance change required

Meets Criteria:	Strongly Met
	Met
	Poorly Met

This summary clearly demonstrates that Option B most strongly meets the performance criteria and accordingly, this option is recommended.



Using this option, the report presents recommendations regarding elements including:

- Governance roles;
- Role of Board within the System;
- Board composition and competencies;
- Board director recruitment, appointment and tenure;
- Board committees;
- Board orientation, education and assessment; and
- Governance instruments.

Conclusion

Meyers Norris Penny recognizes that the recommendations provided within this document represent significant change for the NWT health and social service system. The intent is to incorporate findings regarding context, current situation, and desired future state and develop recommendations that will lead to meaningful changes. These changes are intended to result in the ability to ensure safe and quality patient care for all residents of NWT.

The recommendations provided represent only the initial level of changes regarding governance and accountability. Many of the operational changes will depend on the outcome of other ongoing projects, most significantly, the service delivery review. The ability to coordinate territorial services and define a structure for regional delivery centres depends on a clear definition of core services and an understanding of where these services need to be accessed.

1.0 Project Overview

Meyers Norris Penny (MNP) was engaged by the Government of the Northwest Territories, Department of Health and Social Services (DHSS) to conduct a business process design review with the intent of making recommendations for improvement that will help ensure the effective and efficient delivery of health and social services to the people of the Northwest Territories (NWT).

Four key areas: Accountability; Financial Management; System Resourcing; and Governance Structure guided MNP's review efforts. Our efforts focused on providing practical recommendations and perspectives that address five key result areas:

1. Risk Management
2. Role Clarity
3. Human & Financial Resource Efficiency
4. System Linkage
5. Service Delivery Flexibility and Options

1.1 Project Background and Rationale

The Minister of Health and Social Services is ultimately accountable for the delivery of health and social services in Northwest Territories. Authority and responsibility for administration, including system-wide planning and reporting, overall financial management, policy and legislation is currently delegated to the Department of Health and Social Services (DHSS). Authority and responsibility for delivery of services is currently delegated to one territorial and seven regional Health and Social Service Authorities (HSSA).

The delivery of health and social services in NWT as well as its management and administration must comply with various pieces of legislation. The HSSAs in NWT are governed by Boards of Trustees, who are appointed by the Minister. The day-to-day operations are the responsibility of the Chief Executive Officers who are hired by and report to these Boards. Currently three of the larger HSSAs are operating under a Public Administrator.

A territorial health and social services system must present one vision and an understood functional alignment of roles, responsibilities and accountabilities that recognizes the resource challenges within the system. The Northwest Territories Department of Health and Social Services has identified limitations in their current system that restricts or prevents these qualities. Further, the current structural design is not felt to provide the authority or resources required to effectively and efficiently plan and deliver health and social services in NWT. It is within the context of these realities that the business process review was initiated.

This review is aligned with the current DHSS strategic plan titled "A Foundation for Change", which has outlined three goals: 1- Wellness, 2- Accessibility, and 3- Sustainability. The first priority under Sustainability is to improve governance and accountability to ensure the delivery of quality programs and services and consistent financial management. The actions under this priority are outlined as follows:

- Clarify roles and responsibilities through performance and service agreements with Health and Social Services Authorities
- Implement a funding model for Health and Social Services Authorities
- Focus on the most effective and efficient use of funds for agreed upon programs and services
- Develop and maintain a system of reporting on performance at the HSSA and territorial level

1.2 Project Scope

The scope of the Business Process Design Project is to examine the following components:

5. Board capacity to manage risk, achieve efficiencies, develop linkages and provide opportunity for community input
6. Role clarity between the DHSS and the HSSAs
7. Governance model that ensures balance between integrated service delivery and community input and feedback
8. Service delivery options that allow shared services and ensure performance monitoring and reporting on accountabilities

These were addressed through the review and development of recommendations in the areas of accountability, financial management, system resourcing, and governance structure.

Table 1: Project Scope

Accountability
• Roles and responsibilities are clearly defined and clearly communicated • Performance expectations are clearly communicated • Expectations are balanced with capacities • Reporting between all relevant stakeholders is credible and timely • Ongoing review and adjustment is accommodated
Financial Management
• Systems are adequate and effective • Board financial policies are adequate and effective • Policies and requirements ensure compliance • Variance analysis is accurate • Cost drivers impact are understood • Board reporting is relevant, valid and timely
System Resourcing
• Department funding allocations are adequate and equitable • HSSA funding allocations are fair and clear • HSSA support resources in the Department are adequate – collective overarching supports for the Boards and HSSAs • Surplus/deficit retention policies are appropriate • Department has capacity to provide appropriate and effective monitoring
Governance Structure
• Defines political, territorial, regional and community level roles in determining needs, providing advice and participating in governance • Defines appropriate structure including representation, appointments, and tenure criteria • Defines Board structures and appropriate processes including board recruitment, orientation, training and board assessments • Defines Department and HSSA roles in terms of accountability, responsibilities, and reporting requirements

1.3 Project Outcome

The result of this engagement will be a report and action plan that clearly defines constructive changes to the existing NWT health and social services delivery systems that will:

- Enhance the delivery of services
- Make the optimum use of Government resources
- Ensure clear and appropriate accountabilities
- Balance the benefits of community involvement and control

1.4 Project Approach

To ensure balanced, credible and valid outcomes, MNP used the following four general methods.

1. **Data Collection** – Conducted interviews with HSSA CEOs and DHSS Directors and facilitated sessions with the JSMC and the project Steering Committee to identify strengths, weaknesses, opportunities and threats of/to the current model, and discuss performance criteria for solution.
2. **Best Practice Model Review** – Reviewed four (4) other Canadian jurisdictions using a defined set of parameters to identify opportunities related to organizational structure, governance, accountability and business process.
3. **Review of Current Related Initiatives** – Through interviews and facilitated sessions reviewed other current initiatives within the GNWT that have relevance to this review and potential to impact outcomes.
4. **Policy and Legislative Framework Review** – Reviewed at a strategic level policies and legislation that guides current delivery of health and social services.

Our approach divided the project into three phases and six stages: manageable pieces of work that were each defined by specific deliverables and milestones.

1.5 Report Structure

This report is intended to provide a summary of findings made throughout the engagement process and the resulting recommendations.

- **Section 2.0** provides the rationale for change. These findings were informed by consultations with HSSA CEOs, DHSS Directors and the Steering Committee.
- **Section 3.0** provides system recommendations in the following areas:
    - **Section 3.1** provides recommendations on system financial management and financial roles, instruments, and protocols.
    - **Section 3.2** provides recommendations on system resourcing and funding model.
    - **Section 3.3** provides recommendations on collaboration and consolidation opportunities.
    - **Section 3.4** provides recommendations on system accountability and the delegation and reporting of responsibilities.
- **Section 4.0** provides governance structure options for the GNWT Health and Social Services and recommendations on system governance and the delegation of authority.
- **Section 5.0** provides a conclusion and summary of all recommendations.

2.0 Rationale for Change

Meyers Norris Penny interviewed the project steering committee, HSSA CEOs and DHSS Directors in August 2011 to determine the rationale for change. As part of this process we explored what was working well and what could be improved in regard to governance, accountability, financial management and system resourcing. We also reviewed Legislation, HSSA budgets, HSSA annual reports, HSSA audited financial statements, DHSS strategic plans, DHSS annual reports, and many other background documents and reports. The message we heard was consistent: that the current model and structure was not sustainable, presented a number of risks and required change. One key informant stated that the "system was at a tipping point."

This section presents our observations and explores the rationale for change by:

- Defining the problem(s)
- Identifying design constraints (defined as the limitations within which the solution will be defined)
- Determining solution performance criteria (defined as criteria that will be used to measure what a solution will accomplish once implemented)

These observations and findings were reviewed with the Steering Committee and presented to the Joint Senior Management Committee for discussion and consensus.

2.1 Defining the Problem

Meyers Norris Penny consulted with HSSA CEOs and DHSS Directors to understand their perspective on what was not working well with the health system. The core problem was consistently defined as system **sustainability.** In identifying the root causes of this problem it became clear that these root causes could be grouped into one of six categories: structural design and funding; legislation and policies; process; capacity and capability; environment; or measurement and communication.

1. **Structural Design and Funding** – The current structure and funding model for eight Health and Social Service Authorities does not facilitate the delivery of an integrated service delivery model where patients flow between HSSAs to access various levels of programs and services. Findings from consultations with stakeholders are summarized as:

    - Fragmented structure means integrated service delivery model is not feasible
    - Unclear and overlapping roles in service delivery and system wide projects
    - Limited or unclear authority to make decisions or delegate responsibilities
    - Blurred lines of accountability means reporting does not meet needs
    - Limited coordination of planning, budgeting or decision making
    - Program and service delivery performance expectations are not defined
    - Perspective that JLC and JSMC is not used to full potential to discuss "real issues", make "real decisions", set direction and implement
    - Approved budgets do not align with actual service, program or financial reality of HSSAs
    - Unfunded known and unavoidable costs required to meet service delivery expectations
    - Large amount of contribution agreements in addition to core funding
    - Political role in structure – between MLA, board and community

2. **Legislation and Policies** – Multiple instruments are used to define authority and performance expectations ranging from legislation and formal policies, to ministerial direction, bulletins, and statements in legislature. Findings from consultations with stakeholders are summarized as:

    - No framework to understand "full picture" and determine which instruments are binding
    - Unclear auditing process for compliance, and resulting consequences

- Limited auditing of existing policies except through accreditation process
- Limited coordination to develop similar policies at hospital or HSSA level
- Required funding or resources do not always accompany new policies or programs
- Limited HSSA-level understanding of the process to add new program or service and required resources
- HSSA or Board ability to impact policies versus local politicians
- Have never reconciled or defined who is responsible for developing and maintaining policies, which policies can be similar and which ones need to be different

3. **Process** – A reactive system operating in silos means there are limited system-wide processes and protocol that ensure consistent implementation, coordination of efforts, clear decision making, and system-wide knowledge. Findings from consultations with stakeholders are summarized as:

   - ISDM is model but it has not been formally sanctioned and there is no process or funding to implement
   - Unclear decision making control points to ensure consistent service delivery
   - Can informally by-pass process to get an exception approved
   - Limited understanding and required discussions to determine what level of service is being funded within each HSSA
   - Limited formal and collective knowledge of where each HSSA should send patients for which services
   - Budgeting process does not reflect reality or allow for good management decisions
   - Limited ability to do required risk management or quality assurance
   - A formal appeal process is not in place to follow when decisions need to be challenged
   - Varying degrees of understanding regarding how decisions are implemented

4. **Capacity and Capability** – Regardless of size, the same systems, processes, and procedures are required to deliver and administer health and social services. Findings from consultations with stakeholders are summarized as:

   - Required capacity and capability to deliver services is not always available within HSSAs
   - Required capacity and capability to provide direction and supports is not always available within GNWT departments
   - Required capacity and capability to provide oversight and direction is not always available within Boards
   - Required capacity and capability to support and manage system level projects is not always available with DHSS or HSSAs
   - High turnover means limited historical knowledge and inconsistent leadership
   - Historical decisions, good will and “boutique” federal funding means decisions were made to implement new programs with insufficient long term funding
   - Limited capacity to develop standards where required to ensure cultural specific service delivery

5. **Environmental** – Population and geographic dispersion, cultural differences, language, infrastructure, and demographics can significantly impact the ability to deliver relevant and effective health and social services. Findings from consultations with stakeholders are summarized as:

   - Geography and cost of travel means communities and HSS staff are isolated
   - Complexity of jurisdictions including self government and land claims

- Cultural and specific health issues at community level means certain services may need to be customized
- Consensus government, localized politics and political agendas means tough decisions are difficult to make
- Public expectations that access to services in NWT will be the same as in southern communities are difficult to align with the realities of providing access to services in the north
- Ageing population, chronic disease and limited ownership of personal health in some communities
- Limited infrastructure and environment of fiscal restraint
- Recruitment and retention challenges driven by isolation and environment in communities
- Larger jurisdictions are moving to sub specialists, which means NWT's need for generalists is difficult to fulfill
- Decisions made in other jurisdiction like Alberta or Nunavut can significantly impact NWT's ability to deliver health services
- Language and communication – often no words in Inuit or First Nation language to communicate meaning and ensure understanding of issues

6. **Measurement and Communication** – Poor quality of and limited access to data and information means it is difficult to make informed decisions. Findings from consultations with stakeholders are summarized as:

- Limited communication of service and program standards or expectations
- There are not consistent indicators or performance measurement of outputs and outcomes
- Consolidated information is not available making it is difficult to compare HSSA performance
- Limited feedback on improving HSSA reports is provided
- Limited coordination of community input and issue resolution at Board level means community members do not always recognize the Board's authority
- Limited capacity and capability to do required measurement and reporting
- Difficult to manage data sharing and ensure privacy regarding patient information

2.2 Design Constraints

Meyers Norris Penny consulted with HSSA CEOs and DHSS Directors to understand their perspective on what would limit the solution design. Design constraints can be thought of as the realities that exist within an environment or system that cannot be ignored when considering change. They are the limitations within which the solution must be defined. Again, like with root causes, design constraints could be categorized. Six categories were identified and the details on each are summarized as:

1. **Capacity** – The solution will need to consider the Department and HSSAs capacity to design and implement change. Findings from consultations with stakeholders are summarized as:

- Limited capacity and skills means DHSS, HSSAs and communities are challenged to meet responsibilities for health and social service delivery and administration
- Difficult to attract and retain health professionals to remote communities including Yellowknife
- Constant turn over in all positions mean limited NWT experience and perspective
- Limited information system infrastructure (e.g. Bandwidth)
- Reliant on other systems or organizations (e.g. Aurora College, Alberta Health Services) for resources
- Poor representation of Aboriginal population within DHSS staff
- There is a need to revisit core services document to ensure there is capacity in system to deliver services

2. **Political Environment** – A consensus government system, like that of the NWT requires increased levels of agreement to implement change than that required in a party government system. There can be a higher level of turnover at the Ministerial and Premier levels, which in turn can result in inconsistencies that may impact the government's ability to drive and sustain significant change. Findings from consultations with stakeholders are summarized as:

   - MLA influence at a ministerial level means board authority is not always recognized by MLAs
   - There is a need to put political lens on governance and funding decisions
   - There is a need to flag decisions that will have political impact
   - Difficult to make unpopular decisions in a consensus government

3. **Geographic Isolation** – Solution design and implementation will need to consider the geographic isolation of communities in NWT. Findings from consultations with stakeholders are summarized as:

   - Need for medical travel increases system delivery costs
   - Limited ability to recruit and retain health system leaders, technical staff and allied health professionals
   - Many of the major health issues facing NWT (STD, TB, smoking) will be dealt with at community level

4. **Self Government and Land Negotiations** Solution design and implementation will need to consider current situation and future impact of self government and land negotiations. Findings from consultations with stakeholders are summarized as:

   - Uncertainty regarding self government
   - Negotiations are complicated as they occur at community or regional level, and can include multiple or overlapping regions
   - Communities will make decisions independent of each other
   - Communities are at different places and have different expectations regarding transferred services
   - Can be beneficial to ensure relevance of primary social services and prevention efforts at community level

5. **Fiscal Restraint** – Solution design and implementation will need to accommodate the requirement for fiscal restraint. Findings from consultations with stakeholders are summarized as:

   - New business process design must be Department of Health and Social Services budget neutral
   - Recognition that funds required to manage the change will need to be reallocated funds as opposed to new funding
   - Organizations tend to get protective when money is tight which can limit efforts to collaborate
   - Increased pressure to reduce costs means there is a need to ensure design is towards meaningful changes to the system rather than pure cost savings

6. **Infrastructure, Tools and Information** – Solution design and implementation will need to consider current infrastructure and requirements for changes to tools and information. Findings from consultations with stakeholders are summarized as:

   - Do not have consistent or well understood standards and policies
   - There is a need to consider logistics to implement ISDM
   - Limited infrastructure and tools to implement ISDM
   - Cost drivers are poorly understood or defined

2.3 Performance Criteria

Performance criteria do not define what the solution is, but rather are criteria that will be used to measure what a solution will accomplish once implemented. Informed by the consultations, and secondary research, seven performance criteria were identified and are summarized below. Each criterion is then detailed in the sections that follow.

7. **Accountability** – provides clearly understood roles, responsibilities, accountabilities, performance expectations, performance measurement and compliance. The solution should recognize that accountability for health system performance rests with the minister, but acknowledge the requirement for separation between government and service delivery
8. **Risk management** – provides capacity to appropriately mitigate and manage risks including patient safety and quality services to ensure a sustainable health system
9. **System linkage** – system wide planning and coordination of service delivery results in consistent levels of service and program delivery
10. **Efficient** – facilitates coordination, reduces duplication of efforts, and fosters accurate and appropriate communication for good decision making
11. **Flexible** – allows for ongoing review, revisions and adaptations as required
12. **Sustainable** (Relevant and realistic) – DHSS and HSSA resource requirements for implementation and ongoing sustainability are understood and available with an opportunity for community and stakeholder input and feedback
13. **Feasibility** – cost, required capacity, required timeline, degree of change

2.3.1 Accountability

A system that is accountable provides clarity for all system participants by providing mechanisms for:

- Clear roles and responsibilities within and between HSSAs, DHSS and Minister
- Clear performance expectations and indicators
  - Acts and agreements clearly define performance and reporting requirements
  - Service delivery matrix
- Clear lines of authority and accountability
  - Decision and delegation matrix
  - Reporting requirements (transparency)
- Compliance
  - Audit and review process defined
  - Process to act on recommendations defined
- Consultations and discussions have been clear that accountability needs to be firmly established while ensuring the separation of service delivery from government administration and leadership

2.3.2 Risk Management

A system that manages risk ensures patient safety and quality services by providing mechanisms for:

- Defined risk management process
- Defined roles, responsibility and accountability for risk management
- Required resources, supports and culture for implementation of risk management process

2.3.3 System Linkage

A system that is linked ensures consistent services by providing mechanisms for:

- System wide planning and service delivery coordination
- Policy interpretation, reporting and audit response (transparency)
- Program standards, service delivery and administrative functions
- Case management

2.3.4 Efficient

A system that is efficient ensures coordination by providing mechanisms for:

- Appropriate incentives and accountability for efficient use of resources (human and financial) for:
  - Territory wide health initiatives and strategic planning
  - Administrative functions
  - Seamless patient care or case management
  - Other GNWT department initiatives
- Accurate information through:
  - Defined budgeting process
  - Efficient and effective financial administration, reporting and analysis
  - Appropriate flow of information

2.3.5 Flexible

A system that is flexible accommodates residents' needs by ensuring:

- System reflects the Integrated Service Delivery Model
- System can accommodate self government negotiations
- Funding model can adapt to changing needs
- System responds to community needs

2.3.6 Sustainable

A system that is sustainable is right-funded and provides relevant services by ensuring:

- Programs and Services reflects community needs and allows for input and feedback (Relevant)
- System is supported by a defendable and fair funding model (Realistic)

2.3.7 Feasible

A system option that is feasible ensures an opportunity for success through the following features:

- Is not cost prohibitive
- Currently have, or can realistically attain, required capacity for implementation and ongoing delivery
- Can be implemented in required timeline
- Degree of change required is acceptable given change readiness of all stakeholders

2.4 Office of the Auditor General

In a March 2011 report, the Office of the Auditor General presented findings that were aligned with what we heard from those consulted. Relevant findings presented in the report included:

- Performance agreements with Health and Social Services Authorities are not in place.
- Current funding model does not align with patient flow and therefore does not reflect the needs of each HSSA.
- Management of physician services is not yet occurring at a territorial level.
- Detailed service agreement is not in place between the Department of Human Resources, the Department of Health and Social Services and the Authorities for recruitment and retention of health professionals.
- Lack of system-wide performance indicators and a corresponding program evaluation plan means there is limited information on the performance of the health care system.
- The OAG also reviewed diabetes, home care, long term care, and medical travel and identified concerns regarding:
    - Territory wide program strategies,
    - Relevant program standards,
    - Compliance with standards or guidelines,
    - Consistent program implementation across HSSAs,
    - Protocol to ensure patient records are provided to health care provider, and
    - Measurement and communication of program outputs and outcomes.

2.5 Summary Findings

Table 2: Summary of Findings

Summary Findings	Symptoms
Integrated service delivery model funded and operating in geographic silos	• Blurred roles and responsibilities
	• Territory wide services like physicians and medical travel are not well coordinated
	• Poor case management and limited continuity of care
	• Inconsistent service delivery standards and policies for core services
	• Inconsistent access to territorial and regional level services
	• Challenged to coordinate and control shared administrative services, for example eHealth, medical travel, third party billing, and procurement
	• Inability to move funds between HSSAs based on where services were accessed
Unclear performance expectations, program planning process and inconsistent adherence to policies and program standards	• Limited accountability to Minister of Health and Social Services
	• Inconsistent definition of and funding for core primary, secondary and tertiary level services and programs
	• Inconsistent definition of and funding for additional services and programs through contribution agreements
	• Inconsistent services and programs across the territory

Summary Findings	Symptoms
Limited capacity within communities and recruitment and retention challenges	• Current Boards of Management are not always able to fulfill their mandated role
	• Health and Social Service Authority gaps in MIS/IT, finance and administration management are being filled by department
	• Health and Social Service Authority gaps in funded health professional positions are being filled by other HSSAs
	• Some Health and Social Service Authorities are not able to provide regional level services at all or without the support of other HSSAs
	• Some HSSAs are challenged to do required planning and reporting
	• Inconsistent quality and content in financial and performance reporting between the HSSAs

Meyers Norris Penny considered the system goals and principles defined in the Foundation for Change document, information obtained from consultations, other jurisdiction research (Appendix A), and discussions with the Steering Committee to develop the following lessons learned and summary statements. These were then used to inform the development of system recommendations and design options.

Table 3: Lessons Learned

Lessons Learned
The more recent trends in other jurisdictions like B.C. and P.E.I. have been to decrease health authorities or organizations with the intent to realize efficiencies in service delivery and provide a more seamless, integrated, patient care experience for all residents.
The challenges experienced when health services in P.E.I. were provided by the department reinforced the perspective that pulling authority for service delivery back into the department will move accountability and decision making too far away from the “front lines” and lead to a cumbersome and time consuming decision making process that will likely lean too heavily towards fiscal considerations.
The ability to govern and administer a separate shared services organization that provides services to multiple authorities is still evolving in British Columbia.

Table 4: Summary Statements

Summary Statements
Governance does not need to occur at the community level to ensure relevant and quality service delivery. The current governance model resulted in problems with accountability and standardization, which in turn impacted service delivery. Therefore, changes to the model should isolate problems with accountability, which if dealt with appropriately will allow continued flexibility and increased quality of community service delivery.
Ultimate accountability for health and social services will always remain with the Department.
Appropriate consolidation of transactional functions has potential to resolve issues regarding capacity and capability without unrealistic compromises on quality of function.
Coordinating, collaborating or consolidating delivery and administration of territory wide services can result in efficiencies and better quality of care.
Structure should facilitate an integrated service delivery model and ensure continuum of care. As a result we did not consider options that separated hospitals or acute care administration from primary care.
Structure should recognize capacity limitations and not establish additional positions that require new or increased skills and abilities.
Structure should facilitate increased quality of service delivery at individual, community, regional and territorial levels.
Structure should ensure the sharing of successes at the community, regional and territorial level.

3.0 Recommendations: System

To address the problems outlined in section 2.1 and to improve performance of the system against the performance criteria outlined in section 2.3, recommendations were developed and have been categorized into the following four areas:

5. Financial Management
6. Resourcing
7. Consolidation and Collaboration
8. Accountability

3.1 Financial Management

A financial management system that is operating efficiently is a system that has the ability to implement and manage financial controls, regularly collect and analyze financial data, produce financial reports and ultimately make sound financial decisions. Our consultations with stakeholders and observations identified significant challenges with financial management in the current health system model. Some of these challenges were due to limited capacity and in some cases capability, and others were due to inconsistency in the availability and application of tools and processes. This section provides recommendations in regard to the tools and processes that would be required for improvements to be realized within financial management of the health system.

Problem Summary

Historically, the financial management protocols utilized by the various HSSAs have not provided the DHSS with the ability to monitor HSSA spending in a manner that ensured accountability. HSSA financial performance reporting does not use the same categories as those used by the DHSS and the Finance Board in the Main Estimates or Public Accounts. In addition, each HSSA uses different systems and protocols for financial management and reporting.

The current surplus and retention policy allowed over-funded HAAAs to retain surpluses at the same time under-funded HSSAs posted deficits. The inability to move funds between HSSAs depending on where services were accessed resulted in significant system funding shortfalls for some HSSAs. Surpluses in HSSAs were typically the result of an inability to recruit or retain funded positions, or insufficient need within the HSSA for certain resources. At times this surplus allowed these HSSAs to redirect funds to other programs that were not funded sufficiently on an ongoing basis. The GNWT Finance Board does not allocate funds to specific regions, but to the health system as a whole. This limits the DHSS's ability to request additional funds for those HSSAs in a deficit.

The root causes of these problems are the current surplus and retention policy, the current funding model, inconsistent financial management systems and protocols, unclear reporting requirements and limited capacity of the HSSA's.

Intended Outcome

Clear financial protocols will result in accurate information, presented in a consistent manner that can be used for sound management and governance decisions. In the sections that follow recommendations regarding financial management and a funding model are presented to address these challenges.

3.1.1 Financial Roles

Meyers Norris Penny is recommending a distribution of roles in regard to financial planning, management and performance of the Health and Social Services system as follows. Detail regarding the system levels is provided in subsequent sections of the report.

Table 5: Financial Roles - Proposed

System Levels	Role
GNWT	**Financial Management Board (FMB)**: Is a committee of the Executive Council, which is responsible for the financial planning, management, administration and evaluation of the Government of the Northwest Territories. Their role defined in the *Financial Administration Act* includes: • Accounting and budgeting policies • Public Accounts and Estimates • Controlling and recording financial commitments, assets, liabilities, expenditures and revenues • Evaluating the efficiency, economy and effectiveness of programs • Reviewing annual and long-term expenditure and revenue plans • Any other matter referred to it by Executive Council [1]
	Financial Management Board Secretariat: Provides administrative support for the FMB and has the following responsibilities: • Business planning and budget development • Accounting and financial reporting • Financial systems, controls and monitoring • Information management and strategic information planning • Program design, results measurement and program evaluation • Internal audit • Organizational design
	Minister of Health and Social Services: Is the devolved authority for the health service provision in the Northwest Territories Act and Transfer Agreements with the federal government. Is accountable to the GNWT and the public for the provision of health and social services. Allocates health and social service resources to the HSSA Boards.[2]
HSSA Boards	**Audit, Finance and HR Committee**: On behalf of the board, oversees management's responsibilities for financial reporting. Reviews financial statements and recommends them to the Board for approval and submission to the Minister. Would also review budgets, internal control procedures, and provide advice on auditing and financial reporting issues.[3] Is also responsible for recruitment, evaluation and succession of CEO.
DHSS	**Director Financial and Management Services**: Monitor and evaluate the financial health of the Health and Social Service system. Provides GNWT with operating and capital budgets for system. Reports financial performance to GNWT.
HSSA	**Chief Financial Officer**: Responsible for managing the financial risk of the HSSA through appropriate financial planning, record-keeping, analysis and reporting.
Regional Divisions	**Managers**: Responsible for the development of budgets, accurate financial record-keeping and reporting within their division.

[1] http://www.fin.gov.nt.ca/documents/manuals-handbooks/fmbhandbook.pdf
[2] http://www.hlthss.gov.nt.ca/pdf/manuals/2005/policy/pdf/directives/MINDIRST.pdf
[3] http://www.innovation.ca/en/about-the-cfi/governance/audit-and-finance-committee

3.1.2 Financial Instruments

This section summarizes the required financial instruments that provide the tools for sound financial management. This is not a complete list of all the instruments used by the department or the GNWT, but rather those that were identified as having direct relevance to the HSSAs.

Table 6: Financial Instruments

Financial Instruments	Description
Legislation: Acts and Regulations	Financial rules legislated by GNWT – Financial Administration Act
Financial Policies	Any rules or procedures that guide financial planning, administration, analysis and reporting. These policies may exist at the GNWT, DHSS, Board or HSSA level.
Financial Management Systems	Any systems that store or manipulate financial data including actual transactions, analysis and reports. Currently there are multiple systems being used throughout the health and social services system. Our recommendation is to ensure the systems used are compatible and can provide information in the required categories and format.
Budgets - Regional Budgets - HSSA Budget - DHSS Budget - GNWT Main Estimates	Budgets should align to strategic priorities of GNWT, DHSS and HSSA to allow government, Board and CEO to make statements regarding spending activity, new funding, or redirected funding. Budgets should be detailed at the regional and HSSA levels, but will decrease in detail as they move to the next level of governance. Budget categories should be relevant to all system participants.
Main Estimates	Under direction of the Minister of Finance, the FMB prepares multi-year overviews (Main Estimates) of the projected financial position of the government based on a set of assumptions about revenues, expenditures and federal transfer payments. Main Estimates reflect the GNWT's plan of action regarding anticipated expenditures and revenues for the upcoming fiscal year. They are tabled in the Legislative Assembly by the Minister of Finance. [4]
Ministerial Letter	The Minister of Health sends a letter to each of the Health and Social Services Authority outlining the funding amounts, categories, payment schedule, annual financial reporting requirements and detail on funded active positions.
Accountability Agreement	The Accountability Agreement provides detail on the funding amount, categories, timing, and provides financial direction in the following schedules: • Financial Administration Schedule – Multi-year funding targets – Reallocations (in-year and end of year) – Treatment of surpluses – Balanced budget requirements – Planning for outcomes and fiscal performance (economy, efficiency, effectiveness) – Accounting standards and chart of accounts – Risk management framework – Capital planning • Financial Protocol Schedule (see section 3.1.3)

[4] Main Estimates 2010-11.pdf accessed from http://www.fin.gov.nt.ca/budget-documents/estimates/index.htm

Financial Instruments	Description
Contribution Agreement	Contribution Agreements provide detail on special projects that are funded outside of the accountability agreement.
Service Agreements	Service Agreements with NGOs provide detail on health and social service delivery requirements, and associated funding arrangements and reporting requirements.
Division and HSSA Quarterly and annual Reports	Quarterly and Annual Reports created by HSSA service delivery or administrative divisions that provide detail and analysis on financial performance including identifying any variances and providing explanation, action taken or required future adjustments. These division reports will be consolidated into an HSSA report to be submitted to the Board for review and approval prior to submission to the Minister.
HSSA Audited Financial Statements	The Health and Social Service Authority is responsible for submitting annual audited financial statements to the Minister that have been reviewed and approved by their Board of Directors.
DHSS Annual Report	The Department of Health and Social Services is responsible for submitting an annual report that summarizes the health system program and financial performance.
Public Accounts	The Financial Management Board is responsible for creating Public Accounts that report on GNWT operating expenditures.
Supplementary Appropriations	Any adjustments required to budgets due to funding shortfalls during the fiscal year.

3.1.3 Financial Protocols

Financial protocols are the rules that define the format and transmission of financial information. We have identified various rules that will need to be defined and recommend that they be summarized in a schedule attached to the Accountability Agreement titled, “Financial Protocol”. This schedule should outline rules for the HSSA in the following areas:

Table 7: Financial Protocols

Financial Protocols	Description
Budgeting	Templates that include consistent and relevant revenue and expense categories and detail, required timing and process for budget submission, revisions and approval.
Reporting	Templates, required timing and process for report submission, revision and approval.
Variance Analysis	Definition and expectations regarding variance analysis including an explanation for the variance, any response, action taken or proposed future adjustments.
Surplus and Deficits	Definition and expectations regarding the rules to follow should any deficits or surpluses be identified during a fiscal year.
Reallocations	Definition and expectations regarding the rules to follow should any reallocations be required during the fiscal year.
Audit and Compliance	Process the department and FMB will follow to ensure compliance with performance and financial protocol. This is defined by legislation.
Financial Administration	Defines the process that will be used to consolidate the financial administration back office function. This section of the schedule will likely require updating on an annual basis depending on the progress of planning and implementing this function.
Health Services Administration	Defines process and rules regarding revenue and payment administration and reporting. This would include the establishment of policies and financial protocol for the HSSA in terms of processing Insured Services, Extended Health Benefits, Non-Insured Health Benefits, Health Management Information System, and Medical Travel. Be able to report payment and revenue totals and details by service provider (e.g. Alberta) and service consumer (e.g. Nunavut). Provide quarterly and annual reports on expenses, recoverable, and payables related to transfer payments. Define process and rules regarding how third party revenue will be managed and reported.

Financial Management Recommendations:

- Ensure financial management roles are well defined and understood
- Ensure financial instruments are well defined and understood
- Ensure financial protocols are well defined and understood
- Ensure financial systems are compatible and able to present information in the required categories and format

3.2 Resourcing

System resourcing is the process and protocol to ensure adequate funding for leadership, administration and delivery of quality and safe health and social services. Challenges with appropriate system resourcing decisions and processes were identified. This section provides recommendations on system resourcing.

Problem Summary

A right-funded health system depends on a clear description of mandated health services and programs and a complete understanding of the associated costs to meet performance standards. At present, the health and social services system does not have clearly articulated mandated programs and services nor the associated performance standards and expected costs for these programs and services.

Intended Outcome

The intended outcome is a funding model that ensures the provision of quality and safe services that are aligned with system priorities and population needs.

3.2.1 Current Funding and Reporting Categories

Table 8: Current Main Estimates and Public Accounts Categories:

Categories	Description
Program Delivery Support	Providing a system-wide focus and delivery assistance including technology, support services and health professional recruitment and retention programs. Includes the Health Service Administration Division, the Public Health Division, and the Primary care division.
Health Services Programs	Providing inpatient and outpatient services, public health and chronic care. Includes hospital services, NWT health centres, physician services and funding for medical equipment.
Supplementary Health Programs	Providing benefit programs to eligible residents. Includes programs such as Indigent Health Benefits, Métis Health Benefits, Extended Health Benefits and Medical Travel Benefits.
Community Health Programs	Providing services outside health facilities. Includes institutional care, assisted living, counseling, and intervention and health promotion.
Directorate	Providing leadership and direction to the Department and administrative services for Departmental operations. Includes the Policy Division and Financial services.
Lease Commitments	Infrastructure commitments within HSSAs.
Work Performed on Behalf of Others	Providing services on behalf of others for specific projects or initiatives. Includes federally funded non-insured health benefits and federally funded programs and initiatives.

Table 9 outlines the budgeted Revenue and Expense categories in the annual letter from the Minister to each HSSA.

Table 9: Current HHSS Budget Revenue and Expense Categories

Revenue Categories	Expense Categories
Core Funding Program Delivery Support Health Services Programs Supplementary Health Programs Community Health Programs Other sources of revenue	Expenses Administrative and Support Services Nursing Inpatient / Resident Services Ambulatory Care Services Diagnostic and Therapeutic Services Community Health Services Community Social Services Undistributed

Each HSSA develops a budget using very different categories and does not report in categories consistent with how they are funded. For example, Table 10 outlines the expenditure categories and divisions for the Yellowknife HSSA.

Table 10: Example of HSSA Budget Revenue and Expense Categories

Budget Revenue Categories	Budget Expense Categories Divisions
DHSS – Operating Contribution DHSS – Special Purpose Contribution Other Third Party Contributions Patient / Client Services Revenue Physician Recoveries Other Recoveries / Donations	Compensation Management and Operations Unit Producing Front Line Workers Physicians Employed Purchased Professional Services Supplies Sundry Foster Care Advertising, Insurance, Rent Equipment Referred and Contracted Out Services Buildings and Grounds
Actual Expenditure Categories	**Actual Expenditure Divisions**
Salary and Benefits Physician Compensation Non-government Organizations Foster Care Other Operation Expenses	Administration Clinic Services Community Health Community Social Programs

3.2.2 Funding Model

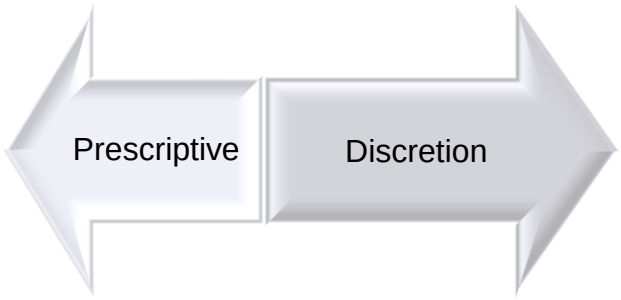
The decision to fund by block or by defined core service areas depends on whether the government needs to be prescriptive with funding allocations to ensure appropriate distribution of funds to service areas. Consideration also needs to be given to how funds are allocated by the Financial Management Board and what accountability or reporting is required to confirm how funds were actually spent. The amount of discretion provided is dependent on who has the required capacity and capability to make good decisions as well as the risk tolerance of those accountable.

Significant effort has been put towards development of the Integrated Service Delivery Model (ISDM), which provides categories of programs and services within which service delivery levels are defined. This can provide a starting point to develop standards, performance indicators and associated funding allocations for mandated programs and services. It is our opinion that a system funding model should be defined by core service areas and aligned with the ISDM. Consultations confirm that the department and HSSAs have accepted and are using the ISDM as a guide for health and social service delivery. Formal approval and sanction should be provided on an updated ISDM that includes an implementation framework. Therefore, rather than recommending a different nomenclature for funded programs and services we recommend using the existing terminology from the ISDM. The budgeting and financial reporting categories chosen should also be meaningful in that they are consistent with requirements for territorial reporting and/or national reporting categories.

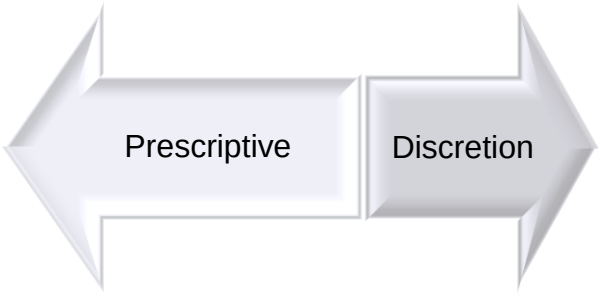
Table 11: Proposed Budgeting Categories based on ISDM Terminology

Main Categories	Sub Categories
Department Supports and Administration	• Directorate • Program Delivery Support
HSSA Administration	• Board • Finance • Corporate Services • Human Resources • Information Systems • Minor Capital
Diagnostic & Curative	• Primary Services and Programs • Secondary Services and Programs • Territorial Services and Programs
Rehabilitation Services	
Protection Services	
Continuing Care Services	
Promotion and Prevention	
Mental Health and Addictions	
Supplementary Health Programs	• Indigent Health Benefits • Métis Health Benefits • Extended Health Benefits • Medical Travel Benefits
Special Projects and Contribution Agreements	• HSSA Administration • Research and Development • Primary Services and Programs • Secondary Services and Programs • Territorial Services and Programs • Consolidated Back Office functions • Third-Party Revenue

All funds required for operations, administration and leadership should be considered including costs such as employee leave and termination benefits and backfill for vacant positions. These types of costs can be estimated based on previous year's experience and on expectations for future years given age, demographics and average retention.



Use of funds at the community level for primary level services should allow a level of discretion to provide flexibility and ensure relevant services.



Use of funds for secondary and tertiary services should be more prescriptive to ensure consistent and appropriate access.

To provide the opportunity for flexibility and innovation, a category of funds should be set aside for special projects to meet specific administrative, territorial, regional or community health or social service needs that do not fall within the funded ISDM categories. The criteria for accessing these special project funds would ensure that these projects are intended to meet a short term need with a defined end date. Should the need become ongoing, they would then be funded as a core service.

System Funding Recommendations:

- Formally sanction ISDM and use ISDM categories for funded core programs and services to budget and report spending at territorial level
- Ensure reporting can easily be transferred to required categories for Public Accounts
- Ensure all costs for service delivery, administration and leadership are funded
- Should approved budgets not meet all costs, it is the responsibility of the GNWT and the Minister (under advisement from the HSSA) to make decisions regarding funding cuts
- Capital funding should remain within government control
- Financial protocol and compliance mechanisms to ensure operating surplus retention, reporting and variance analysis requirements are clearly defined and enforced
- All core programs and services should be defined in the Accountability Agreement
- Additional special projects should be funded through separate Contribution Agreements and summarized in the Accountability Agreement. Contribution Agreements should outline goals and objectives, inputs, outputs/activities, expected outcomes, end dates and reporting requirements
- Use of funds at primary level should have more discretion than those at secondary or tertiary levels

3.3 Consolidation and Collaboration

An objective of this project was to identify opportunities for system linkage including consolidation of back office functions. Three categories of opportunities for collaboration (between more than one entity) or consolidation (into one organization) were identified

1. **System collaboration**: develop shared vision and build interdependent system
2. **Back office consolidation:** combine management and delivery of business support functions
3. **Clinical support consolidation:** combine management and delivery of clinical support functions

Each consolidation opportunity example identified will require more investigation before implementation to:

- More specifically define the problem and understand the opportunity,
- Design the consolidated function,
- Determine the implementation requirements, and
- Determine the potential impacts.

3.3.1 Opportunities

The stages of collaboration[5] and options for consolidation were used as the basis for considering opportunities for system integration.

Table 12: Stages of Consolidation through to Communication

Opportunity	Description	Potential Areas
Consolidate Combine business and management functions between HSSAs	Move similar functions out of individual organizations and have service provided by only one organization. Overall goal is **to remove duplication of efforts and address capacity, recruitment and retention issues.** Consolidated services can be provided in four general ways: • Shared Service – consolidated services are delivered by a new, jointly managed, organization • Managed Service – consolidated services are delivered by one of the existing organizations through a formal joint services agreement • Shared Leadership – organizations continue to deliver own services but operate under shared leadership that provides planning and coordination • Outsource – contract with a separate organization to deliver back office service for all organizations	• Physician services • Case management • Human Resources • Fleet management • Financial processing • MIS, IT and IM • System and technical support • eHealth • Telehealth • Procurement and equipment purchasing • Labs and diagnostic services • Pharmaceuticals • Medical travel administration, medivac and escorts • Legal support
Collaborate	Entities have engaged in shared planning and decision making that is taken seriously in the business decisions	• Ongoing ISDM development and

[5] Source: adapted from Gray, 1985

Opportunity	Description	Potential Areas
Develop shared vision and build interdependent system between HSSAs and the DHSS	of each entity – such that each entity is willing to change its practices to achieve a shared goal. DHSS and HSSAs are vested in the collaborative – rather than in individual entities. Examples include joint strategic planning process to develop and implement initiatives that pursue shared goals. Overall goal is to **develop system goals and priorities that are relevant and can be realistically implemented within an interdependent system.**	implementation • Service delivery policies • Program standards • System needs analysis • Community input and feedback • Strategic and business planning • Measurement and reporting • Quality assurance • Risk management •
Coordinate Limit duplication of services through coordination of service delivery	Entities have committed to sharing resources in order to accomplish shared goals, and have implemented activities that depend upon these shared resources. However, the entities are not changing their core business or sharing decision making outside the area of coordination. Overall goal is **to coordinate individual efforts thereby ensuring the needs of the population are met efficiently and effectively.**	• Aboriginal Self Government • GNWT community wellness initiatives in all departments • GNWT shared services • FNIHB
Cooperate Discover shared interests and work together	Entities have established policies and practices that involve ongoing exchange of information integrated into routine practice/business. They negotiate mutual roles and share resources to achieve joint goals. Their common characteristics are shared interests, joint decision making and integration of efforts. Examples include sharing hospital policies to reduce duplication of effort. Overall goal is to **work together to discover and address shared interest and concerns.**	• Community leadership • Community organizations • Professional associations • Other provincial and national health agencies and bodies (e.g. Canadian Institute for Health Information), or government • Other jurisdictions
Communicate Have dialogue and common understanding	Entities have established mechanisms for communicating with other entities or individuals. Communication can be one-way or two-way, using either formal or informal mechanisms. Examples include newsletters, radio programs, posters, and community forums. Overall goal is to **create awareness and understanding.**	• Community members • Special interest groups

Table 13: Summary of Recommendations for System Collaboration, Clinical Support Consolidation and Back Office Consolidation

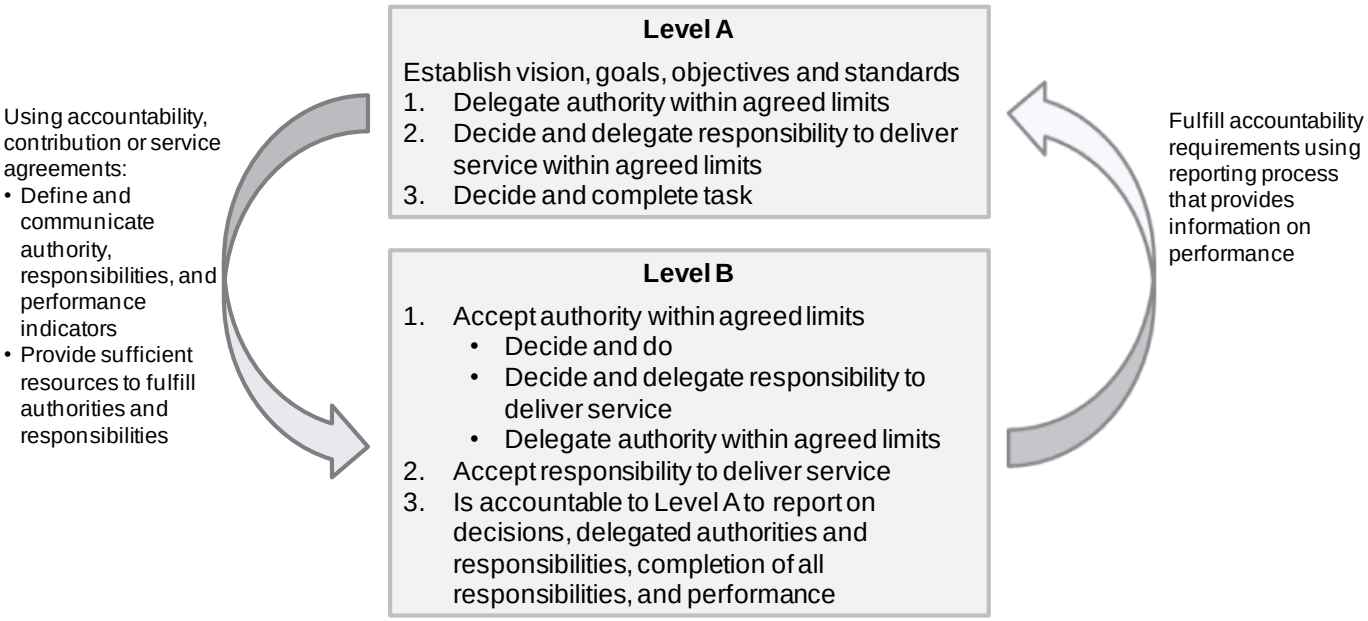
	System Collaboration Recommendations	Clinical Support Consolidation Recommendations	Back Office Consolidation Recommendations
Purpose	Develop system goals and priorities that are relevant and can be realistically implemented	Remove duplication of effort and ensure "right service, right place right time" - Successful Integrated Service Delivery Model Implementation	Remove duplication of efforts and address capacity, recruitment and retention issues
Potential Benefits	• Improved leadership • Improved direction • Improved planning and reporting • Improved standards and policies	• Improved quality assurance and risk management • Improved equity in system resourcing • Improved accountability and sustainability • Improved ability to provide seamless service delivery	• Improved consistency through a standardized approach • Improved quality through use of best practices in process and technology • Improved efficiency through reduced duplication of efforts and reassignment of resources to value add activities • Improved sustainability through reduced requirement for functional expertise capacity
Potential Concern	• The ability to ensure required communication, cooperation, trust and accountability to truly collaborate	• Having appropriate structure, authority, accountability and capacity to achieve system coordination and collaboration	• Previous bad experience with design and implementation process – change management • Loss of positions in communities • Loss of control in communities • Increased time to process requests

Opportunity Examples	• Ongoing ISDM development and implementation
	• Service delivery policies
	• Program standards
	• System needs analysis
	• Community input and feedback
	• Strategic and business planning
	• Measurement and reporting
	• Quality assurance
	• Risk management
		• Physician services
		• Pharmaceuticals
		• Labs and diagnostic services
		• Continuity of care: case management, bed management, wait lists, territorial admissions and placements
		• Medical travel administration, medivac and escorts
			• Fleet management
			• Human Resources
			• Financial processing
			• MIS, IT and IM
			• System and technical support
			  – eHealth
			  – Telehealth
			• Procurement and equipment purchasing
			• Legal support

3.4 Accountability

In the current health system model, the Minister of the Department of Health and Social Services has delegated authority to the eight (8) Health and Social Service Authorities (HSSAs) in NWT. The act of giving authority for decision making and delegating responsibilities creates a need to report on the resulting decisions, activities and performance. This section provides recommendations on tools and processes to ensure system accountability.

Figure 1: Accountability



Clear roles and responsibilities are critical to understanding the authority you possess, your position in the system, the decisions you need to make and the responsibilities you need to fulfill. In addition, clear communication regarding the limits or boundaries of authority, expectations or performance indicators and the mechanisms for accountability are required.

Problem Summary

Unclear or unacknowledged authority, unclear roles and responsibilities, and unclear expectations or performance indicators have resulted in poor or inconsistent reporting and as a result limited accountability.

Intended Outcome

A clear accountability framework articulates appropriate direction, performance management and reporting requirements on outputs and outcomes. A framework allows for a comparison of actual system performance against established performance standards.

The sections that follow outline a recommended accountability framework including:

- The limits to authority.
- Balancing responsiveness with accountability.
- Roles and responsibilities.
- An accountability structure.

- A decision matrix to define who is accountable, responsible, consulted, informed and provides support for specific areas of decision making.
- Instruments or tools for accountability.
- Current gaps in the framework

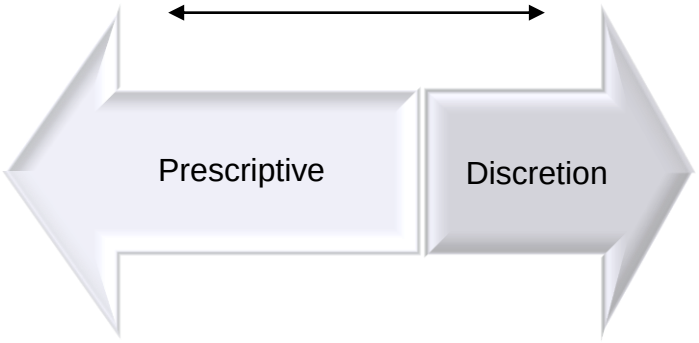
3.4.1 Limits to Authority

There is a need to define the philosophy of the health system in terms of where the line falls between prescribed and discretionary health system management and service delivery. The amount of authority delegated to the HSSAs must be defined clearly with boundaries and limits to the type and amount of discretion they have, or do not have, in decision making. The amount of discretion provided is dependent on who has the required capacity and capability to make good decisions as well as the risk tolerance of those accountable. If a health system leans towards being prescriptive, then it will also need to define who has the authority to prescribe and how those decisions will be made.

Our recommendation would be to provide limits and boundaries to authority and responsibilities but ensure the system is not too prescriptive and allows for creativity and innovation. For example, the setting of standards by defining the actual process would be too prescriptive whereas setting standards regarding outputs and outcomes allows for flexibility in process.

The limits and boundaries to delegated authority need to be set in legislation. The performance expectations attached to responsibilities and the resulting accountability need to be defined in program standards, policies and what we have called Accountability Agreements between the Minister and the HSSAs. Authorities and responsibilities for the recommended model are outlined in the sections that follow.

Figure 2: Prescriptive vs. Discretion



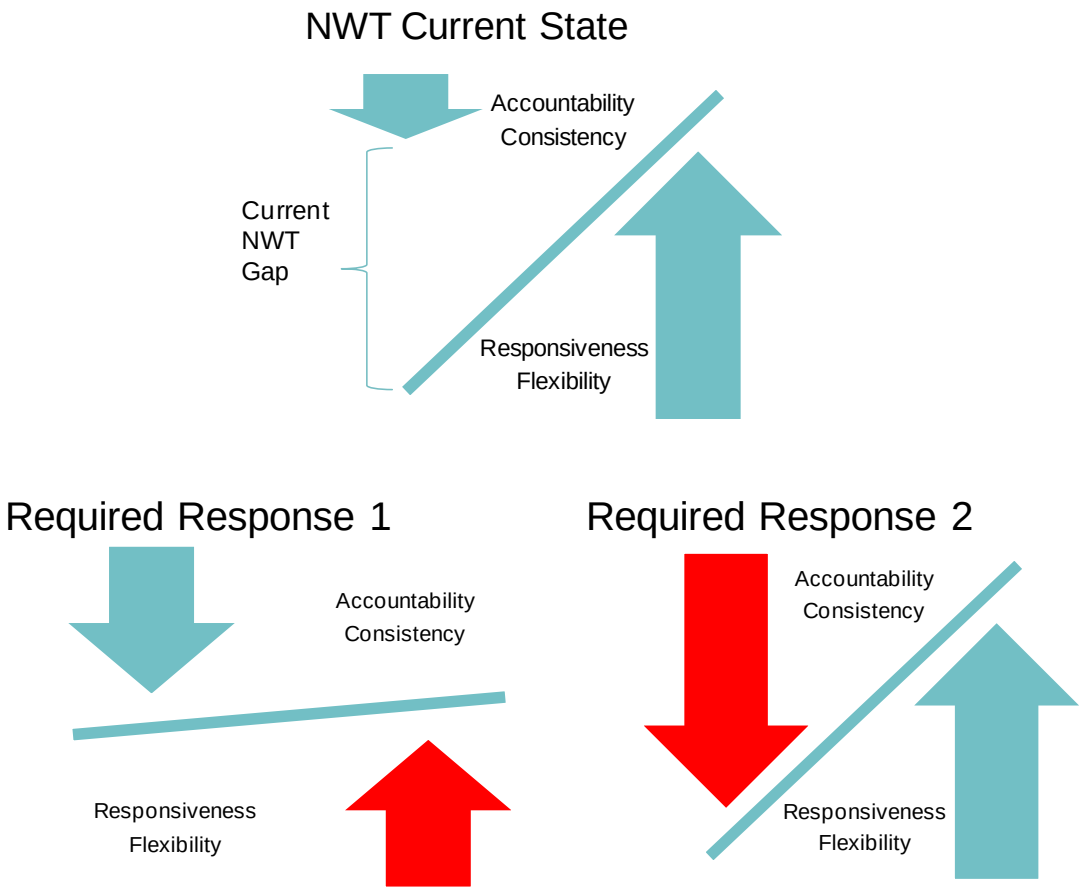
3.4.2 Balancing Responsiveness with Accountability

Health systems are constantly striving for a balance between accountability and responsiveness. Increased responsiveness and flexibility requires greater accountability through mechanisms or instruments that ensure consistent service delivery standards.

If a system provides increased responsiveness and flexibility without mechanisms for consistency (standards and compliance) and accountability (measurement and reporting) then there is a natural and required response to reduce flexibility or increase accountability to regain balance.

When a system finds itself in a state of imbalance like that illustrated in the graphic “NWT Current State”, the required initial response (Response 1) is to reduce flexibility until such a time that strong service delivery standards and compliance mechanisms can be developed and implemented. (Response 2)

Figure 3: Balancing Responsiveness with Accountability



3.4.3 Key Roles and Responsibilities

Key roles and responsibilities for system participants need to be clearly defined, communicated and understood to ensure a viable and sustainable system. Table 14 outlines the key roles and responsibilities of the GNWT, Department of HSS, a Governance Board and HSSAs. Instruments used to define roles and responsibilities are further defined in Table 18 Accountability Instruments and Table 32 Governance Instruments.

Table 14: Key Roles and Responsibilities

Role	Responsibility	Instruments
Government of NWT		
Define the boundaries of authority given to DHSS and HSSAs		- Legislation: acts and regulation
Approve budget and provide sufficient funds		- Finance Board - Main Estimates
Establish legislative priorities for NWT		- Cabinet and Standing Committee
Deliver some back office consolidation functions through departments		- Service agreements
Department of Health and Social Services		
Provide System Direction	Ensure NWT adheres to principles of accessibility, universality, portability, comprehensiveness and public administration	- Canada Health Act
	Understand, measure and report the health status of NWT residents	- Health Status Report
	Set Health and Social System direction and territorial priorities for health and social services	- System Strategic Plan
	Recommend budget to Financial Management Board	- Funding Model
	Establish appropriate funding model and ensure fiscal accountability	- Funding Model
	Establish, maintain and communicate Health and Social Services regulations, acts, standards, policies and directives	- Program Standards - Department Policies - Ministerial Directives
Support and Compliance	Define the programs, services, infrastructure, access, quality and relevance of health and social services	- DHSS Business Plan and Action Plan - ISDM
	Provide services regarding vital statistics, registration of health care, insured services, extended health benefits, and non-insured health benefits.	- Health Services Administration

Role	Responsibility	Instruments
	Establish expectations of HSSAs • Define limits and boundaries to authority and responsibility assigned to the HSSAs • Define service delivery requirements – insured services and benefits • Define performance requirements, indicators and reporting requirements	- Accountability Agreement
	Ensure compliance with authority and associated responsibilities through reporting process	- Annual DHSS performance and variance reports - Audited DHSS financial statements
System Collaboration	Maintain and build intergovernmental linkages	- Committees - Task Forces
	Communicate to and engage with system stakeholders	- Community level forums - Community Health Services Satisfaction Reports
	Support and collaborate with the NWT HSSA	- JSMC, JLC
	Redirect issues or complaints	- Patient concerns resolution process
Health and Social Service Authority Board		
Accountability	Promote ethical and responsible decision making by establishing a code of conduct and defining organizational values	- Board Charter and by-laws
	Safeguard integrity in financial reporting by having the capacity to understand financial information, hiring reputable external auditors and establishing an audit committee function	- Financial Administrations Act - Governance Terms of Reference and Policies - Audited financial reports
	Ensure timely and balanced disclosures by having a relevant communication structure as defined by any regulatory requirements with a balance between good news and bad	- Board Charter - Quarterly and annual performance and variance reports
	Understand and respect the rights and needs of stakeholders by establishing communication policies, publishing annual reports and other communications to stakeholders	- Community Level Forums - Quarterly and annual performance and variance reports
Stewardship	Establish responsibilities of board and management by establishing governance policies, defining CEO, Chair and board member job descriptions, and defining committee structures and mandates	- Board Charter - Position descriptions - Terms of Reference - Policies and By-laws

Role	Responsibility	Instruments
	Ensure CEO competence, performance and succession	- Position Description - Policies and By-laws
	Provide direction through the development of a strategic plan that is aligned with the GNWT priorities for health	- HSSA Strategic Plan
	Understand risk and risk management by identifying the risks, understanding potential risks, and understanding management's risk identification and mitigation plans	- Risk Management Plan - Terms of Reference
	Relationship management with CEO, Minister and Stakeholders	- JLC and JSMC - Community level forums
Performance and Effectiveness	Ensure an effective and transparent appointment process that ensures: • Regional and cultural representation • Health and social service sector experts • Functional experts (strategy, operations, finance, communication, HR)	- Board Charter - Policies and By-laws
	Add value through an effective board chair who ensures positive dynamics at the board table	- Position Description - Policies and By-laws
	Add value by measuring individual board members, board as a whole and board chair	- Position Description - Policies and By-laws
	Add value by ensuring a positive board and organization culture • Board orientation, development and training • Board assessment • Recommendation to Government regarding succession of board members	- Board Charter - Terms of Reference - Policies and By-laws
Health and Social Service Authority		
Overall direction and planning	Gather public and other stakeholder input	- Community level forums
	Assess health status and health needs of population	- Community level forums - Health status monitoring
	Define vision, mission and values for HSSA	- HSSA Strategic Plan
	Determine health and social services priorities within priorities and standards set by DHSS	- HSSA Strategic Plan
	Define strategic priorities, key expectations and associated performance measures	- HSSA Strategic Plan
	Define, implement and review organizational policies and by-laws	- HSSA Policies and By-laws
	Comply with acts, regulations, territorial policies and ministerial directives	- HSSA Strategic Plan
Relationship management	Between Board and Minister of Health and Social Services	- Joint Leadership Committee
	Between Department (DM, ADM and department directors) and HSSA (CEO and management)	- JSMC, committees, task forces

Role	Responsibility	Instruments
	With regions, communities and NWT residents Community relations function Approach will be different within each region or even community depending on context	- Community level forums ○ Print and Radio, etc - Patient concerns resolution process
	With other stakeholders (professional associations, NGOs, special interest groups)	- Working Groups - Committees
Service delivery integration	ISDM implementation through Regional Delivery Centres	- HSSA Policies - HSSA Business Plan / Action Plans - Task Force
	Medical Officer of Health, hospital privileges, medical staff bylaws	- Policies and By-laws - Committee
	Define, implement and review clinical service delivery standards	- Policies and By-laws - Task Force
	Contractual arrangements with NGOs for service delivery	- Service agreements
	Medical travel coordination and administration	- HSSA Policies - Committee
Fiscal management	Establish fiscal policies and internal controls	- Financial policies and by-laws
	Budget, allocate and report financial resources for service delivery to regional delivery centres and departments	- Budgets/projections
	Review fiscal performance and variance reports quarterly and take required action	- Quarterly and annual HSSA performance and variance reports - Audited annual HSSA financial statements
Risk management and Quality Assurance	Define, implement and support a risk management process	- Identify, mitigate, manage and report risk
	Address concerns from NWT residents or through Department	- Patient concern resolution process

Performance management	Monitor, evaluate and report delivery of quality health and social services	- Quarterly and annual performance and variance reports
		  ○ Performance indicators
		  ○ Measurement tools

	Respond to compliance and performance concerns	- Quarterly and annual performance and variance reports
Clinical support consolidation	Physician services	- Committee
	Pharmaceuticals	- Task Force
	Labs and diagnostic services	- Task Force
	Continuity of care: case management, bed management, wait lists, territorial admissions and placements	- Committees
	Medical travel coordination, administration, medivac and escorts	- Committee

Role	Responsibility	Instruments
Back office consolidation	Fleet management	- Task Force
	Human resources – planning, recruitment, retention, professional development, succession	- Committee
	Financial processing	- Task Force
	MIS, IT, IM – system and technical support, eHealth and Telehealth	- Task Force - Committees
	Procurement and equipment purchasing	- Task Force
	Legal support	- Task Force

The previous table provides a detailed summary of the roles, responsibilities and instruments for accountability. Table 15 below further defines the authority relative to each system participant and provides a summary of responsibility and methods for communication.

Table 15: Summary of Roles, Authority, Responsibilities and the Methods for Communication.

Role	Authority	Responsibility	Methods
GNWT Provide overall direction & support	Within limits, decides on and delivers: • Policies, strategic priorities and goals Within limits, delegates authority to DHSS • Health and social services	• Define policies, strategic priorities and goals • Define delegated authority • Provide sufficient resources to DHSS to fulfill authority and responsibilities • Deliver some back office consolidation	• Acts and Regulations
DHSS Provide direction & implementation support	Within limits, decides and delivers: • Strategic priorities and service delivery standards Within limits, decides and delegates responsibility to deliver: • Services and programs Within limits, delegates authority for: • Back office consolidation • Clinical collaboration	• Define strategic priorities for health system • Define core services and programs standards, performance indicators, and ensure compliance • Define delegated authority and responsibilities • Provide sufficient resources to divisions of DHSS and NWT HSSA to fulfill delegated authority and responsibilities • Coordinate efforts with other GNWT departments	• Special Ministerial Task Forces • Strategic Plan • Accountability Agreement with NWT HSSA • Joint Senior Management Committee • Joint Leadership Committee
HSSA Implementation	Within limits, decides and delivers: • Services and programs • Clinical standards Within limits, decides and delegates responsibility to deliver: • Back office consolidation • Clinical collaboration	• Define vision, mission and values for HSSA • Define decisions made • Define and deliver system integration • Deliver defined tertiary services to residents of territory • Deliver assigned secondary services to residents of region and territory • Deliver assigned primary services to residents of region • Deliver assigned clinical coordination, back office consolidation, or clinical support consolidation • Gather input and feedback from communities	• Board committees • Strategic and Business plans with financial forecasts/budgets • Accountability/Contribution/ Service agreements with GNWT and NGOs as required • Business and action plans with financial forecasts/budgets • Hospital accreditation process • Community level forums

3.4.4 Accountability Structure

The act of delegating authority to make decisions or delegating responsibility "to do" implies a level of accountability to report. This section provides a summary of accountability "to report" what information, to who, in what formats, and at what times.

Table 16: Accountability Summary

Role	Accountability	To who	In what format	Timing
GNWT Provide overall direction & support	• Report on GNWT direction • Report on authority delegated • Report on direction and resources provided • Report on GNWT performance	• Residents of NWT • DHSS	• GNWT Political Agenda	• Three years
			• Main estimates	• Annually
			• Public accounts	• Annually
DHSS Provide HSS direction & implementation support	• Report on system needs and issues – context and relevance • Report on decisions made regarding strategic direction to NWT HSSA – design and delivery • Report on decisions made regarding strategic projects for DHSS – design and delivery • Report on completion and performance of responsibilities - outputs • Report on health status – impact and effects • Report on health and social system performance – impact and effects	• GNWT • HSSA	• H&SS System Strategic Plan	• Three years
		• DHSS	• Department Business/Action Plan	• Annually
		• GNWT • Residents of NWT	• Health status reports	• Periodic
			• Summary performance, variance and financial report	• Quarterly
			• Detailed performance, variance and financial report	• Annually
HSSA Implementation and back office	• Report on direction and decisions regarding results to be achieved – context and relevance • Report on actions to be taken by whom	• HSSA	• HSSA Strategic Plan	• Three years
		• Delivery Centres	• HSSA Business Plan/Action Plan with projections	• Annually

Recommendations: System

Role	Accountability	To who	In what format	Timing
	and associated costs and performance targets – design and delivery • Report on delegation, and completion and performance of responsibilities - outputs • Report on impact and effects • Report on actions to be taken by whom and associated costs and performance targets – design and delivery • Report on completion and performance of responsibilities - outputs • Report on impacts and effects	• HSSA Board • DHSS • Minister	• Summary performance, variance and financial report	• Quarterly
			• Detailed performance, variance and financial report including audited financial statements	• Annually
			• Service Delivery Action Plan with associated budget	• Annually
			• Summary performance, variance and financial reports	• Quarterly
			• Detailed performance, variance and financial reports	• Annually

3.4.5 Decision Matrix

This decision matrix is a categorical listing of key decisions that are commonly required to administer and operate an integrated health system. To ensure that accountability and responsibility are clearly understood we have identified who is accountable for the decision (A), who is responsible for the decision (R), who provides support to the decision maker (S), who is consulted prior to the decision (C), and who is informed once the decision is made (I).

Table 17: Decision Matrix

Decisions	Department of H&SS		HSSA	
	Minister	Department	Administration	Service Centres
Governance and Direction				
System priorities	A	R, S	C, I	
System funding	A	R, S	C, I	
Program standards	A	R, S	C, I	
System policies	A	R	C,I	
Strategic system direction	A	R	C, I	
Management and Operations				
Business and action plans	A	S	R	C, I
Clinical standards	A	S	R	C, I
Delivery policies and by-laws	A	S	R	C, I
Public Health and Public Guardian	A	R	C,I	C,I
Service delivery staffing and spending	A	S	S	R
Administrative staffing and spending	A	S	R	C, I
Capital planning	A	R	C,I	C, I
Non-capital facilities on-going maintenance	A	I	R	C, I
Procurement	A	I	R	C, I

R = Responsible for making decision
A = Accountable for making decision
S = Supports decision making
C = Consulted prior to making decision
I = Informed post decision

3.4.6 Accountability Instruments

Accountability instruments outlined in Table 18 will help to ensure successful implementation of the recommended system structure.

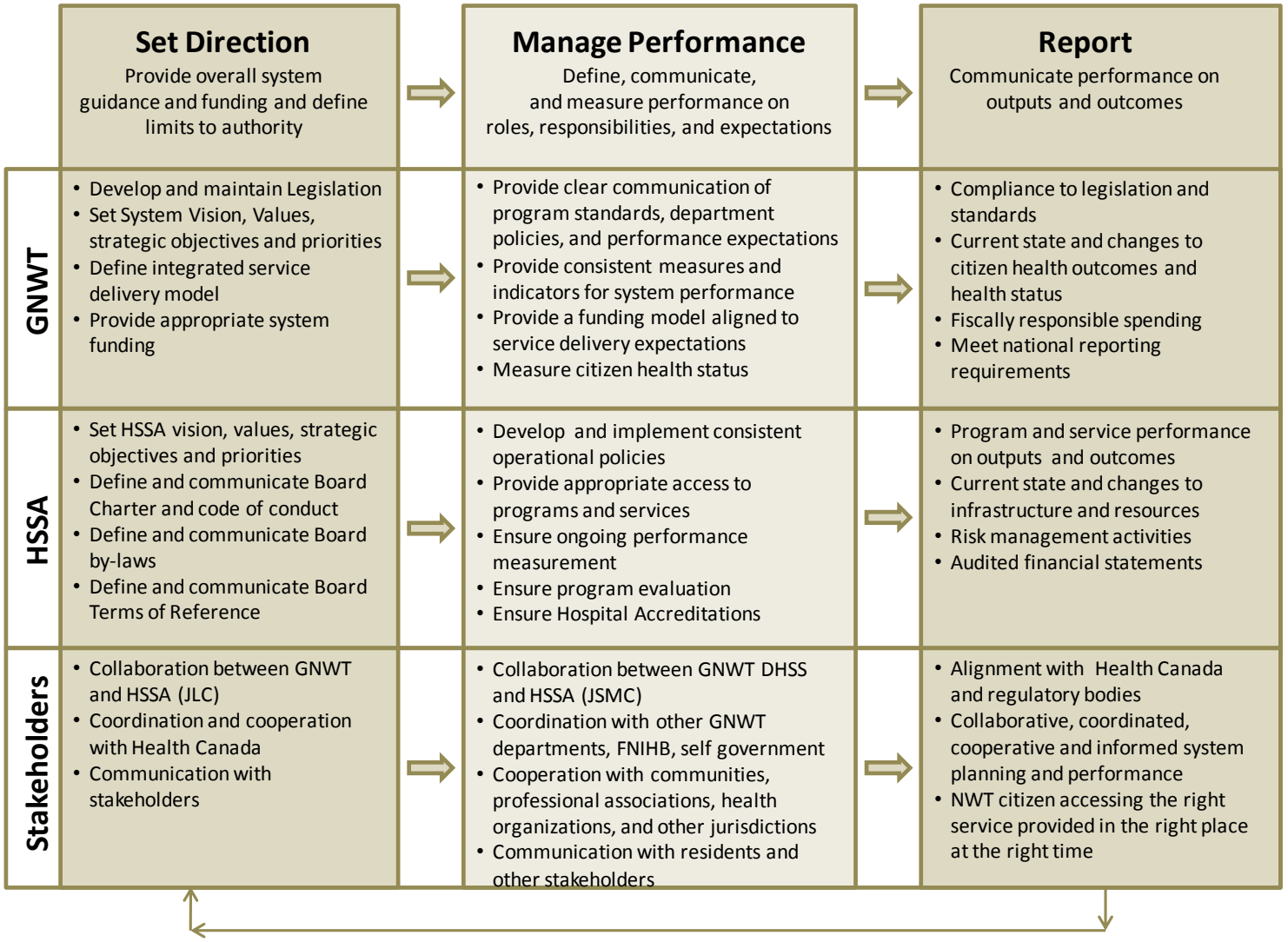
Table 18: Accountability Instruments

Role	Instrument	Description
Communicate Roles, Responsibilities and Expectations		
Department of H&SS	Ministerial Directives	Provides direction to DHSS and HSSAs regarding performance expectations on special events or emerging issues. Should a special event or an emerging issue become a permanent situation then policies or standards will need to be developed or updated
	Program Standards	Provides direction to DHSS and HSSAs regarding program performance expectations on permanent programs
	Department Policies	Provides direction to DHSS and HSSAs regarding general performance expectations on a specific situation
	System Strategic Plan	Based on Budget Address, Legislation and Main Estimates – outlines current state, vision, mission, values and system strategic priorities
	Department Business Plan	Based on System Strategic Plan – outlines department structure, services, communication strategy, operational requirements and associated departmental projections
	Department Action Plan	Based on Department Business Plans - details projects and required actions with associated outcomes, responsibilities, timelines and required resources
	Accountability Agreement with HSSA	An agreement between the DHSS and the HSSA outlining authority, roles, responsibilities, performance expectations, accountability and funding
	Joint Leadership Committee	Collaboration or cooperation mechanism between DHSS Deputy Minister and HSSA Board Chairs
	Joint Senior Management Committee	Collaboration or cooperation mechanism between DHSS Assistant Deputy Minister and HSSA CEOs
	Committees or working groups	Cooperation mechanism between GNWT departments, agencies (including HSSAs) and outside organizations
	Task Forces	Change mechanism to examine specific areas of opportunity or concern and make recommendations
H&SS Authority	HSSA Strategic Plan	Provides direction to HSSA regarding vision, mission, values and strategic priorities
	HSSA Business Plan with budgets or projections	Provides direction to HSSA regarding structure, services, communications, operations, resource requirements (people, financial and infrastructure) and associated performance indicators
	HSSA Action Plans	Projects and activities associated with strategic and business plan that outline expected outcomes, responsibilities, timelines

Role	Instrument	Description
		and required resources
	Terms of Reference	Provides a description of authority, roles and responsibilities for board committees
	Position Description	Provides a description of authority, roles and responsibilities for board chair, board members, and CEO
	Operational Policies	Provides direction to HSSA regarding operations
	Clinical Standards	Provides direction to clinicians regarding standards of care
	Contribution Agreements	Provides direction to NGOs and other GNWT departments regarding contracted service delivery, roles, responsibilities, performance expectations, accountability and funding
Communicate Performance and Variance to Expectations		
Government of NWT	Public Accounts	Consolidated financial statements for all departments within the GNWT
Department of H&SS	NWT Health Status Reports	Published every five years, it provides a measure of NWT population's health and well being
	Annual DHSS Performance and Variance Report and Audited Financial Statements	Published annually to provide a snapshot of the health and social services system performance against goals and summary of expenditures
	Community Health Services Satisfaction Reports	Report most recently published in 2009 based on satisfaction questionnaires distributed during 2008
	Patient Concern Resolution Process	Defined process in collaboration with the HSSA to examine and address patient concerns
	Community Level Forums	Communication mechanism between community and DHSS and/or HSSA
H&SS Authority	Quarterly and Annual HSSA Performance and Variance Reports	Provides a measure of system performance and how it compares to expectations including risk management update
	Annual Audited HSSA Financial Statements	Provides a measure of system financial performance and how it compares to expectations

3.4.7 Accountability Framework

An accountability framework provides a visual representation of health system management roles, responsibilities, performance expectations, and reporting measures. A recommended framework was developed and is presented below.



3.4.8 Gaps in Framework

In our opinion, the current health system framework does not ensure sufficient accountability and has inadequate controls. This is due to a number of factors:

- The DHSS has defined core programs in the Integrated Service Delivery Model. However we came to understand that the ISDM has not been formally sanctioned and does not provide a clear understanding of required infrastructure and access points within the NWT. This is required to communicate clear expectations and provide associated funding for service delivery within each of the HSSAs to ensure system wide health and social services that meet the needs of the population.
- The DHSS has not specifically defined or communicated consistent program standards and associated performance indicators to measure outputs or outcomes of funded programs and services. This is required to communicate consistent system and program performance expectations, measures and indicators within an Accountability Agreement. This will ensure HSSA reports provide the data and information required to communicate HSSA performance and as a result system performance.
- The DHSS does not have adequate capacity to provide feedback to, or follow up with, eight HSSAs regarding the required content or timeliness of HSSA annual reports or financial reports. This is required to understand HSSA and system performance and ensure compliance.
- The HSSAs have limited capacity (human resources and information systems) to measure and report on program and service delivery performance indicators. This is required to understand system performance.

This section provides direction to address gaps that have been identified in the framework.

ISDM Implementation

The ISDM requires formal sanctioning in order to realize its full benefits as a guiding document for the system. Access points should be defined for the primary, secondary and territorial services indentified within the ISDM along with the required infrastructure and resources. This is required to support a funding model and define service and program delivery expectations for each HSSA.

Program Standards

Program Standards have not been defined for all HSS programs. In addition, some that have been defined are not always relevant for NWT delivery. Program standards are required to communicate performance expectations and associated performance indicators to HSSAs.

System and Program Performance Indicators

To understand HSSA and system performance, consistent system and program performance indicators must be developed. Data collection tools and resources will also be required to ensure indicators are measured and data is collected, analyzed and findings are presented in required reports. This will increase the system's ability to ensure compliance and control, quality assurance, and risk management.

3.4.9 Accountability Agreement

To more clearly communicate accountability to HSSAs we are recommending the development of an Accountability Agreement. The purpose of this agreement is to ensure mutual understanding of roles, responsibilities, associated performance expectations, required resources, and reporting requirements to ensure accountability. To reinforce the accountability framework proposed in section 3.4.7, the current Contribution Agreement will need to be modified. The outline presented in the table below is an initial recommendation that should be reviewed and modified by the DHSS as required.

Table 19: Accountability Agreement

Agreement Section/Schedule	Description	Current State
Sections 1 through 12		
Section 1.0 Purpose of Agreement	Refers to relevant Legislation and Acts (compliance). Defines overall Mission: To promote, protect and provide for the health and wellbeing of the people of the NWT. Wellness, Accessibility and Sustainability. Defines purpose of agreement: To communicate roles, responsibilities, performance expectations, reporting requirements and associated funding allocations to the HSSAs.	Does not exist currently
Section 2.0 Definitions	Provide definitions for key terms used in the Agreement.	Currently exists as Section 1.0 Will need to be updated with additional terms used within new Schedules
Section 3.0 Term	Timeline of agreement. For example: April 1, 2011 to March 31, 2012.	Currently exists as Section 2.0
Section 4.0 Financial Contribution and Related Provisions	Define the total amount to be paid and payment installment amounts and dates. Will refer to relevant schedules: • Schedule 6 – Financial Administration • Schedule 7 – Compliance • Schedule 8 – Budget	Currently exists as Section 3.0 and Schedule 2 Will need to be updated to refer to appropriate Schedules
Section 5.0 Accountability	Defines Accountability and refers to relevant schedules: • Schedule 2 – System Integration and Planning • Schedule 3 – Performance Requirements • Schedule 4 – Special Projects • Schedule 5 – eHealth • Schedule 7 – Compliance	Replaces current Section 4.0 on Reporting and Evaluation Will need to be developed
Section 6.0 Audits and Inspections	Defines expectations and process for GNWT audit or inspection.	Currently exists as Section 5.0 Will need to determine if information is still valid.
Section 7.0 Confidentiality	Defines expectations regarding confidentiality. Refers to relevant Legislation.	Currently exists as Section 6.0
Section 8.0 Liability and Indemnity	Defines responsibility of GNWT and HSSA regarding liability and indemnity.	Currently exists as Section 7.0

Agreement Section/Schedule	Description	Current State
Section 9.0 Insurance	Defines expectations regarding insurance. Refers to Schedule 9.	Currently exists as Section 8.0
Section 10.0 Termination	Defines rights of GNWT regarding termination.	Currently exists as Section 9.0
Section 11.0 Dispute Resolution	Defines protocol for dispute resolution between GNWT and HSSA.	Currently exists as Section 10.0
Section 12.0 General	Defines protocol for amendments, notifications, and other general statements. Contact information for both GNWT and HSSA.	Currently exists as Section 11.0
Schedules 1 through 9		
Schedule 1 General	Provides a description of the schedules' purpose, current state and future development. This section will also identify the Schedules that are currently under development and therefore require updating on an annual basis.	Does not currently exist
Schedule 2 System Integration and Planning	Outlines the limits of authority (scope of decision making), roles and responsibilities, and accountability. Provides detail regarding the expectations and required protocol for community engagement, system planning, and system integration.	Does not currently exist
Schedule 3 Performance Requirements	Provides detail regarding system performance expectations for clearly defined core services that align to the ISDM. This section will also identify any program standards that need to be followed along with performance indicators, associated measures and variance resolution.	Does not currently exist
Schedule 4 Special Projects	Defines any special projects or programs that are not core-funded and identify associated agreements and funding allocations.	Does not currently exist
Schedule 5 eHealth	Identifies performance requirements for the collection, storage and use of data and information for health system management and defines expectations regarding eHealth.	Does not currently exist
Schedule 6 Financial Policies and Protocol	Identifies performance requirements for effective financial management and administration. This would include reference to applicable Legislation, policies, and protocol. Please refer to Table 6 Financial Instruments and Table 7 Financial Protocols for more information	Some information can currently be found in Section 3.0 Will need to be supplemented by additional information on financial policies and protocol

Agreement Section/Schedule	Description	Current State
Schedule 7 Compliance	Outlines compliance protocols. For example reporting format, content and timing requirements, rewards for successful performance, and consequences or required interventions for poor performance. This section should include a summary table of all required reporting and timelines to monitor compliance.	Currently exists as Schedule 3. Will need to be supplemented by detail regarding reporting format and content.
Schedule 8 Budget	Defines the budget. Ensure the budget is aligned with performance expectations of service delivery and administration responsibilities as defined in legislation, accountability agreement, policies and program standards.	Currently exists as Schedule 1 and Schedule 1.1. Will need to be revised categories in funding model a
Schedule 9 Insurance Requirements	Detail regarding HSSA and GNWT responsibilities regarding insurance.	Currently exists as Schedule 4.

Accountability Recommendations:

- Define program and service delivery levels for each HSSA once service delivery review is complete.
- Define program standards and associated performance indicators
- Use Accountability Instruments identified in Table 9 to define and communicate roles, responsibilities and expectations as well as communicate performance and variance from expectations.
- Develop Accountability Agreement to reinforce and communicate accountability structure and update as standards and performance indicators are developed.

4.0 Recommendations: Governance

While the recommendations detailed in section 3.0 in regard to financial management, resourcing, consolidation and collaboration, and accountability provide guidance to address many of the identified problems, their implementation will not address all of them. In particular, key problems identified that would remain unaddressed with implementation of the articulated recommendations include:

- The capacity of the DHSS to provide support and monitor compliance for eight HSSAs.
- The capacity and capability within the eight Boards and HSSAs to govern and manage health and social service delivery.
- The ability to integrate service planning and delivery as a result of segmentation into eight separately funded and managed HSSAs.

Accordingly, it becomes apparent that further change is warranted to realize the full benefits of implementing the aforementioned recommendations. Specifically, it became clear that we must look at the manner in which the health system is governed to provide the best opportunity to:

- Enhance the delivery of services in NWT;
- Manage risk;
- Make the optimum use of Government resources;
- Ensure clear and appropriate accountabilities; and
- Balance the benefits of community involvement.

Governance is the set of structures, processes, policies, legislation, and by-laws that define the way an organization is directed, administered or controlled.

In the sections that follow, we investigate health system governance options for the GNWT with a goal of recommending an option that supports and optimizes the recommendations on financial management, resourcing, consolidation and collaboration, and accountability.

4.1 Arms' Length Requirement

Germane to all of our discussions with stakeholders and our review of other Canadian jurisdictions was the requirement for a health service delivery system to be separate and distinct from government. So we started with this tenant in mind. To understand this requirement more specifically, we review in Table 20 the pros and cons of an arms' length governance structure.

Table 20: Arms' Length Pro and Con

Pros	Cons
Keeps clinical and operational decisions in the hands of individuals with the required knowledge and skills	Creates an additional layer of management
Keeps clinical and operational decision making out of the "Political" arena	Requires a delegation of authority (may be perceived as giving up 'control')
Keeps decision making close to operations which allows for increased flexibility and responsiveness	Requires the creation of a external Board and HSSA with the resultant requirement for an accountability framework (while an accountability framework would be required if there was not an arms' length entity created, it would be inherently more straight forward to manage as it would be internal to the government)

Allows government to focus on health policy, standards, system performance (areas where they have the required knowledge and skills)	Consistently directing health issues to an HSSA has proven to be difficult in the NWT due to the independent nature of MLA's and the non-party electoral system. Moving from eight to one HSSA does not in and of itself remove this barrier, unless this new HSSA is perceived by the MLA's to have the authority and ability to address their constituents needs
Allows managers to be more accountable as they will more readily accept the authority that has been delegated to them. (it will empower them)	
Allows the government to put distance between itself and decisions if warranted/desired	
Ensures continuity of health service delivery should there be a Minister or MLA change as a result of an election	
Aligns with the common belief of clinicians and administrators that 'arms length' is more appropriate	
The experience in PEI, where they went from eleven HSSAs to no HSSAs and now to one HSSA, demonstrated first-hand the importance of an Arms' Length Health Delivery System	

4.2 Governance Options Considered

In considering the scope of this review, the rationale for change articulated in section 2.0, and the recommendations articulated in section 3.0 we developed a series of health system design concepts. Fundamentally, there were six concepts that could be considered for health and social service system design in the NWT.

1. Status Quo – change nothing, but provide supports to do things better
2. Health and Social Service Authorities – look to HSSAs to provide leadership for health and social service delivery implementation
3. Department – look to department to provide leadership for health and social service delivery implementation
4. Private – look to private enterprise to provide leadership for health and social service delivery implementation
5. Other Jurisdictions – look to other jurisdictions to provide leadership for health and social service delivery implementation
6. Hybrid (Private/Public, HA/Department) – share leadership for health and social service delivery implementation

Concept #'s 1, 4, 5, & 6 were each eliminated from further consideration as they were not deemed to be feasible to the NWT. Discussion with the Steering Committee led to the conclusion that authority for implementation leadership needs to be clearly defined with the required resources and direction provided. Options for placement of authority were identified along with the strengths and challenges associated with each. As a result, concept #'s 2 and 3 were identified as potentially feasible and these system concepts were then specifically investigated, refined and developed into three potential governance options.

The functional charts illustrated below are meant to represent functional areas under the responsibility of the ADM, DM or HSSA. They do not represent an organizational chart but instead identify who has responsibility for the various functional areas. Three functional categories have been articulated as:

1. **Direction and Support:** Responsibility for planning, providing guidance, establishing standards, communicating expectations, and reporting on performance
2. **Service Delivery:** Responsibility for coordination and delivery of primary, secondary and tertiary health and social services
3. **Corporate Services:** Responsibility for performance audit, compliance, and corporate support services

The Joint Senior Management Committee (JSMC) does not play a role in governance of the system, but instead is a mechanism for the CEO and the Deputy Minister or Assistant Deputy Minister to collaborate on system wide initiatives and strategic priorities.

Recommendations: Governance

Direction and Support	
Child & Family Services	To provide direction, information and oversight to DHSS, HSSAs and health facilities regarding child and family services.
Population Health	To provide direction, information and oversight to DHSS, HSSAs and health facilities regarding population health.
Health Services Administration	To provide services regarding vital statistics, registration of health care, insured services, extended health benefits, and non-insured health benefits.
Legislation, Acts, Policies & Standards	To provide direction, information and oversight to DHSS, HSSAs and health facilities regarding acts, regulations policies and standards.
System Measurement & Reporting	To provide direction, information and oversight to DHSS, HSSAs and health facilities regarding system planning, measurement, and reporting.
Service Delivery	
Shared Services Authority System Collaboration, Back Office and Clinical Support Consolidation	A separate organization responsible for ensuring system collaboration and integration of back office and clinical support functions.
System Collaboration Primary, Secondary and Tertiary Services and Programs	To engage in system collaboration with the department. To coordinate and deliver primary, secondary and tertiary health and social services to residents in defined geographic area. To gather input and feedback from residents in terms of needs and satisfaction with services.
Back Office and Clinical Support Consolidation	To define and coordinate delivery of back office and clinical support consolidation activities.
Corporate Services	
Finance, Infrastructure, IT & Legal	To provide support, information and oversight to DHSS, HSSAs and regional delivery centres regarding finance, infrastructure and legal.
Quality Control & Risk Management	To monitor performance and compliance in terms of satisfaction, quality and safety and risk management.
Public Relations, Communication & Advisory	To provide consistent and relevant communication in relevant formats to all system participants and stakeholders. To provide information to DM and Minister in terms of queries, issues and concerns raised by MLAs or NWT residents.

4.3 Option A

In option A, HSSAs no longer have boards and become regional delivery centres reporting directly to the ADM. A territorial Health Advisory Board reports to the minister and has the following characteristics:

- Representative of population and includes health experts
- No authority to make decisions or delegate responsibilities
- Responsible for providing advice to Minister regarding health and social services
- Responsible for providing a venue for citizen input and feedback

The Department of Health and Social Services is:

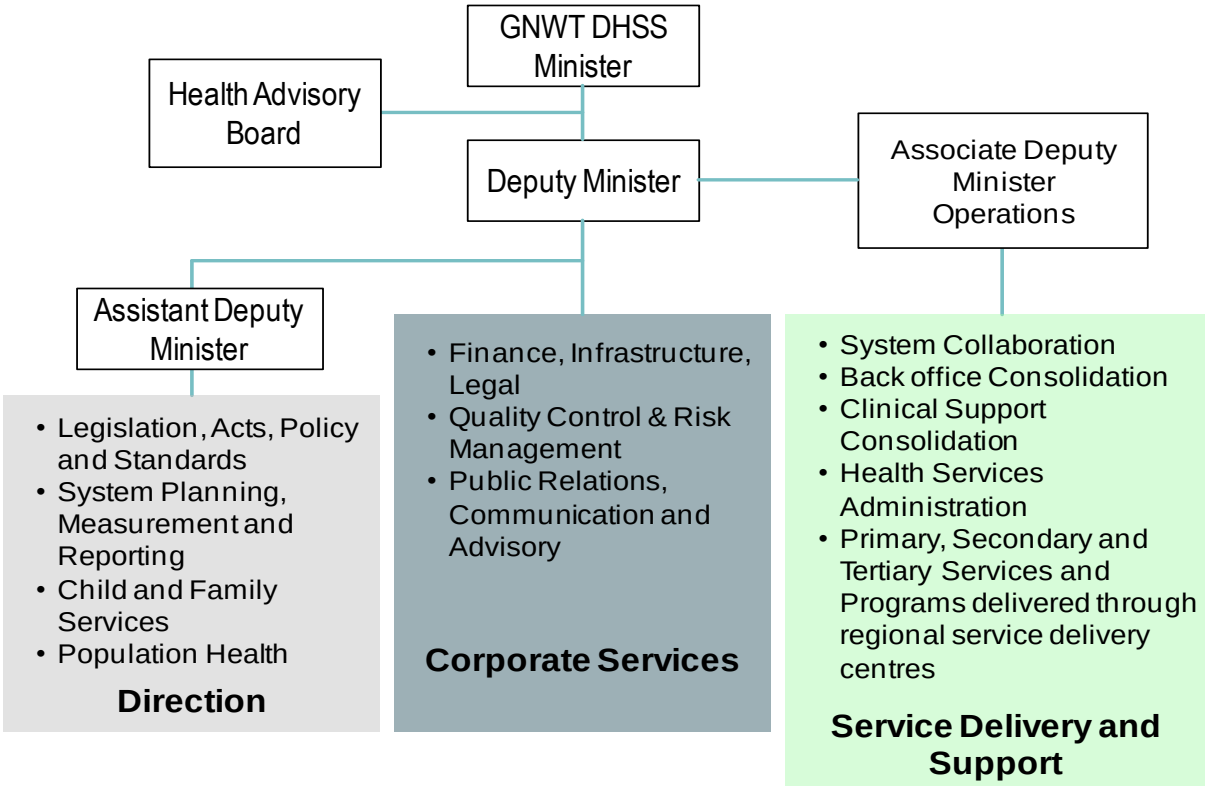
- Accountable and responsible for setting vision, strategic direction, establishing standards and ensuring compliance
- Accountable and delegates responsibility for service delivery to regional delivery centres
- Accountable and responsible for Back Office and Clinical Support Consolidation and System Collaboration (ex. DHSS is responsible for coordinating system needs, analysis, and planning)
- Can delegate responsibility for certain back office or clinical supports to:
  - Regional Delivery Centres (e.g. Yellowknife is responsible for procurement)
  - GNWT (e.g. Department of Public Works Technology Service Centre is responsible for IT support)
  - Contracted service provider (e.g. Private organization is contracted to conduct searches for health and allied health professionals)

Regional Delivery Centres are responsible for service delivery and have the following characteristics:

- Representative of self government and geographic areas to ensure appropriate access to services
- Responsible for soliciting input and feedback from residents in their geographic area
- Responsible for delivering primary services to the residents in their geographic area
- May also be responsible for delivering secondary or tertiary services to residents of NWT
- Flexibility to ensure service delivery is relevant to population within established standards
- Service delivery responsibilities are defined in detailed accountability agreements with associated budgets
- Accountable to the ADM within DHSS through defined reporting requirements

4.3.1 Option A Governance Structure

Figure 4: Option A Governance Structure



4.3.2 Option A Assessment

Table 21: Option A Pro and Con Assessment

What this structure achieves – Pros	What this structure takes away – Cons	What this structure requires – Considerations
– Demonstrates that the ultimate authority and accountability rest with the Minister – All responsibilities for delivery and risk management rest within the department – Ability to ensure system linkage within DHSS as well as between other GNWT departments – Back office consolidation – No authority has been delegated, decision making is clear – Patient has one resource for concern or issues that can deal with entire service experience	– No authority has been delegated outside of government organization, decisions rest with bureaucracy – Puts decision making regarding the clinical delivery of health and social services within government – Limited ability to take the initiative and be innovative regarding service delivery at the regional and community level – No community involvement in health and social service authority through boards	– Capability and stability within the DM and ADM roles – Capacity and capability within the department to administer health and social service delivery – New mechanisms for community input and feedback

Table 22: Option A Assessment against Performance Criteria

Meets Criteria:	Strongly Met Met Poorly Met
Performance Criteria	**Assessment**
Accountability - Provides clearly understood roles, responsibilities, accountabilities, performance expectations, performance measurement and compliance	• No longer have arm's length health system • Government has full responsibility for success and for failure • Patient has one resource for concern or issue that can deal with entire service experience
Risk Management - Provides capacity to appropriately mitigate and manage risks including patient safety and quality services to ensure a sustainable health system	• Government has responsibility for entire risk management process • There is the potential for conflict of interest between best interest of community or individual and best interest of government
System Linkage - System wide planning and coordination of service delivery results in consistent levels of service and program delivery	• Service delivery and system resourcing will be internal to the department allowing potential for system linkage both within health and social services as well as with other government departments • Potential for less focus on community health and more on acute care due to high costs of acute care
Efficient - Facilitates coordination, reduces duplication of efforts, and fosters accurate and appropriate communication for good decision making	• Back office and clinical support consolidation frees up resources and ensures consistency • May become bureaucratic and in turn, may lose ability to be efficient and flexible
Flexible - Allows for ongoing review, revisions and adaptations as required	• Authority to develop programs and services will no longer be at community level • Structure does not encourage initiative or innovation • Common perception that government organizations are not able to provide flexibility
Sustainable - Resource requirements for implementation and ongoing sustainability are understood and available with an opportunity for community and stakeholder input and feedback	• Would only be viable as a short term solution as other jurisdictions have identified serious challenges with this option • No boards takes away one venue for community input and feedback over health and social services • There is the perception of less citizen control over health system
Feasible Cost Required capacity Required timeline Degree of change	• Cost of change would be for design of new structure, systems and processes, and change management • Does not add system layers and therefore should have sufficient capacity within existing GNWT staff • Will require significant restructuring to build department functional areas from existing HSSA staff • All health system staff are GNWT employees (with the exception of

Meets Criteria:	Strongly Met
	Met
	Poorly Met
Performance Criteria	**Assessment**
	CEOs, physicians, and Hay River staff) although this may not be well understood and therefore would still represent significant change

4.4 Option B

In option B the eight HSSA's become one Territorial HSSA. The Regional Delivery Centres report into CEO who is accountable to a Board of Governance. The JSMC is provided with the authority, responsibility and accountability to mandate collaboration between the department and the HSSA.

The department of Health and Social Services (DHSS) is:

- Accountable and responsible for setting vision, strategic direction, establishing standards and ensuring compliance
- Responsible for providing direction and support to NWT HSSA in the delivery of health and social services

The NWT HSSA Board of Governance is:

- Representative of population and includes health "experts"
- Responsible for developing strategic plan, providing direction and ensuring risk management, quality assurance, and financial/ performance accountability
- Responsible for providing a venue for citizen input and feedback

The NWT HSSA has:

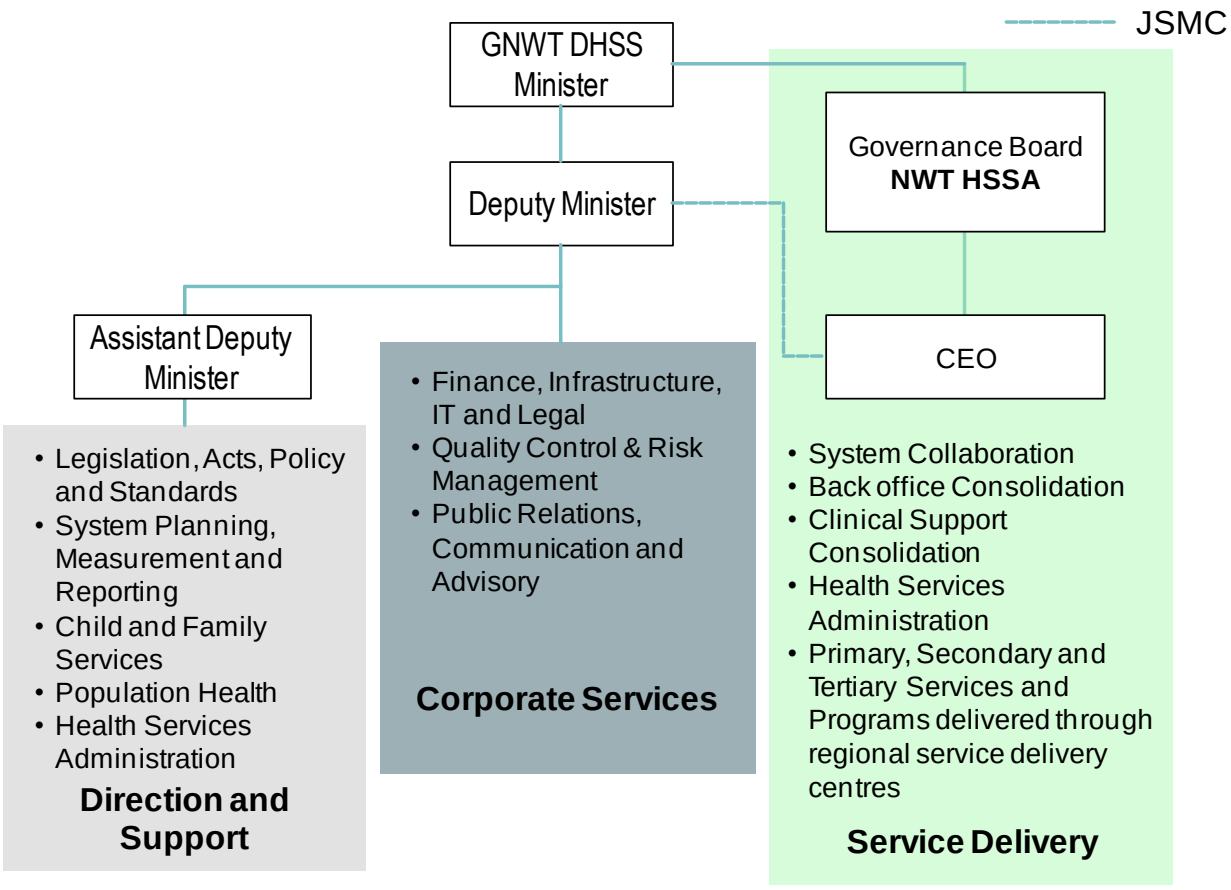
- Responsibility for ensuring system integration and collaborating with DHSS
- Authority to delegate responsibilities regarding back office consolidation, clinical support consolidation, and service delivery to:
  - Regional Delivery Centres (e.g. Yellowknife is responsible for procurement)
  - GNWT (e.g. Department of Public Works Technology Service Centre is responsible for IT support)
  - Contracted service provider (e.g. Private organization is contracted to conduct searches for health and allied health professionals)
- Potential responsibility for delivering some tertiary care services in-territory, pending the outcome of the service delivery review
- Responsibility for coordinating out-of-territory tertiary services
- Authority, responsibilities and reporting requirements are defined in three year DHSS accountability agreements with associated budgets

Regional Delivery Centres are:

- Representative of self government and geographic areas
- Responsible for soliciting input and feedback from residents in their geographic areas
- Responsible for delivering primary services to the residents in their geographic area. Service delivery responsibilities and reporting requirements are defined in annual NWT HSSA action plans
- Responsible for developing budgets, performance measurement and reporting of delegated service delivery responsibilities
- Potentially also responsible for delivering secondary or tertiary services to residents of NWT
- Flexible to ensure service delivery is relevant to population within established standards
- Accountable to the CEO of NWT HSSA on the fulfillment of responsibilities

4.4.1 Option B Governance Structure

Figure 5: Option B Governance Structure



4.4.2 Option B Assessment

Table 23: Option B Pro and Con Assessment

What this structure achieves – Pros	What this structure takes away – Cons	What this structure requires – Considerations
– Simplifies accountability as only one HSSA is accountable to the Minister – Simplifies collaboration or cooperation between the DHSS and only one HSSA – Simplifies financial management protocol and system resourcing model – Department plays support role only and does not get involved in service delivery – Delegates responsibility to deliver health and social services to one HSSA governed by a board of directors – Governance board ensures health services are not directly controlled by the Minister – Geographical delivery centres continue to be responsible for delivery of services and gathering community input and feedback – The ability to consolidate back office and clinical support functions – The ability to integrate primary, secondary and tertiary clinical services for consistent service delivery across the territory	– Regions of NWT do not have individual boards of management but report instead into CEO of NWT HSSA – Regional authority for delivering, administering, measuring and reporting of health and social services delivery (responsibility remains)	– Management and leadership capability and stability of governance board chair and directors – Management and leadership capability and stability within the NWT HSSA CEO – Mechanisms to ensure feedback and input is received from regions. This could be accomplished in a number of ways including regional advisory committees reporting directly in the board

When reviewing option B the relationship between the CEO and the Deputy Minister was discussed. This is a working relationship where regular conversations occur without the involvement of the Board or Minister. The ability of the JSMC to facilitate this relationship was discussed and option B_1 was developed for consideration.

Option B_1 on the following page, shows a more direct line of accountability between the NWT HSSA CEO and the DM and moves the governance board to an advisory board directly to the Minister. In reality this structure is the same as that identified in option A with a board that has no impact on service delivery, providing an advisory role to the Minister.

Figure 6: Option B_1 Governance Structure

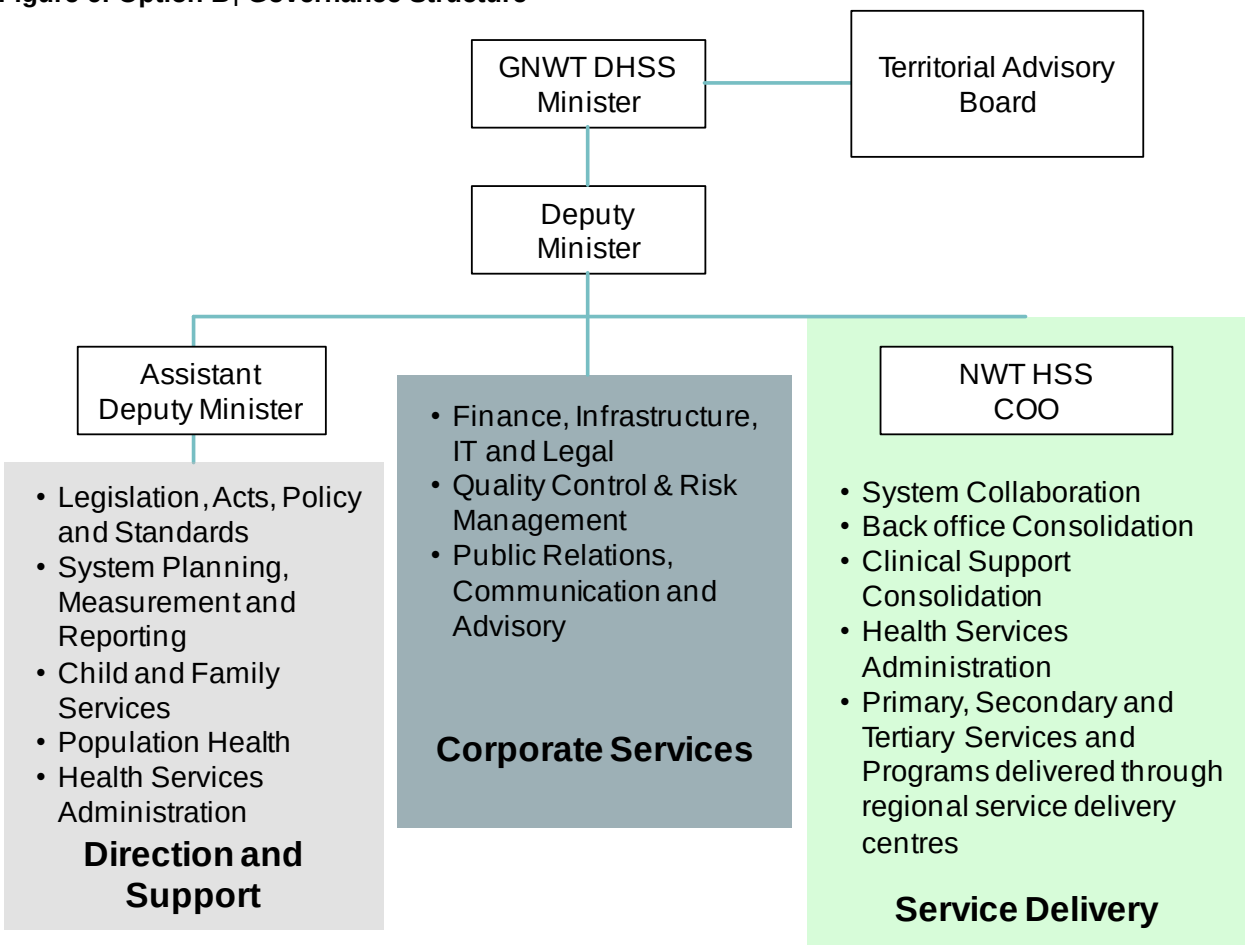


Table 24: Option B Assessment against Performance Criteria

Meets Criteria:	Strongly Met Met Poorly Met
Performance Criteria	**Assessment**
Accountability - Provides clearly understood roles, responsibilities, accountabilities, performance expectations, performance measurement and compliance	• Allows better accountability than status quo as government has assigned responsibility and authority to only one organization • No longer have multiple individual geographic regions accountable directly to the government • Patient has one resource for concern or issue that can deal with entire service experience
Risk Management - Provides capacity to appropriately mitigate and manage risks including patient	• Responsibility for risk management process rests with NWT HSSA with accountability to DHSS • No longer have individual regions reporting risk management

Meets Criteria:	Strongly Met Met Poorly Met
Performance Criteria	**Assessment**
safety and quality services to ensure a sustainable health system	directly to the government
System Linkage - System wide planning and coordination of service delivery results in consistent levels of service and program delivery	• Service delivery and system resourcing will be coordinated by one organization allowing potential for better system linkage than status quo
Efficient - Facilitates coordination, reduces duplication of efforts, and fosters accurate and appropriate communication for good decision making	• Back office and clinical support consolidation frees up resources and ensures consistency
Flexible - Allows for ongoing review, revisions and adaptations as required	• Consistent decision making process • Service delivery responsibility and accountability remains at community level whenever possible • Services or functions that have been consolidated or centrally coordinated do not require flexibility
Sustainable - Resource requirements for implementation and ongoing sustainability are understood and available with an opportunity for community and stakeholder input and feedback	• Only one board may create perception of less community input, feedback and control over health and social services • Community input and feedback responsibility at service delivery level helps to develop relevant programs and services • Due to size and influence of board, there will be a greater dependence on the skills and capacity of board chair and trustees
Feasible Cost Required capacity Required timeline Degree of change	• Cost of change would be for design of one new structure, systems and processes, and change management • Does not add system layers and therefore should have sufficient capacity within existing GNWT staff • Will require significant restructuring to consolidate functional areas into one HSSA • All health system staff are GNWT employees (with the exception of CEOs, physicians, and Hay River staff) although this may not be well understood and therefore would still represent significant change

4.5 Option C

In option C the eight HSSAs become three Regional HSSAs with three CEOs accountable to three Governance Boards.

The department of Health and Social Services is:

- Accountable and responsible for setting vision, strategic direction, establishing standards and ensuring compliance
- Responsible for providing direction and support to regional HSSAs and shares services authority in the delivery of health and social services and system integration

The three HSSA Boards of Governance and one Shared Services Board of Management are:

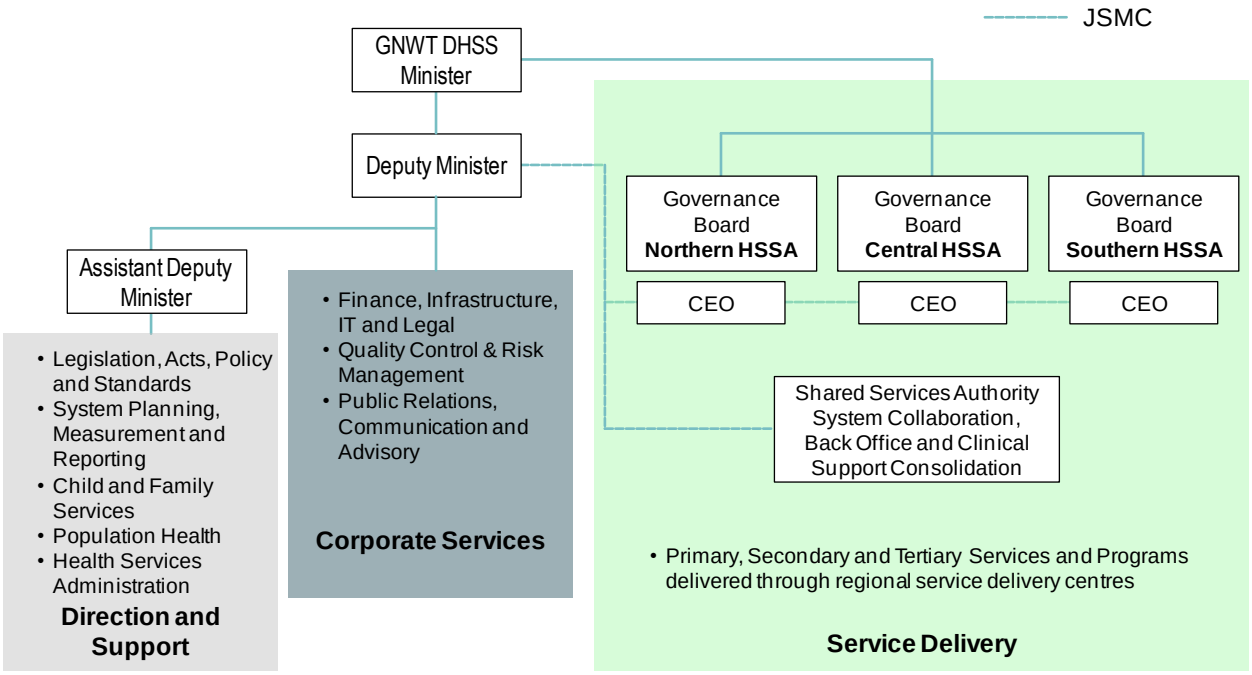
- Representative of population and includes health “experts”. The Shared Services board includes an advisory committee made up of the three CEOs from each of the Regional HSSAs
- Responsible for developing strategic plan, providing direction and ensuring risk management, quality assurance, and financial/ performance accountability
- Responsible for providing a venue for citizen input and feedback

The JSMC is provided with the authority to mandate collaboration between the department and the HSSA.

- Northern, Central and Southern Health and Social Service Authorities (Regional HSSA)
  - Authority to delegate responsibilities regarding primary and secondary service delivery
  - Responsible for delivering primary and secondary services to the residents in their geographic area and assigned tertiary services to all NWT residents
  - Authority, responsibilities and reporting requirements are defined in three year DHSS accountability agreements with associated budgets
- Shared Services Authority
  - Responsible for ensuring system integration and collaborating with DHSS and three regional HSSAs
  - Responsible for planning, coordinating and delivering back office, clinical and management supports and has authority to delegate responsibilities regarding back office and clinical support consolidation to:
    - Regional HSSA (ex. Central HSSA is responsible for procurement)
    - GNWT (ex. Department of Public Works Technology Service Centre is responsible for IT)
    - Outsourced service provider (ex. Private organization is contracted to conduct searches for health and allied health professionals)
- Regional Delivery Centres
  - Representative of self government and geographic areas
  - Responsible for soliciting input and feedback from residents in their geographic areas
  - Responsible for delivering primary services to the residents in their geographic area
  - Flexibility to ensure service delivery is relevant to population within established standards
  - Responsibilities and reporting requirements are defined in annual action plans with associated budgets
  - Accountable to the CEO of regional HSSA on the fulfillment of responsibilities

4.5.1 Option C Governance Structure

Figure 7: Option C Governance Structure



4.5.2 Option C Assessment

Table 25: Option C Pro and Con Assessment

What this structure achieves – Pros	What this structure takes away – Cons	What this structure requires – Considerations
– Simplifies accountability somewhat as only three HSSAs are now accountable to the Minister – The ability to consolidate back office functions through a shared services organization – Simplifies collaboration or cooperation somewhat between the department and three HSSAs – Department plays support role only and does not get involved in service delivery – Delegates responsibility to deliver health and social services to three HSSAs governed by governance boards – Governance boards ensures	– Some regions of NWT do not have individual boards of management but report instead into CEO of one of three regional HSSA – Takes away some regions' authority for delivering, administering, measuring and reporting of health and social services delivery (responsibility remains)	– Capability and stability of four sets of governance boards – Capability and stability within the regional HSSA CEOs – Mechanisms to ensure system integration and collaboration occurs between the three HSSAs and the Department – Mechanisms to ensure appropriate authority and accountability for back office and clinical support consolidation

What this structure achieves – Pros	What this structure takes away – Cons	What this structure requires – Considerations
health services are not directly controlled by the Minister – Regional service centres continue to be responsible for delivery of services and gathering community input and feedback		

Table 26: Option C Assessment against Performance Criteria

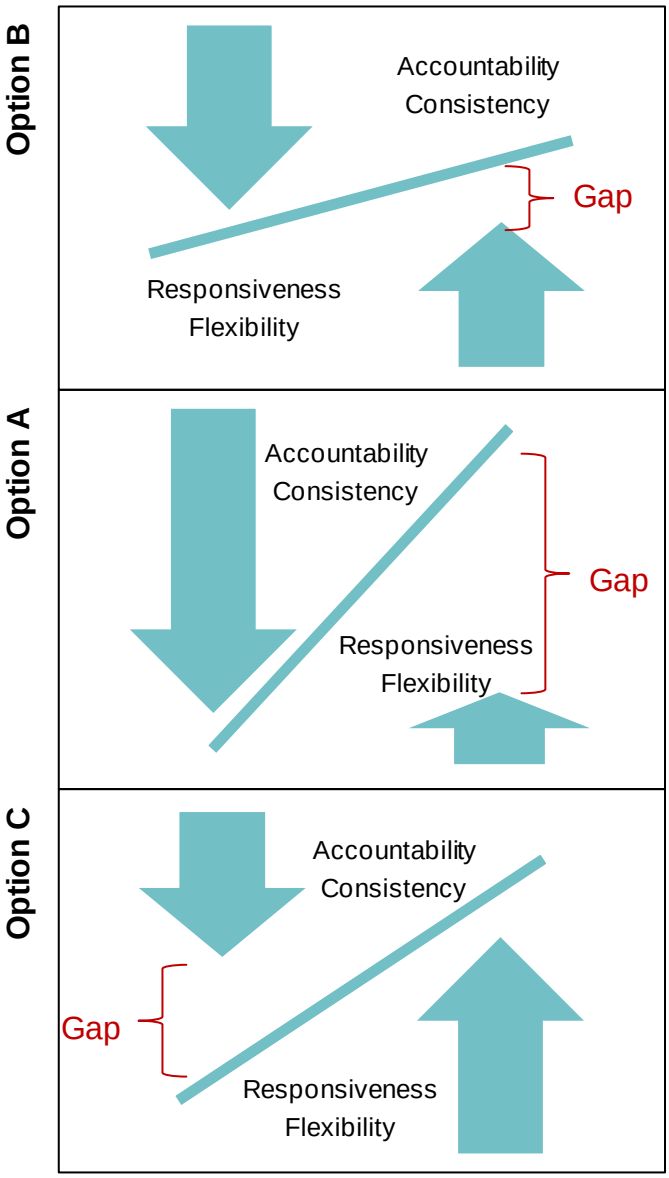
Meets Criteria:	Strongly Met Met Poorly Met
Performance Criteria	**Assessment**
Accountability - Provides clearly understood roles, responsibilities, accountabilities, performance expectations, performance measurement and compliance	• Better than status quo, but there are still four separate organizations with boards accountable to the DHSS • Patient has four avenues for concern or issue that can only deal with a portion of the service experience
Risk Management - Provides capacity to appropriately mitigate and manage risks including patient safety and quality services to ensure a sustainable health system	• Can be coordinated by the shared service organization but there are still three separate HSSAs managing risk and reporting to the DHSS
System Linkage - System wide planning and coordination of service delivery results in consistent levels of service and program delivery	• Shared service organization provides a venue for system linkage but has limited ability to ensure coordination and collaboration between the three HSSAs and DHSS • Responsibility for system integration rests with the shared service organization who is accountable to the Minister of GNWT and has no authority over the three HSSAs • Responsibility for tertiary services and case management is assigned to three HSSAs who will still need to coordinate and collaborate
Efficient - Facilitates coordination, reduces duplication of efforts, and fosters accurate and appropriate communication for good decision making	• Back office consolidation and clinical collaboration provides opportunity for increased efficiency
Flexible - Allows for ongoing review, revisions and adaptations as required	• More complex model with separate organization responsible for system integration will reduce flexibility • Three HSSAs provide a more clear delegation of authority to regions for control over service delivery

Meets Criteria:	Strongly Met Met Poorly Met
Performance Criteria	**Assessment**
Sustainable - Resource requirements for implementation and ongoing sustainability are understood and available with an opportunity for community and stakeholder input and feedback	• Depends on skills and capacity of four sets of board chairs and trustees • Reduces but does not eliminate a number of root causes
Feasible Cost Required capacity Required timeline Degree of change	• Cost of change would be for design of three new structures, systems and processes, and change management • Does not add system layers and therefore should have sufficient capacity within existing GNWT staff • Will require significant restructuring to consolidate functional areas into three HSSA • All health system staff are GNWT employees (with the exception of CEOs, physicians, and Hay River staff) although this may not be well understood and therefore would still represent significant change

4.6 Option Analysis

4.6.1 System Accountability

Meyers Norris Penny feels that governance Option B achieves the best balance between accountability/consistency and responsiveness/flexibility.



Using the result of the criteria analysis, MNP is recommending the governance structure defined as option B. This option performs best when measured against the seven performance criteria and provides the best balance between accountability and flexibility given the requirements of risk management, system linkage, efficiency, sustainability, and feasibility.

Option A was not recommended due to its inability to separate service delivery from government (arms length). While option A allows for the greatest and most direct accountability of the three options, it achieves this at the expense of the system's ability to be responsive or flexible.

Option C was not recommended. It does: increase accountability; reduce responsiveness somewhat by reducing the number of HSSAs; and ensures consistency in back office and clinical collaboration through a shared services association. However, accountability is not sufficiently increased to attain balance. It also increases complexity with the introduction of a new organization. System integration remains problematic with three separate Health and Social Services Authorities, and many of the current state problems and constraints remain unaffected or unimproved.

4.6.2 System Financial Management and Resourcing

In Option A, the ability to implement sound financial management practices is significantly improved as this would be the responsibility of the DHSS. However, this option does not create any separation between the funding body and service delivery, an element that was previously identified as being germane to any governance model. The ability for management and staff to challenge the status quo and implement creative solutions would be limited by this option.

In Option B, many of the issues regarding the funding model and managing the financial function within eight HSSAs are eliminated by moving to one HSSA. An arms' length structure is maintained and the DHSS would only be funding one HSSA responsible for submitting audited financial statements for the delivery of health and social services throughout NWT. As a result, the line of communication between DHSS and the HSSA is direct and can be efficiently and effectively managed. Financial reporting will be simplified significantly and only one set of audited financial statements will be required.

In Option C, the issues regarding the funding model and managing the financial function are reduced by moving from eight HSSAs to three, but not to the same extent as in Option B. The challenges of integrating services and funding multiple HSSAs remains, albeit, being reduced from eight to three.

4.6.3 Summary

Table 27: Option Analysis Summary

Criteria	Option A	Option B	Option C
Accountability	Does not provide arms' length management of health and social service delivery	One organization and board provides greater clarity of governance role and the capacity to fulfill that role	Four separate HSSAs with boards reporting to DHSS
Risk Management	Government has responsibility for entire risk management process but is accountable only to itself	Government delegates responsibility to one accountable HSSA	Government delegates responsibility to three separately accountable HSSAs who manage risk independently
System Linkage	Service delivery and system resourcing will be internal to the department allowing system linkage	Service delivery and system resourcing will be coordinated by one HSSA	No authority or accountability to ensure system collaboration between three HSSAs
Efficient	Allows for consolidation of back office and clinical support but as a bureaucratic organization will likely not be efficient due to the inability to delegate decision making	Back office and clinical support consolidation managed by one HSSA reduces duplication, frees up resources, ensures consistency, and allows for best practices	Back office consolidation and clinical support collaboration in a separate organization provides opportunity for greater efficiency but organization has no control over HSSAs to ensure collaboration
Flexible	Structure does not encourage initiative or innovation	Service Delivery Authority is delegated to regional centres, which allows for relevant services and programs at territorial and community level	Delegation of control over service delivery to three regional HSSA boards with limited ability to coordinate at the territorial level
Sustainable	Would only be viable as a short term solution due primarily to the advantages of an arms' length health system	Improved sustainability through reduced requirement for functional expertise capacity	Reduces but does not eliminate root causes
Feasible	Going from 8 to 0 HSSAs – significant governance change required	Going from 8 to 1 HSSA – moderate governance change required	Going from 8 to 3 HSSAs – no significant governance change required

Meets Criteria:	Strongly Met
	Met
	Poorly Met

4.7 Recommended Governance Structure

The recommended governance structure for the health system in NWT is outlined in Figure 8. This structure represents significant change from the current structure which includes eight Health and Social Service Authorities (HSSAs).

Problem Summary

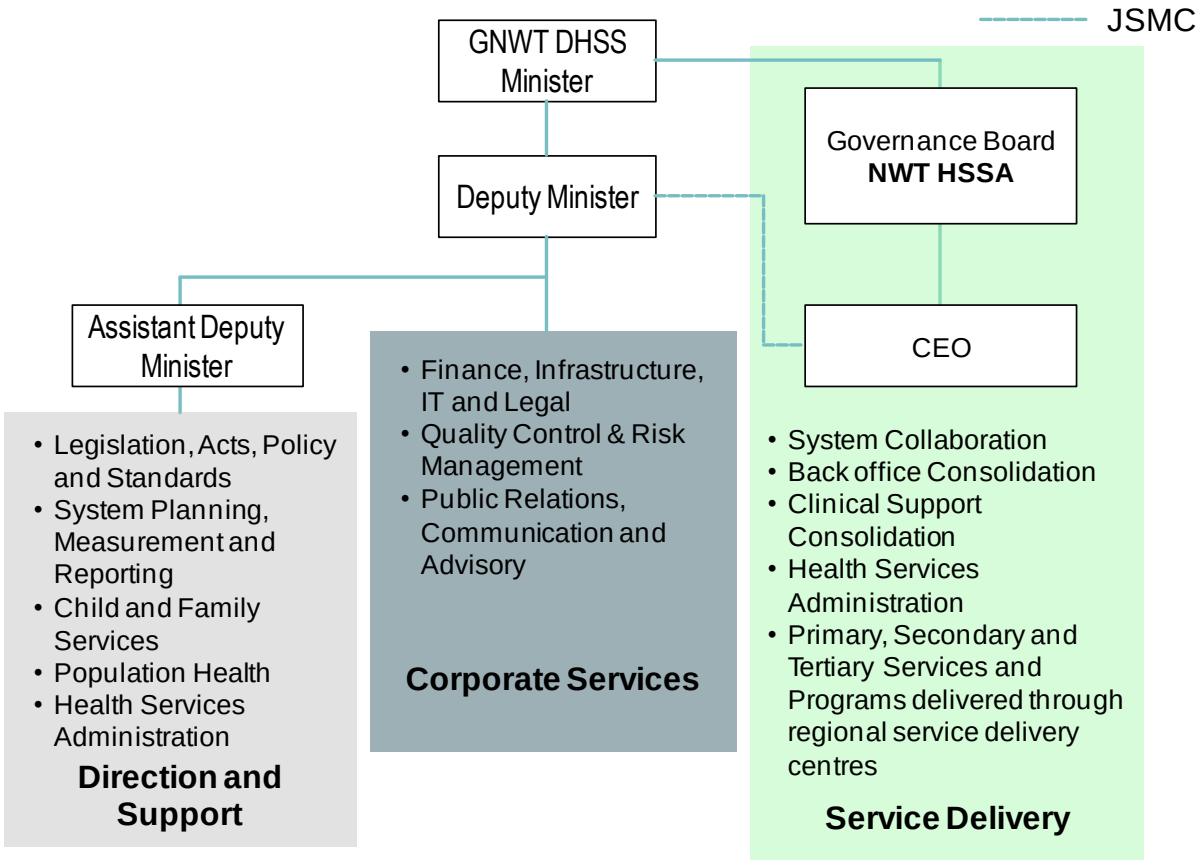
The current governance structure for the NWT health and social services system is not working as intended, nor is it sustainable. This was the clear consensus of those consulted. Governing a system through eight separate Health and Social Service Authorities is not an efficient or effective model when considering the delivery of services to a population of approximately 40,000 residents, over half of which reside in Yellowknife and the immediate surrounding area. There are considerable challenges to recruit and retain appropriately skilled and experienced board members, CEOs and administrative staff for the eight separate HSSAs. The operational and governance lines between the HSSAs and the department have blurred resulting in unclear and unacknowledged authority, unclear roles and responsibilities, unclear expectations, poor reporting, and as a result limited accountability.

Intended Outcome

The intended outcome of this recommended change to governance will be an integrated system that is able to provide consistent, quality and safe patient care effectively and efficiently.

The sections that follow are intended to provide: an outline of the governance roles within the system; an articulation of best practices; an outline of required instruments for governance; and a discussion on the role regional delivery centres can play in the structure.

Figure 8: Recommended Option B

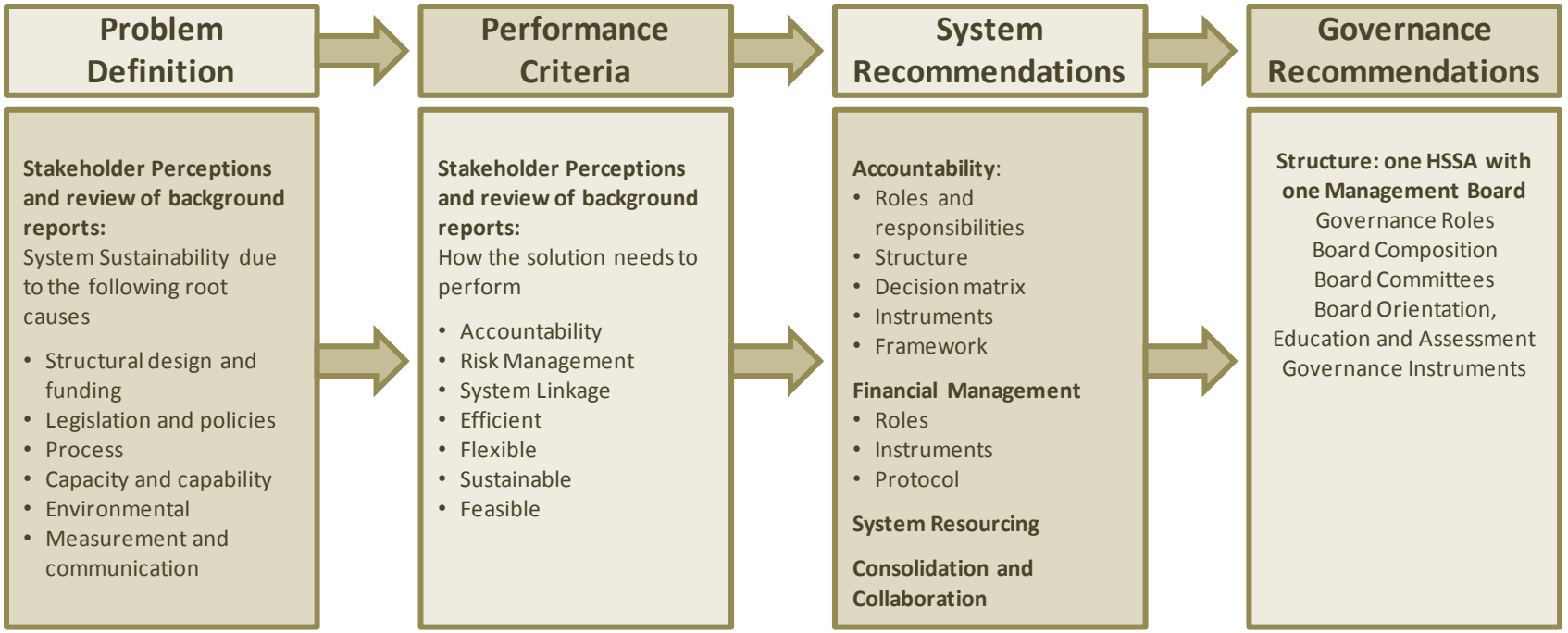


Recommendations: Governance

To develop the governance recommendation we employed a structured logic process whereby we:

- Firstly, revisited the core problems that any new structure must address;
- Secondly, reviewed the performance criteria against which the structure would be measured;
- Thirdly, assessed the requirements for change and developed recommendation in the four areas of accountability, financial management, system resourcing, and consolidation and collaboration; and
- Lastly, assessed governance models that could optimize health system performance.

Figure 9: Logic Flow to Recommended Governance Structure



4.8 Regional Service Delivery Centres

We are recommending that service delivery centres remain "regional' and define a service area with available programs and services. We have made this recommendation based on our assessment of the importance of:

- Preserving local service delivery where appropriate (i.e. language, cultural and community needs)
- Maintaining a local presence for Health and Social Services

The number and boundaries of regional delivery centres and related core services and programs have not been defined as part of this engagement. The DHSS is currently working on a Service Delivery Review that will be used to define the implementation of the Integrated Service Delivery Model. This will provide a clear definition of core funded programs and services and understanding regarding access within the various communities and regions. This work should be used to identify and define the "regional" service delivery centres. The number, locations and size of Regional Service Delivery Centres could take into account considerations such as:

- Geography
- Number of residents
- Number and size of communities
- Cultural boundaries
- Self government
- Distance from and accessibility to larger centres for secondary and territorial/tertiary services
- Capacity to deliver primary, secondary and territorial services
- Needs and health issues of region

Should future clinical support and back office consolidations result in significant reductions of staff and program requirements in regional service delivery centres, then consolidation could occur and the proposed option does not preclude this. A decision regarding the potential consolidation of service delivery centres would require more investigation following implementation of a governance model and completion of the service delivery review currently being undertaken by DHSS.

Service Delivery Centre Recommendations:

- Define Regional Delivery Centres once service delivery review complete (see section 4.8)
- Authority to make decisions within defined parameters regarding defined service delivery responsibilities
- Based on geography and access to core services
- Number, size and role will be dependent on service delivery review, ISDM implementation, and consolidation of back office and clinical support functions

4.9 Governance Board versus Advisory Board

At the territorial level, we are recommending a Governance Board to provide the required oversight and direction to the NWT HSSA CEO. An Advisory Board at the territorial level would have no authority to provide direction and therefore would not provide an arms' length delivery system. An Advisory Board would act only as an advisor to the Minister.

One territorial governance board would still require geographic representation and mechanisms for input and feedback from communities. Regional advisory committees have been recommended (See section 4.11.4) that report into the board to ensure the perspectives of the regions are heard at the governance level. A Governance Board is critical to ensure that the delivery of health and social services is separate from the government administration and leadership. (See section 4.1 for a discussion on Arms' Length) Although there was not sufficient capacity within NWT to ensure appropriate skills and experience for eight Management Boards, there should be sufficient capacity to ensure the appropriate skills and experience for one Governance Board. The ability to successfully implement and sustain this governance structure will be dependent on the influence, skills, abilities and experience of the new Governance Board and the NWT HSSA CEO.

4.10 Governance Roles

Table 28 is intended to outline the governance roles of the various players within the NWT Health and Social Service System, and identify who they are accountable to.

Table 28: Governance Roles

Governance Role:		**Accountable To:**
Minister – devolved authority through the Northwest Territories Act		
Provide input and feedback to	GNWT	Legislative Assembly and Residents of NWT
Provide advice and support to	Cabinet Standing Committee Finance Board	
Provide direction to	HSSA Board DHSS DM	
Address concerns / issues to	Cabinet	
HSSA Governance Board – delegated authority through the HIHSSA Act		
Provide input and feedback to	HSS Minister	HSS Minister
Provide advice and support to	HSS Minister HSSA CEO	
Provide direction to	HSSA CEO	
Address concerns / issues to	HSS Minister	
DHSS – delegated authority through Legislation		
Provide input and feedback to	HSS Minister	HSS Minister
Provide advice and support to	HSSA CEO	

Governance Role:		Accountable To:
Provide direction to	DHSS Departments	
Address concerns / issues to	HSS Minister	
Health and Social Service Authority – defined responsibility through CEO Position Description and Accountability Agreement		
Provide input and feedback to	HSSA Board	HSSA Board
Provide advice and support to	HSSA Board Service Delivery Centres	
Provide direction to	HSSA Departments Service Delivery Centres	
Address concerns / issues to	HSSA Board	
Service Delivery Centres – defined responsibilities through business and action plans		
Provide input and feedback to	HSSA CEO	HSSA CEO
Provide advice and support to	HSSA CEO Community organizations	
Provide direction to	Service Delivery Centre Staff Program Staff NGO delivery agencies	
Address concerns / issues to	HSSA CEO	
Community Leadership or NGOs – defined responsibilities through Contribution Agreements		
Provide input and feedback to	HSSA CEO Service Delivery Centres	Residents of Community
Provide advice and support to	HSSA CEO Service Delivery Centres	
Provide direction to	Community Departments or NGO staff	
Address concerns / issues to	HSSA CEO	
MLAs – defined responsibilities through Legislative Assembly and Executive Council Act		
Provide input and feedback to	HSS Minister	Constituents
Provide advice and support to	HSS Minister Community Leadership	
Provide direction to	n/a	
Address concerns / issues to	HSSA CEO	
Issue Resolution –	**Should concerns / issues not be addressed through assigned channels, then access concern resolution process within authority to mediate and collaborate on solution or move issue to next level of authority.**	

4.11 Governance Best Practices and Recommendations

The Board Resourcing and Development Office within the Office of the Premier in the Province of British Columbia is recognized as a governance best practice. Their mandate is to bring "professional processes to the area of director appointment and corporate governance in the public sector". This Office provides significant guidance to the boards within BC on the role of corporate governance in public sector organizations and best practices for governance and disclosure[6]. The governance structure used in British Columbia's Provincial Health Services Authority used this guidance and best practices to develop a comprehensive corporate governance structure. Accordingly, we have structured our board structure recommendations based on the Corporate Governance for the Provincial Health Services Authority[7] with accommodations for specific contextual elements.

4.11.1 Role of Board within the System

The role of the board of directors is to give long term direction and short term support to the HSSA to ensure consistent success with the responsibilities set out by the government. This is accomplished by setting and communicating the mission, vision and values of the HSSA and ensuring performance within understood standards of services.

Recommendation:
- Develop Board Charter that defines role, responsibilities and governance processes

The board of directors is comprised of individuals who collectively carry out their responsibilities, are not involved in HSSA management, and have no material interest in the HSSA. For example a board member cannot also be an employee of GNWT or employed as a physician within the system.

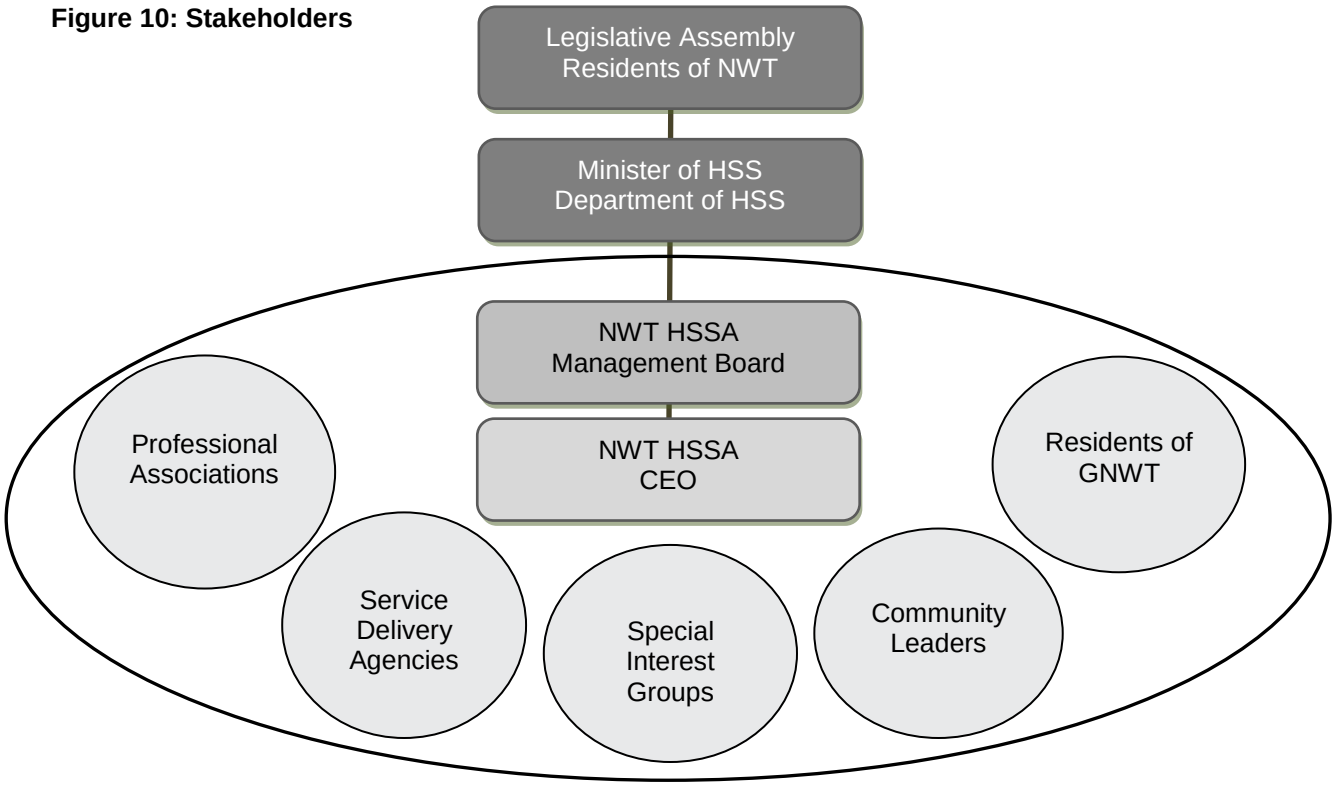
Once the board of directors is selected, they will collectively develop and publish a Board Charter that details their roles, their responsibilities and the governance procedures used. The charter should also define:

- Areas of responsibility that are defined in governing legislation
- Limitations to board's decision making authority
- List of all required reports including those from the CEO to board as well as those to external stakeholders (eg. Minister, DHSS, Community)
- Delegation of responsibility to management or committees
- Decision making process
- Statement distinguishing governance from management
- Legal obligations and liabilities of the board
- Commitment to continual board assessment and improvement
- Statement defining mechanisms to engage community and system stakeholders

The ability to engage stakeholders to ensure a clear understanding of needs, context and issues is critical to ensure the HSSA has the capacity to fulfill its authority and responsibilities to the Minister. Figure 10 depicts the stakeholders that the Board and Health and Social Service Authority will need to engage to ensure their ability to make good decisions regarding the governance and delivery of health and social services.

[6] http://www.fin.gov.bc.ca/brdo/governance/corporateguidelines.pdf - accessed December 9, 2010
[7] http://www.phsa.ca/AboutPHSA/PHSAboard/CorporateGovernance.htm - accessed December 8, 2010

Figure 10: Stakeholders



The board takes direction from, and is accountable to, the Minister of Health regarding health priorities, expectations regarding required programs and services, and standards of care. In addition, the board's role of strategic guidance and ensuring required performance is separate from the day-to-day management of the HSSA, which is the responsibility of the CEO. The CEO is appointed by the board with approval of the Minister of Health.

The successful implementation of this governance structure is critically tied to the ability of this Board to govern effectively.

4.11.2 Board Composition

The ability to provide good governance depends on the ability to ensure the right people, with the right competencies and personal attributes, are on the board. Competencies include knowledge, skills and experience whereas personal attributes include behaviour, attitude, and values.

Table 29 is based on the Institute of Corporate Directors Key Competencies and summarizes the required competencies and personal attributes for individual director effectiveness.

Table 29: Board Key Competencies

Key Competencies for Director Effectiveness[8]	
Competency Group: **Knowledge**	
Knowledge of Specific Industry	Understands the environment in which the company operates. Understands the strategy and respective roles.
Knowledge of Role	Understands responsibilities, accountabilities and liabilities as a board member.
Competency Group: **Analytical & Technical Skills**	
Financial Acumen	Can read and interpret financial reports.
Group Decision Making Orientation	Can identify and diminish 'group think' tendencies and recognize biases in board discussions.
Process Orientation	Makes decisions and seeks outcomes through the consistent application of a logical sequence of steps.
Competency Group: **Thinking**	
Conceptual Thinking Skills	Makes connections between apparently separate issues, sees patters, trends or relationships and develops mental frameworks to explain and interpret information.
Independent Thinking Skills	Maintains own convictions despite undue influence, opposition or threat.
Open-Minded / Information Seeking Skills	Vales the diverse opinions of others and build innovation on the foundation of other peoples' views.
Competency Group: **Personal Style**	
Ambiguity Tolerance	Based on limited information, retains a positive outlook when the group is unable to resolve an issue or reach a conclusion and is willing to make a risk-adjusted decision when the outcomes are uncertain. Seeks decisions that optimize the relationship between risk and reward.
Effective Judgment	Applies common sense, measured reasoning, knowledge and experience to come to a conclusion.
Integrity	Trustworthiness and conscientious and can be relied up on to act and speak with consistency and honesty.
Self-awareness	Accurately assesses strengths and weaknesses of self and others and can manage them successfully.
Bias to Learn	Invests time learning about the organization, its issues and people, the industry, and environment in which it operates.
Competency Group: **Social Style**	
Orientation to Resolve Conflict	Ensures conflict is resolved with justice and fairness in order to restore healthy relationships.
Effective Communication and Listening Skills	Gives and receives information with clarity, attentiveness, understanding and perception.
Influence and Impact Skills	Ability to influence board members and stakeholders in negotiating and impacting at the company level.

[8] Adapted from the Institute of Corporate Directors Key Competencies for Director Effectiveness, Copyright 2006

Table 30 outlines the key board member attributes that need to be present at the board level to ensure a successful NWT HSSA Governance Board.

Table 30: Recommended Board Attributes

Recommended Competencies
• Financial knowledge and experience • Clinical knowledge and experience • Organizational design understanding • Communication skills • Change leadership skills • Collaborative negotiation and communication • Commitment to system success • Understanding of and experience with NWT culture and priorities • Collectively reflect and represent the population of NWT

4.11.3 Board Director Recruitment, Appointment and Tenure

The success of this transition will in large part rest on the abilities of the Governance Board and therefore the recruitment, appointment and tenure process is critical. We recommend that a governance task force (or some other mechanism) be struck to define the criteria, identify candidates, and manage the process for board member selection and appointment. It should be within the Minister's authority to appoint members to this task force and/or assign initial board members. Once the board is defined, the governance task force should remain within the board structure as a committee (Governance and Nominations) to ensure this process continues to follow established processes and to ensure a strong functioning board is attained long-term. The competencies and personal attributes will be used to identify gaps in existing board composition, to develop selection criteria, and to identify and evaluate potential candidates.

We recommend that this board include eight members plus one board chair. Although the Government and Minister retain the ultimate authority for appointing all candidates, we recommend that candidates for the board chair and two directors (clinical and financial competencies) be appointed by the Minister. The remaining director positions would be appointed through a collaborative process with both Minister and the governance task force participating in the recruitment and evaluation of candidates.

Each board member, including the chair, must agree to a specified term of service, which is reviewed and confirmed on an annual basis. We recommend that initial positions be established in rolling terms. Meaning that 1/3 of initial board will have agreed to a four (4) year term, 1/3 to a three (3) year term and 1/3 for a two (2) year term. Each member will have the option to renew for another three (3) year term once their initial term is complete upon approval of the Minister. This allows the HSSA board governance task force/committee to manage succession and ensure the board continually has the appropriate competencies. After serving the maximum number of terms, board members can return after one or two years.

Table 31: Rolling Terms for Board Members

Initial term	2011	2012	2013	2014	2015	2016	2017
2 yr			renew				
3 yr				renew			
4 yr					renew		

Once board members are appointed, appropriate information (term, position, biography) regarding board members should be made available on the HSSA's web site. A position description for board chair will be developed to ensure a clear understanding regarding their role, responsibility and limits to authority.

Director Appointment Recommendations:

- Governance Task Force (or other mechanism) to establish Board
- Rolling terms for Board members on initiation
- Eight Board members plus chair
- Minister appoints Board chair and two directors
- Minister and task force collaboratively appoint remaining members
- Minister has authority to extend terms of members or remove members prior to the end of their term

4.11.4 Board Committees

The Board of Directors sets the mission, vision and values for the HSSA but can delegate responsibility to committees for areas such as finance and audit, governance and nominating, human resources, and compensation. The board of directors compiles Terms of Reference that outline for the committee in question their required competencies and their responsibilities. The committees are informed of best practices as they relate to their specific functions.

Board Committees that would be relevant to this new board are:

- **Governance and Nomination Committee** – responsible for establishing and leading the recruitment, appointment, succession and performance of board members. Initially this committee's responsibilities for establishing the initial board will be undertaken by the Change Leadership Task Force. (see Appendix B) Competencies: organizational design.
- **Audit, Finance and HR Committee** – responsible for the fiscal management and reporting of the HSSA as well as the appointment, performance and succession of the CEO. Competencies: financial literacy, business management.
- **Regional Advisory Committees** – responsible for providing ongoing input and feedback to the GNWT HSSA Board and CEO on regional concerns or issues to inform the strategic and business planning process.

Board Committee Recommendations:

- Committees within Board to handle ongoing responsibilities
    - Governance and Nomination
    - Audit, Finance and HR
    - Regional Advisory
- Terms of Reference to clearly outline responsibilities and required competencies

4.11.5 Board Orientation, Education and Assessment

A formal training and orientation process is used whenever a new director, chair or member of a committee is appointed. This could include an introduction to the board of directors, reference manual with basic knowledge regarding process, roles and responsibilities, and a formal orientation process. This should include a series of meetings with agency staff, site tours and specific board competency training to ensure the new board member:

- Understands the HSSA's mandate, operations and working environment

- Connects with key individuals including fellow directors, CEO, senior management, and key employees
- Understand the relationships with the Minister, department directors, community stakeholders, and professional regulatory bodies

Performance assessments for the board, chair and committees should be conducted on a yearly basis by reviewing the board charter, chair position description, and committee terms of reference. In addition an annual evaluation of individual directors is undertaken to understand gaps in competencies and establish possible areas of improvement.

Board Development Recommendations:
- Formal orientation, board education and performance assessments to ensure required competencies and capacity to fulfill mandate
- Protocol defined in governance policies

4.12 Governance Instruments

Governance instruments are tools or documents that assist in defining and communicating governance. We are recommending the following instruments are utilized within the new governance structure.

Table 32: Governance Instruments

Role	Instruments	Description
Communicate Authority and Resources		
Government of NWT	Legislation	Northwest Territories Act
	Main Estimates	Budgets approved by the Legislative Assembly for the upcoming year for all departments
Department of H&SS	Legislation	There are 28 pieces of legislation that the DHSS is responsible for administering. The Hospital Insurance and Health and Social Services Administration Act (Section 13) outlines the delegation of authority
	Funding Model	Based on authority, responsibilities and associated performance expectations outlined in acts, regulations, program standards, department policies, ministerial directives and accountability agreement
NWT HSSA Governance Board	Board Charter and by-laws	Provides a description of the limits of authority for the governance board and outlines their responsibilities
	Terms of Reference	Provides a description of the limits of authority for board committees, board chair, board members, and CEO (also outlines roles and responsibilities and therefore are also Accountability Instruments) Examples of Terms of Reference that will be required include: • CEO • Board Chair • Director • Governance / Recruitment and Appointment Committee • Audit, Finance and HR Committee • Communication Committee • Change Leadership Task Force • Quality and Patient Safety Task Force • System Integration Task Force

Role	Instruments	Description
Communicate Authority and Resources		
	Governance Policies	Provides direction to Board regarding governance of HSSA. Examples of Governance Policies that will be required include: • Board recruitment and appointment • Code of Conduct • Board Compensation and Expense • Board Conflict of Interest • Board Meetings • Board and CEO Performance Evaluation Process • Board training and development • Issue Resolution and Mediation • Community performance feedback and needs identification • Relationship with Media • Relationship with Government • Relationship with NGOs
	Risk Management Plan	A plan to manage risk and ensure patient safety and quality services by defining: • Risk management process • Roles, responsibility and accountability for risk management • Required resources, supports and culture for implementation of risk management process

4.12.1 Acts and Regulations

Changes to legislation will be required to implement the new structure. Acts and Regulations are critical as this is where the limits and boundaries to delegated authority are defined. The Department of Health and Social Services is responsible for administering 28 pieces of legislation. Although MNP is not an expert in NWT H&SS legislation we have made some initial observations in this section that provide some background, identify unique situations, and provide an initial outline of required changes.

Background

Over the years the NWT government has made changes to the number of Boards of Management / HSSAs, going from an original twelve (12) HSSAs to the current eight (8). These changes would suggest that the NWT government has the necessary authority to make these changes. Previous changes include:

- When Nunavut was formed three out of twelve HSSAs were transferred to this new territory. This transfer resulted in the realignment of the boundaries of some of the other HSSAs.
- As a result of the Beaufort Delta land claim separate Beaufort and Sahtu HSSAs were created.
- Due to an inadequate population basis for effective service delivery the Deninu and Lutsel HSSAs were dissolved.

It is not clear whether the current Hospital Insurance and Health and Social Services Administration Act provides the necessary authority for the NWT government to make the changes required. To transition to one HSSA, all the current HSSAs will need to be dissolved and one new HSSA created.

- Under section 5. (f) of the HIHSSA Act the Minister “may authorize the establishment of health facilities and social services facilities…” Nowhere in the Act is there a similarly clear statement allowing the minister to redraw HSSA boundaries or dissolve HSSAs.

- Under section 12. (2) the minister is given the explicit authority to change the name assigned to a Board of Management "when the minister considers it advisable to do so." The new name for the single territorial HSSA could be achieved under this section.
- Under section 17 the Act outlines how the minister may appoint a Public Administrator to manage the affairs of the HSSA. When that occurs the authority and responsibilities of the HSSA devolve on to the Public Administrator. It would appear that this ends the existence of the Board of Management. Subsequently the Act states that the minister may terminate the appointment of a Public Administrator "and specify the conditions under which the operation of the HSSAs shall be carried on after the termination (17.4). Section 17.1 states the reasons under which a Public Administrator may be appointed. It is quite possible that more if not all of the current HSSAs could have a PA appointed using one of more of these reasons.

In summary, the Minister has the power to appoint a Public Administrator and subsequently to decide how to manage the HSSA after the PA has been terminated. While it is somewhat convoluted this route could conceivably be used to dissolve all the current HSSAs and to create one new one.

Unique Situations

There are two HSSAs that have unique characteristics that must be considered: Hay River and Tlicho:

- The Hay River Community Health Board, incorporated under the Societies Act, is continued under the HIHSSA Act as a Board of Management called the Hay River Health and Social Services Authority (HRHSSA). According to the Act the Hay River employees are not employed in the public service within the meaning of the Public Services Act. This would require an amendment to the Act to determine the HRHSSA employees' employer of record should the HRHSSA be dissolved. The simplest solution would be to bring the HRHSSA employees within the Public Services Act.
- The Tlicho Community Services Agency is deemed to be a Board of Management or HSSA according to the HIHSSA Act. This agency was established under the Tlicho Community Services Agency Act and under that Act its employees are deemed to fall within the Public Services Act. This community agency also has responsibility for education services. While the initial assumption may be that this HSSA can remain even if there is a decision to go to one territorial HSSA – in practice that could present some real problems. The concern would be to determine how the new territorial HSSA would relate to Tlicho Community Services Agency. An amendment to the Act or a Directive from the Minister are two possibilities to deal with this. An initial scan of the Tlicho Community Services (TCS) Act suggests that the Act already gives considerable authority to the NWT government and the Minister. Under section 22 of the TCS Act the minister may dissolve the board. This is actually much more power than the Minister has under the HIHSSA Act. Also the Minister may appoint a Public Administrator under the TCS Act. This concern would require additional exploration if there is a decision to move to one territorial HSSA.

In summary, our opinion is that some legislative actions are required to move to one HSSA. However, the government has made boundary adjustments and reduced the number of HSSAs in the past and done so under the current Act. This is something that will need to be further examined in the next phase by DHSS to determine the full extent of revisions required.

Implementation Considerations

The Government of Northwest Territories Health and Social Services legislation will require changes that enable the movement to a new system structure as well as changes that need to be done as purely housekeeping measures.

The Hospital Insurance and Health and Social Services Administration Act and associated regulations need to be amended and should likely be separated into two Acts:

1. Hospital Insurance Act
    - Define insured services and benefits

- Defines insured persons
- Defines the powers of the minister

2. Health and Social Services Administration Act
    - Defines the powers of the minister including his/her power to appoint or dissolve HSSAs and change boundaries
    - Defines the DHSS and their scope of responsibilities
    - Defines the NWT Health and Social Service Authority and their scope of responsibilities
    - Defines the NWT Health and Social Service Authority Governance Board

The Medical Care Act will need to be amended or incorporated into the Hospital Insurance Act. The Public Health Act will not need any amendments for implementation of recommendation. The Child and Family Services Act is currently undergoing a review and the new governance structure should be considered and reinforced in new Act.

The Public Service Act will need to be amended:

- Reference to Boards of management and exceptions for Hay River – Schedule A

The Financial Administration Act will need to be amended:

- Reference to Boards of Management changed to Boards of Governance – Schedule A
- Prescribed content and quality of plans and annual reports for public agencies – Part IX - 91 and 96
- Audit protocol to ensure compliance. For example operating budget for HSSAs do not currently encompass all known business and activity costs - Part IX - 92(2)
- Changes to any financial reporting or management processes should be approved by the Comptroller General

The Tlicho Act will need specific attention as this represents an area of self government with the potential to draw down social services from H&SS in the upcoming years.

Legislation Recommendations:

- Revise Acts and Regulations to clearly define system governance and the delegation of authority
- Ensure Acts and Regulations clearly identify Minister as having ultimate accountability
- Ensure Acts and Regulations clearly defines the relationship between the board and the minister, and the department and the authority CEO
- Ensure Tlicho Act clearly defines relationship (authority, role, responsibilities, accountability) between GNWT and the Tlicho government in the area of Health and Social Services

5.0 Conclusion

Meyers Norris Penny recognizes that the recommendations provided within this document represent significant change for the NWT health and social service system. The intent is to incorporate findings regarding context, current situation, and desired future state and develop recommendations that will lead to meaningful changes. These changes are intended to result in the ability to ensure safe and quality patient care for all residents of NWT.

The recommendations provided represent only the initial level of changes regarding governance and accountability. Many of the operational changes will depend on the outcome of other ongoing projects, most significantly, the service delivery review. The ability to coordinate territorial services and define a structure for regional delivery centres depends on a clear definition of core services and an understanding of where these services need to be accessed.

5.1 Summary of Recommendations

In sections three through six of this report, recommendations were presented in the areas of financial management, system resourcing, collaboration and consolidation, accountability, governance, change management and implementation. A summary of recommendations is provided below.

Figure 11: Recommended Governance Structure

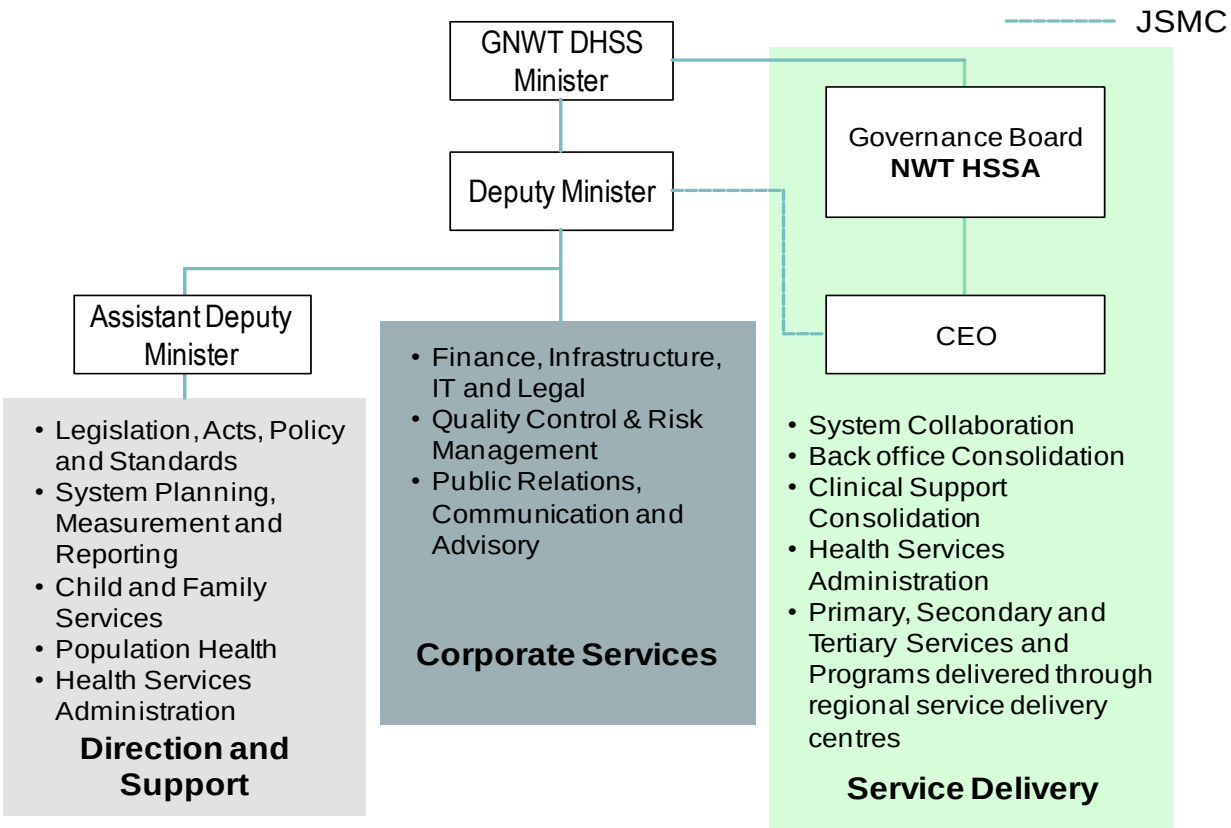


Table 33: Summary of Recommendations

Financial Management Recommendations

- Ensure financial management roles are well defined and understood (see section 3.1.1)
- Ensure financial instruments are well defined and understood (see section 3.1.2)
- Ensure financial protocols are well defined and understood (see section 3.1.3)
- Ensure financial systems are compatible and able to present information in the required categories and format

System Resourcing Recommendations

- Formally sanction ISDM and use ISDM categories for funded core programs and services to budget and report spending at territorial level (see section 3.2.2)
- Ensure reporting can easily be transferred to required categories for Public Accounts
- Ensure all costs for service delivery, administration and leadership are funded
- Should approved budgets not meet all costs, it is the responsibility of the GNWT and the Minister (under advisement from the HSSA) to make decisions regarding funding cuts
- Capital funding should remain within government control
- Financial protocol and compliance mechanisms to ensure operating surplus retention, reporting and variance analysis requirements are clearly defined and enforced
- All core programs and services should be defined in the Accountability Agreement
- Additional special projects should be funded through separate Contribution Agreements and summarized in the Accountability Agreement. Contribution Agreements should outline goals and objectives, inputs, outputs/activities, expected outcomes, end dates and reporting requirements
- Use of funds at primary level should have more discretion than those at secondary or tertiary levels

Accountability Recommendations

- Define program and service delivery levels for each HSSA once service delivery review is complete.
- Ensure roles and responsibilities are well defined and understood (see section 3.4.3)
- Define program standards and associated performance indicators
- Use Accountability Instruments to define and communicate roles, responsibilities and expectations as well as communicate performance and variance from expectations (see section 3.4.6)
- Develop Accountability Agreement to reinforce and communicate accountability structure and update as standards and performance indicators are developed (see section 3.4.9)

Governance Recommendations

Service Delivery Centre

- Define Regional Delivery Centres once service delivery review complete (see section 4.8)
- Authority to make decisions within defined parameters regarding defined service delivery responsibilities
- Based on geography and access to core services
- Number, size and role will be dependent on service delivery review, ISDM implementation, and consolidation of back office and clinical support functions

Structure Recommendations

- Ensure delivery system at arms' length from government by developing a successful governance board that provides direction to one territorial Health and Social Services Authority
- Ensure governance roles are well defined and understood (see section 4.10)
- Develop Board Charter that defines role, responsibilities and governance processes
- Ensure instruments of Governance are well defined, understood and kept up to date (see section 4.12)

Board Competencies

- Financial knowledge and experience
- Clinical knowledge and experience
- Organizational design understanding
- Communication skills
- Change leadership skills
- Collaborative negotiation and communication
- Commitment to system success
- Understanding of and experience with NWT culture and priorities
- Collectively reflect and represent the population of NWT

Board Director Appointment

- Governance Task Force to establish Board
- Rolling terms for Board members on initiation
- Eight Board members plus chair
- Minister appoints Board chair and two directors
- Minister and Task Force collaboratively appoint remaining members
- Minister has authority to extend terms of members or remove members prior to the end of their term

Board Committees

- Committees within Board to handle ongoing responsibilities
  - Governance and Nomination
  - Audit, Finance and HR
  - Regional Advisory
- Terms of Reference to clearly outline responsibilities and required competencies

Board Development

- Formal orientation, board education and performance assessments to ensure required competencies and capacity to fulfill mandate
- Protocol defined in governance policies

Legislation

- Revise Acts and Regulations to clearly define system governance and the delegation of authority
- Ensure Acts and Regulations clearly identify Minister as having ultimate accountability
- Ensure Acts and Regulations clearly defines the relationship between the board and the minister, and the DHSS and the HSSA CEO
- Ensure Tlicho Act clearly defines relationship (authority, role, responsibilities, accountability) between GNWT and the Tlicho government in the area of Health and Social Services

Appendix A - Other Jurisdiction Insights

We looked to the experiences of four other Canadian jurisdictions in regard to health and social services system governance and organizational structures to understand potential options for GNWT and potential pitfalls to avoid.

Table 34: 2010/2011 Selected Health Budget Data

Region	% of Budget	3-yr Growth Rate	Cost/Capital
British Columbia	43%	14.2%*	$3,983
Manitoba	48%	24.3%*	$5,255
Ontario	47%	20.7%*	$4,566
PEI	34%	34.7%	$3,603
NWT	25%	17.7%	$7,505

* Includes health portion only

British Columbia

Ministry of Health Services

The Ministry of Health Services in BC has overall responsibility for ensuring that quality, appropriate, cost effective and timely health services are available to all British Columbians and works collaboratively with the Ministry of Health Living and Sport. The Ministry sets province-wide goals, standards and expectations for health service delivery by health authorities (Government Letters of Expectation). This is accomplished through the development of social policy, legislation and professional regulation, funding decisions, negotiations and bargaining, an accountability framework for health authorities, and through the oversight of health professional regulatory bodies.

The Ministry also manages some provincial programs and services including Health Insurance BC (Health Benefits Operations, Medical Services Plan and Pharmacare), B.C. Vital Statistics Agency, Emergency and Health Services Commission (BC Ambulance Service and HealthLink BC), and Ministry of Housing and Social Development delivers Social Services in BC.

Health Authorities

In BC there are currently five regional health authorities and one provincial health authority. The five Regional Health Authorities are responsible for delivering a full continuum of health services to meet the needs of the populations within their respective geographic regions. The Provincial Health Authority is responsible for managing the quality, coordination and accessibility of selected province-wide health programs and services including BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Research Centre for Children, BC Women's Hospital and Health Centre, Perinatal Services BC, BC Provincial Renal Agency, BC Transplant Society, Cardiac Services BC, Emergency and Health Services Commission, and BC Mental Health and Addiction Services. The rationale for PHSA is that provincial services and highly specialized services account for 1/3 of the province's spending on hospital care.

Accountability and Reporting

Health Authorities are governed by a nine-member board appointed by the Minister of Health Services in accordance with the Health Authorities Act. Health Authority Boards are responsible for identifying population health needs, planning appropriate programs and services, ensuring programs and services are properly funded and managed, and meeting performance objectives. The board also oversees the conduct of the Authority's business and supervises management.

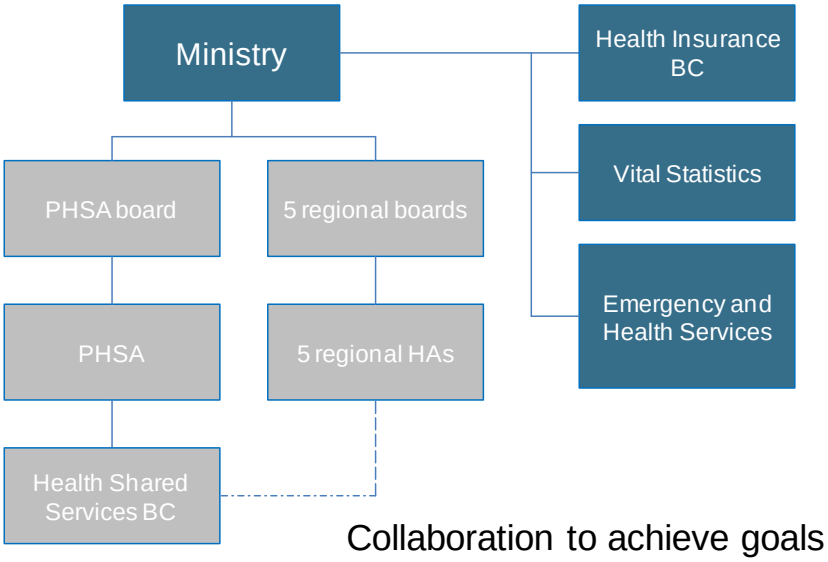
The mechanism to ensure accountability is the Government Letters of Expectation (GLE), which outlines government expectations for health services delivery and outcomes. Annual targets are set for accountability measures, and may vary between HAs. Long-term targets are set and monitored to allow for an understanding of trends. There is an expectation that to meet targets HAs will need to collaborate and share accountabilities with other HAs including the PHSA, however we could not identify specific mechanisms to ensure this collaboration. Some performance measures are applicable to all HAs while others are only applicable to the PHSA or regional HAs.

The Ministry publishes a two year Service Plan that reports on the strategic context, goals, objectives, strategies and performance measures and provides a summary of the financial requirement estimates. The Health Authorities report on progress through annual Health Authority Performance Accountability Reports. The Ministry also publishes an Annual Service Plan Report that reports on the year's highlights, performance and financial results.

New Initiatives

1. Patient focused funding model for BC's 23 largest hospital with the intent to incorporate this model with all health authorities.
2. BC Health Authority Shared Services Organization (now called Health Shared Services BC), that identified opportunities where health authorities can improve cost effectiveness and service quality by working collaboratively on common services like accounts receivable, payroll, supply chain, accounts payable and technology services. This organization became a division of the Provincial Health Authority as at September 17, 2010. Management Board members of shared services organization are the CEOs of the 6 health authorities, the COO of the Ministry of health Services, and two independent directors. A new contract with Microsoft is expected to save $34 million over the next six years on computer software and related services.
3. Joint purchasing agreement between the provinces of Alberta and BC.

Figure 12: BC Governance Structure



Manitoba

Manitoba Health

In 2009 Manitoba Health and Healthy Living was divided into two departments: Manitoba Health (MH) and Manitoba Healthy Living, Youth and Seniors (MHLYS). Health care is delivered by MH, MHLYS, grant agencies, arm's length health authorities, independent physicians and other alternate or fee-for-service providers. MHLYS oversees health promotion and prevention and MH oversees primary health care, public health, mental health, pharmacare, insured benefits, home care, protection for people in care. Ministers delegate responsibility and authority to the eleven (11) regional health authorities (RHAs) for the delivery of health care services. Legislation, regulations, ministerial directions, policy and guidelines identify the responsibilities and expectations of the health authorities.

The role of Ministry is to set strategic direction, establish legislation, policy and guidelines, define strategy and program development, and assume funding and fiscal accountability. The Ministry of Family Services and Consumer Affairs deliver social services in Manitoba.

Regional Health Authorities

Regional Health Authorities (RHAs) are responsible to plan, manage, deliver, monitor and evaluate health services. They operate through legislation (Regional Health Authority Act) and have input into the development of provincial policy and planning direction and into standards development. Regional Health Authorities are responsible for both institutional and community-based health services including hospitals, personal care homes, home-care services, mental health services and public health services and have overall responsibility for implementing and establishing a sustainable, integrated system of health services. The relationship between the Ministers and Health Authorities is intended to be collaborative using forums such as the Manitoba RHAs' Council of Chairs and Council of CEOs, and the deputy's Health Senior Executives. The relationships between RHAs are cooperative through the not for profit Regional Health Authority of Manitoba Inc. and community input is provided, to varying degrees of success, through community advisory committees.

Accountability and Reporting

Health Authorities are governed by a board typically based on the Carver governance model, which focus on strategic planning and setting policy and leave operational issues to the RHA CEOs and management. Boards vary in size from 11 to 20 members who are appointed by the Minister of Health. Manitoba Health publishes an annual report providing information on strategic direction, actual results and financial performance.

Each RHA publishes an annual report in accordance with the Regional Health Authorities Act that provides information on the health services provided, the costs of those activities, the health status of the RHA population, the effectiveness of the health services provided, and the audited financial statements. RHAs are legislated to conduct community health assessments on an ongoing basis to determine the determinants of health, current health status, emerging issues, and the characteristics and performance of the health system of their region. Each RHA publishes a five year strategic plan typically two years after the last community health assessment, as well as a regional health plan that is submitted to the Minister. Some hospitals and personal care homes maintain responsibility for the administration of their facilities and do not fall within an RHA.

Figure 13: Manitoba Governance Structure

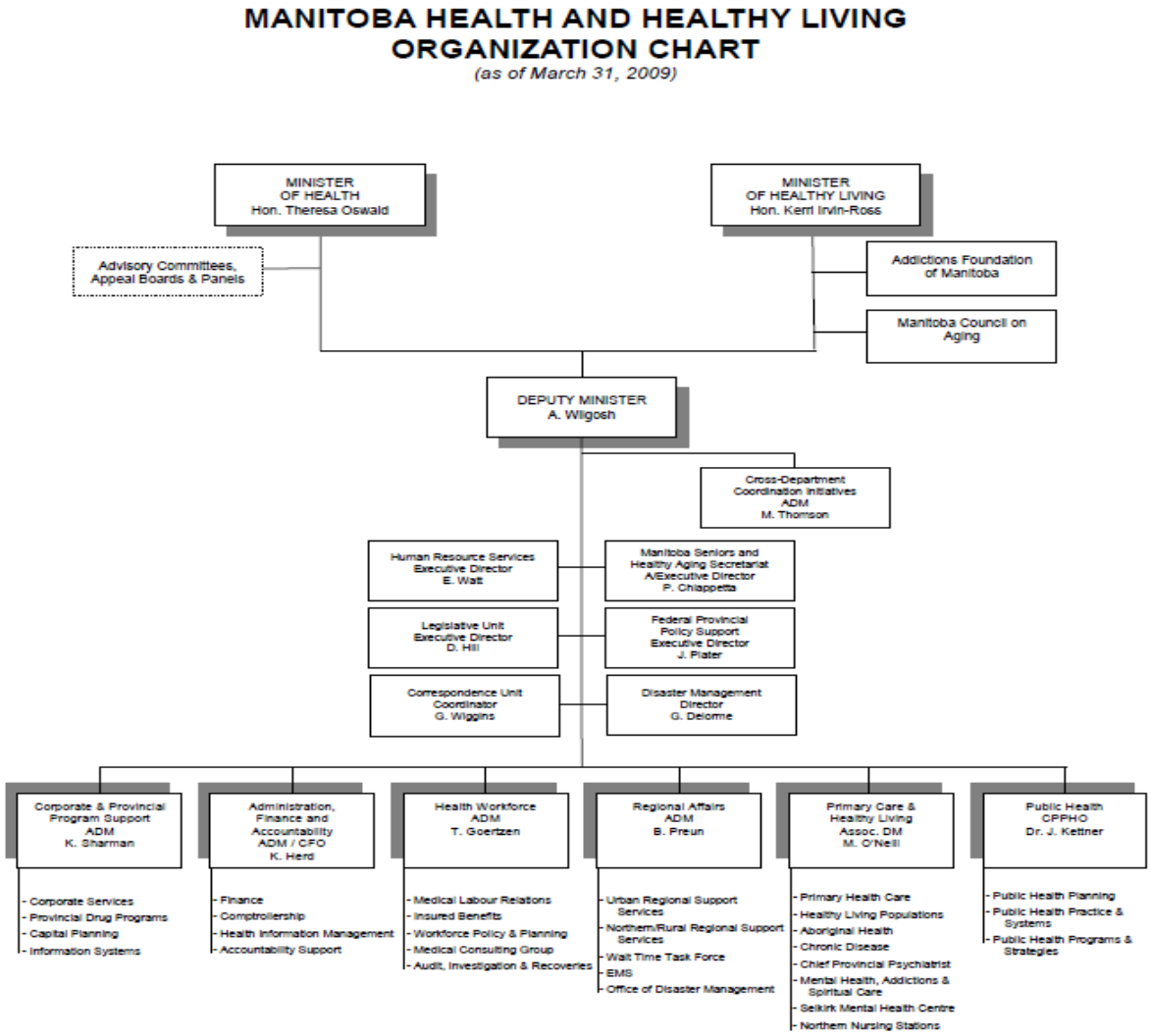


Table 35: Manitoba Governance Structure

	MHHL	HAs	Other	Public
Establish Expectations *Policy guides action and sets broad strategies*	• Provincial strategies • Facilitate coordination • System leadership and governance • Establish legislation, regulations and standards	• Develop regional service delivery strategies • Participate in development of strategies across regions • Provide regional and organizational health system leadership, governance and stewardship • Establish regional standards and guidelines	• Develop strategies specific to the role of the organization • Provide leadership, governance and stewardship in regards to organizational role	• Indirectly influences service expectations • May participate in broad strategies • Influences system's leadership and governance
Measure, monitor and report *Assessment determines and priorities needs; identifies resources*	• Assess provincial health status and needs • Determine provincial priorities and funding needs • Monitor regulations and standards • Oversees compliance	• Assess regional health status and needs • Determine regional priorities • Carry out community health assessment • Allocate regional funding • Provide health surveillance and monitoring	• Measure and monitor effectiveness of priorities • Ensure appropriate allocation of funding • May provide health surveillance and monitoring functions specific to organizational function	• Measure and monitor health needs through feedback • Participate in determining regional priorities through communication and participation in assessment process
Evaluation and Feedback *Ensures management and delivery of services*	• Ensure needed legislation • Determine core services • Ensure accountability for public spending • Approve health plan • Lead and participate in research initiatives • Ensure accountability	• Manage organization and delivery of services • Develop and submit health plan • Monitor services and effectiveness of actions • Initiate practice-based research and participate in provincial research • Communicate with public and ministers to ensure quality health care	• Independently manage performance of organization • Monitor service and effectiveness of actions • Communicate with public and government to ensure organization's function is beneficial to the health care system	• Provide feedback and evaluation through media and public responses • Communicates with ministers or health authorities to ensure quality health care is provided

Ontario

Ministry of Health and Long-Term Care (MOHLTC)

The MOHLTC has recently become less involved in the delivery of health care and more focused on providing overall direction and leadership by focusing on planning and guiding resources. Their responsibilities include: establishing overall strategic direction and provincial priorities; developing legislation, standards, policies and directives; monitoring and reporting on the performance of the health system and the health of Ontarian; planning and establishing funding models and levels of funding; and ensuring that ministry and system strategic directions are fulfilled. The Deputy Minister of MOHLTC oversees the work of 9 Assistant Deputy Minister with the assistance of an Associate Deputy Minister. The province of Ontario has recently been divided into 14 Local Health Integrations Networks (LHIN). In addition to the MOHLTC there is also the Ministry of Health Promotion, and the Ministry of Children and Youth Services.

Local Health Integration Network (LHIN)

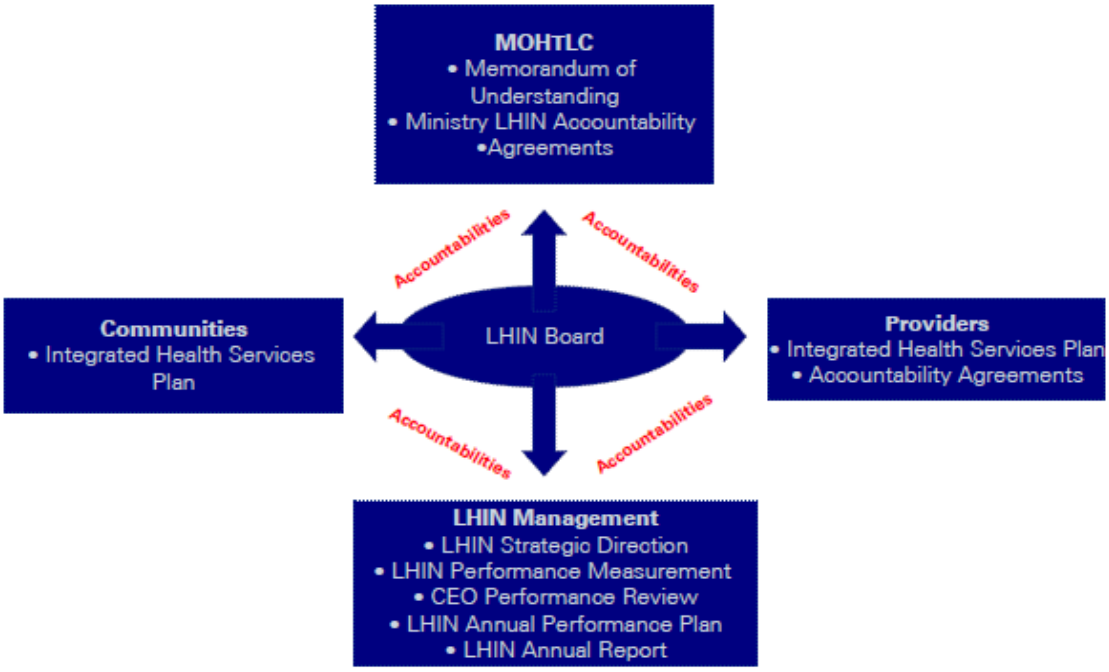
LHINs are not responsible for the delivery of health services but for integrating health services in each of their geographic regions. They are responsible for the planning, funding, integration and system management of public and private hospitals, community care access centers, community support service organizations, mental health and addiction agencies, community health centers, and long term care homes.

Accountability and Reporting

Each LHIN is governed by a nine member board bound by the accountability agreements with the MOHLTC and are established under the Ontario Local health System Integration Act. LHIN boards are appointed by an Order-in-Council through a transparent and consistent process. LHINs are accountable to the MOHLTC through the MOHLTC-LHIN Accountability Agreements (MLAA) and Memorandum of Understandings (MOUs). The MLAA describes the LHIN's authority and responsibility for health planning, funding, integration and system management, outlines accountabilities for each LHIN as well as for the MOHLTC, and describes the respective funding and performance obligations. Health Service Providers (HSPs) are accountable to their respective LHINs through two-year service accountability agreements (SAAs). There are three different kinds of service accountability agreements: (1) Multi-Sector Service Accountability Agreements (M-SAA): community care access centres, community support services, community mental health and addictions services, and community health centres; (2) Hospital Service Accountability Agreements (H-SAA); AND (3) Long-Term Care Home Service Accountability Agreements (L-SAA).

The MOHLTC publishes an Annual Results-Based Briefing Book that includes the annual report on performance and financial results, outlines key priorities and expenditures for the upcoming year and outlines current legislation affecting policy and direction. Each LHIN provides a three-year Integrated Health Service Plan that aligns with provincial priorities, builds on previous plans, and lists success performance measures. Each LHIN publishes an Annual Service Plan that outlines how they will implement the health care strategies and objectives, and an annual report that reports on community engagement, integration activities and performance and also provides quarterly reports to MOHLTC. Health Service Providers provide LHINs with quarterly and annual reports on performance and hospitals submit Hospital Annual Planning Submissions.

Figure 14: Ontario Accountability Structure



Prince Edward Island

Department of Health

As of July 6, 2010 the responsibility for the delivery of all health services was transferred from the PEI Department of Health and Wellness to a new Crown corporation named Health PEI. A 2008 provincial health system review recommended the establishment of a board run health authority (or equivalent) responsible for the operation of the province's health care system. The previous system was governed within the Department of Health which had the following weaknesses: decision making authority for all operational decisions were vested with spending; health care managers were unable to respond swiftly to issues as decision had to work their way up through the operational structure of the system as well as through the departmental structure; and managers were less accountable because their decisions were not in their hands. Accountabilities, roles and responsibilities of the Minister of Health and Wellness and Health PEI are outlined in the *Health Services Act.*

Health PEI

A Health Governance Advisory Council was appointed to recommend a governance structure that provided a high level of accountability and determined who makes what decision, how do responsibilities get monitored and how are people held accountable, and identified risk ownership based on responsibilities. The desired outcomes included: more timely decisions achieved through a simplified process where managers are empowered to manage within a scope consistent with their assigned responsibilities; improved mechanics for citizen/stakeholder engagement where issues can be addressed as close to the front line as possible and service planning is evidence and health-needs based; and an operating environment where clinical risks are minimized and quality outcomes are optimized. Health PEI is intended to allow for the development of more consistent standards, practices and will improve access to health services – care is provided in the right place, at the right time, by the right person.

Governance and Reporting

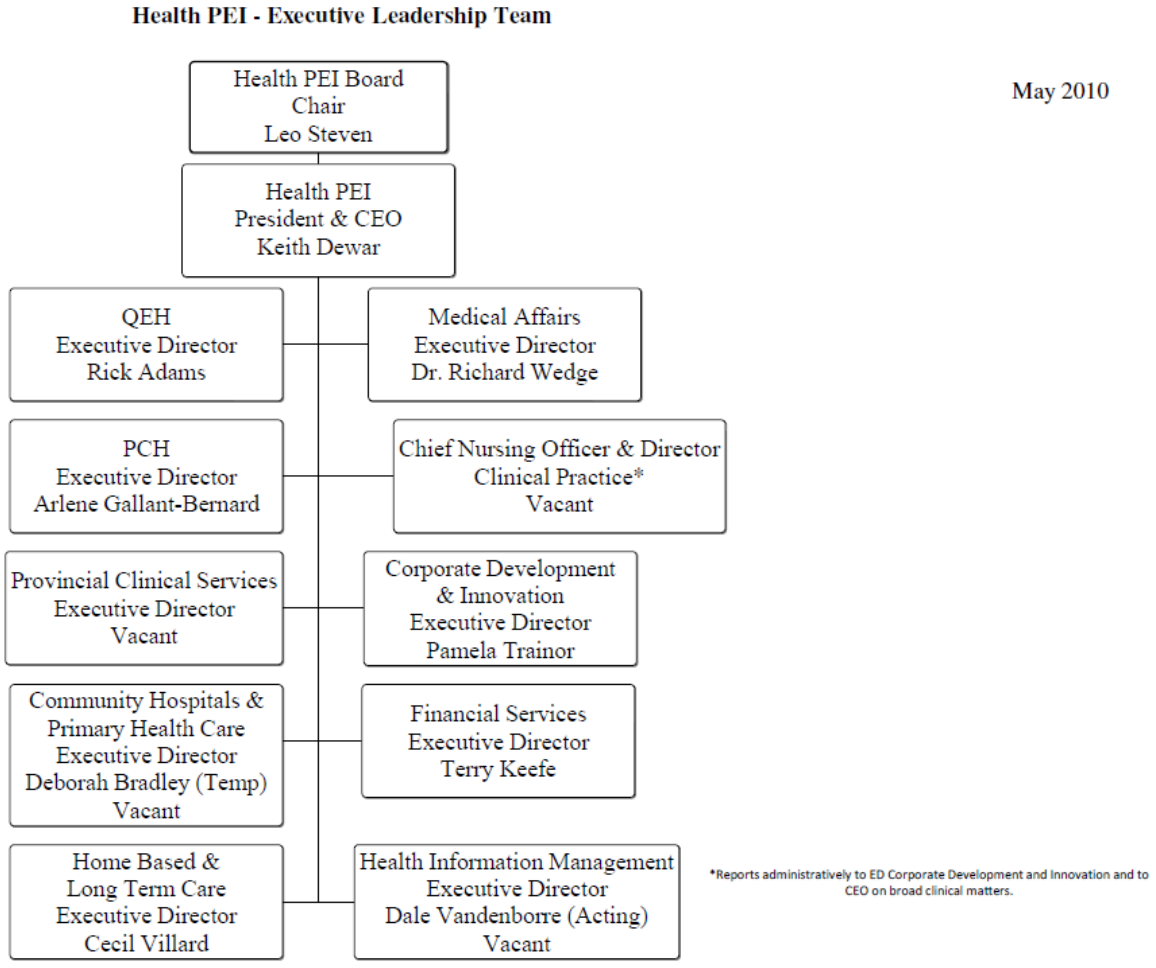
The Board of Health PEI governs operations, is responsible for oversight and risk management, and reports to the Minister through the Board Chair. They are responsible for developing and implementing bylaws to govern medical staff and ensure quality of health services once approved by the Minister. Directors are appointed by the Minister and currently include ten members. Health PEI is established under the PEI Health Authority Act and operates under the PEI Health Services Act.

Health PEI provides the Minister of Health and Wellness with an annual business plan and budget as well as a three year strategic plan which includes a public engagement strategy. They also prepare annual business plans, budgets and strategic plans. The Minister of Health and Wellness develops a provincial health plan that includes: principles for the provision of health services in the province; goals, objectives and priorities for the provision of health services; the health services to be provided and the health facilities to be operated; a comprehensive financial plan; any other matter prescribed by the regulations.

Current Initiatives

The new system is grounded in evidenced-based decision making and is focused on improving health by enhancing access and refocusing the emphasis on health care delivery to primary health care and services that can be appropriately and safety provided locally. It is recognized that the new structure will take some time to fully implement. Although transfer of power has taken place, no accountability framework has been established and there are currently no planning/performance reports in place. The Transition Management model is currently underway and is intended to transform how patients move through the health care continuum in PEI in a seamless, coordinated and planned fashion.

Figure 15: PEI New Governance Structure



Appendix B – Implementation Plan and Change Management

Preliminary Implementation Plan

Implementation planning is a critical component of a successful project. To be completed effectively technical experts need to be involved and consulted. Technical experts are those individuals who have the required experience and information to identify and define required implementation activities and their associated resource requirements. An initial implementation planning session was held with the Steering Committee on March 3rd, 2011. This was used to develop the preliminary implementation plan provided in Appendix B.

The implementation elements listed in the Table 36 were identified by MNP as critical elements for implementation and are discussed in detail in earlier sections of the report. The degree of specific change required to each of these elements will be determined by the technical GNWT experts, during detailed implementation planning.

Table 36: Implementation Elements

Implementation Element	What it Achieves
Legislation, Acts and Regulations	Structure and boundaries
By-laws, Policies and Standards	Rules
Authority, Roles and Responsibilities, Accountability	Clarity for system participants
Systems, Processes, Tools and Resources	Capacity requirements for transition and operations

In addition there are other initiatives currently underway that will need to be considered as part of the implementation process.

Table 37: Other Initiatives

Initiative	Description
Service Delivery Model	Primary, secondary and tertiary services
Medical Travel Review	Processes and procedures
Physician Model	Medical directors, staff doctors, locums
Child and Family Services	Act reform
Supplementary Health Benefits	New criteria regarding health benefits
Health Benefits Department	Lean process activities
DHSS IS Department	Governance, accountability, responsibility review
GNWT Shared Services	Back office consolidation – Finance and HR
Mental Health Strategy	Clinical collaboration - Territory-wide initiative
Pharma / Med Surgical Review	Back office consolidation - Procurement

Implementation Requirements

Implementation and ongoing sustainability of the new system will require changes and resources such as skills, tools and capacity. It is anticipated that although initial effort will be required to implement the change, ongoing system operations will result in a net decrease in resource capacity. Each operational area with resource requirements is discussed in Table 42 and depicted in Table 43 on the following page.

Table 38: Implementation Requirements

Governance
This will require initial changes and new tools and capacity but once transition has occurred there will be no additional resource requirements.
Service Delivery
There will be significant changes to the documentation of service delivery standards, policies and the implementation of the ISDM. It is not expected that this will require increased skills or tools long term, however this will require increased capacity during the transition phase to plan and implement changes.
Resource Management
Leadership and management of health and social service delivery requires strategic alignment with the Human Resource business functions such as recruitment, retention, and training. In addition it is critical to have access to staffing summaries and staff performance measures for ongoing management. Accordingly we recommend returning some elements of HR management to the HSSA and using GNWT only for transactional HR functions such as pay roll and benefits. This will require some change, new skills, new tools and increased capacity.
Financial, IT, MIS and IM functions will be consolidated and require significant change during transition, but skills, tools and load capacity requirements will be reduced.
Performance
The transition phase will require changes, new skills and tools and increased capacity; however it is expected that once implemented ongoing performance management will not require additional resources.
Accountability/Communication
The transition phase will require some change management due to the need to educate and ensure compliance, however this will not require additional resources on an ongoing basis. In addition, board governance capacity requirements will be reduced as there will be a move from eight to one board.
Project and Change Management
The implementation phase will require significant focus on project and change management to ensure a successful transition. These functions will need dedicated resources for the implementation period.
Sub Projects
Service delivery model: Policies, by-laws, and program standards, Infrastructure, Primary, secondary and tertiary services.
Clinical support consolidation: Pharmaceuticals, Labs and diagnostic services.
Back office consolidation: Human Resources, IT, MIS and IM, Financial administration, Procurement and equipment purchasing, Fleet management, Legal.
Medical travel business process design.

Appendix B – Implementation Plan and Change Management

Table 39 provides an initial outline of operational areas that will require some level of change, new skills or tools, or increased capacity. As the implementation plan is defined a more detailed table can be built. The years 2011 and 2012 represent required change, skills and capacity for transition, where as "Future" represents required change, skills and capacity for sustainability.

Table 39: Resource Implications based on Implementation Requirements

		Governance			Service Delivery			Resource Management			Performance			Communication		
		Acts and regulations	Planning and Budgeting	Accountability and Performance Agreements	Standards and Policies	ISDM Implementation	Clinical Supports	Staff	Financial	IT, MIS, IM	Measurement	Quality assurance	Risk mgm	Relationship Management	Reporting	Community input and feedback
Level of Change	2011	+	+	+	+	+	+	+	++	++	++	++	++	+	+	+
	2012	+	+	+	+	+	+	+	++	++	+	+	+	+	n/c	n/c
	Future	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c	n/c
New Skills, Tools	2011	n/c	+	+	n/c	n/c	+	+	-	-	++	++	++	n/c	+	+
	2012	n/c	+	+	n/c	n/c	n/c	+	-	-	+	+	+	n/c	n/c	n/c
	Future	n/c	n/c	n/c	n/c	n/c	n/c	+	-	-	n/c	n/c	n/c	n/c	n/c	n/c
Required Capacity	2011	+	+	+	+	+	n/c	+	n/c	n/c	+	+	+	n/c	n/c	n/c
	2012	n/c	n/c	n/c	+	+	n/c	+	-	-	+	+	+	n/c	n/c	n/c
	Future	n/c	n/c	n/c	n/c	n/c	n/c	+	-	-	n/c	n/c	n/c	n/c	n/c	n/c

n/c represents no change
\+ represents an increase
\- represents a decrease

System Task Forces

A Task Force is a working group that is established to address a specific need or issue within a specific time frame. We have chosen to use the title "Task Force" to reinforce the importance of the group. Membership would be appointed by the Minister with representation from the HSSA, DHSS, and subject matter experts. The following Task Forces have been identified to address key success factors during the initial change and development process:

- **Change Leadership Task Force** – responsible for the evolution and development of the new HSSA structure. Competencies: project management, organizational design, communication, change management.
- **System Integration Task Force** – ensure the development of working relationships with other community stakeholders, NGOs, professional associations, and GNWT to provide the ability to coordinate and collaborate.
- **Back Office Consolidation Task Force** – ensure the feasibility and transition to consolidated back office functions.
- **Clinical Support Consolidation Task Force** – ensure the feasibility and transition to consolidated clinical support functions.

Major Activity Streams

Initial implementation planning took place on March 3rd, 2011. It is critical that the technical experts who understand the process required for each of these activity streams be involved in the detailed implementation planning. As an initial step sub projects have been identified that will likely occur concurrently but still have dependencies that will need to be identified and mapped within a broader project management framework. For each of these activity streams specific tasks will need to be defined in terms of responsibility, timeline, budget, resources, dependencies and required change management. This Preliminary Implementation Plan provides an initial description of potential activities and timelines. These will need to be reviewed and revised on an ongoing basis.

Table 40: Implementation Activity Streams, Outputs and Outcomes

Activity Stream One – Governance
Outputs:
• Cabinet approval of recommended governance structure • JMC and JSMC acceptance of recommended governance structure • NWT acceptance of recommended governance structure • Revisions to Legislation to allow restructuring • Appointment of interim board for initial development work • Appointment of permanent board • Appointment of HSSA CEO
Outcomes:
• Board structure and processes implemented to ensure capacity and capability to govern and direct health and social service delivery. • Clear legislation, by laws, and protocol implemented that define the delegation and limits of authority and responsibilities along with their associated accountability

Activity Stream Two – Accountability

Outputs:

- ISDM implemented
  - Development of ISDM to define access to health and social service programs and services
  - Development of ISDM to define infrastructure and resource requirements
  - Used to inform funding model and accountability agreement
- Service and Program Standards Defined and approved
  - Used to inform funding model and accountability agreement
- Performance Indicators defined
  - Outputs, outcomes, indicators and targets defined
  - Used to inform the accountability agreement
- Accountability Agreement developed
  - Initial revisions and development of Sections and development of Schedule 1 General, Schedule 2 System Integration and Planning, Schedule 4 Special Projects, Schedule 5 eHealth, and Schedule 9 Insurance Requirements
  - Revisions to financial policies and protocol and development of Schedule 6 Financial Policies and Protocol
  - Development of reporting templates and development of Schedule 7 Compliance
  - Final Accountability Agreement developed once standards, performance indicators and funding model are developed (Schedule 3 Performance Requirements and Schedule 8 Budget)

Outcomes:

- Sanctioned ISDM implemented that provides framework for service delivery throughout NWT.
- Defined regional delivery centres.
- Clear program standards and service delivery policies implemented to ensure consistent service delivery throughout NWT.

Future Activity Streams: Develop new Organizational Structure for Department and HSSA
Back Office and Clinical Support Consolidation

These will be possible once Activity Streams One and Two are complete and a new HSSA exists

Outcomes:

- Leadership, Divisions, Offices, and required staffing and resources defined and implemented within department, HSSA and Regional Delivery Centres to accommodate new authority, roles and responsibilities
- Back office consolidation opportunities have been evaluated, defined and implemented.
- Resources have been redeployed within region or system to other value-add activities.
- Clinical support consolidation opportunities have been evaluated, defined and implemented.
- Resources have been redeployed within region or system to other value-add activities

Implementation Templates

The implementation plan provided in this section is an initial outline of sub-projects and specific activities required to move this initiative forward. Sample reporting templates are provided below for consideration.

Table 41: Detailed Implementation Overview Template

Ref.	Activity	Status Update	Next Steps	Timing	Implementation Team	Resource Needs	Cost Factors

Table 42: Implementation Plan Summary Template

Major Activity	Tasks	Timing	Responsibility

Table 43: Implementation Status Report Template

Major Activity	Task/Tactic	Progress	Reason for Delay (where applicable)	Revised Completion Date

Figure 16: Process Map for System Governance Implementation

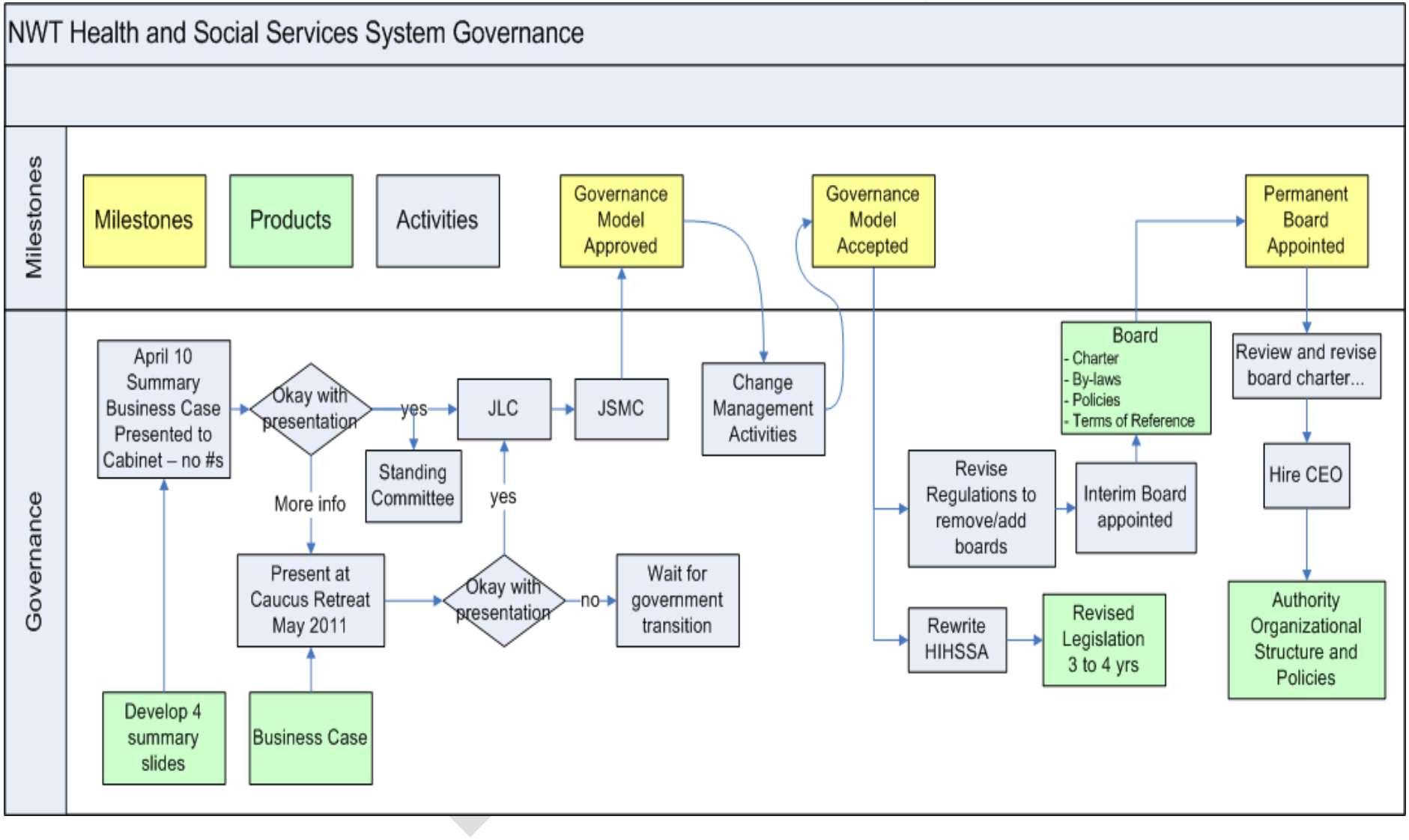


Figure 17: Process Map for System Accountability Implementation

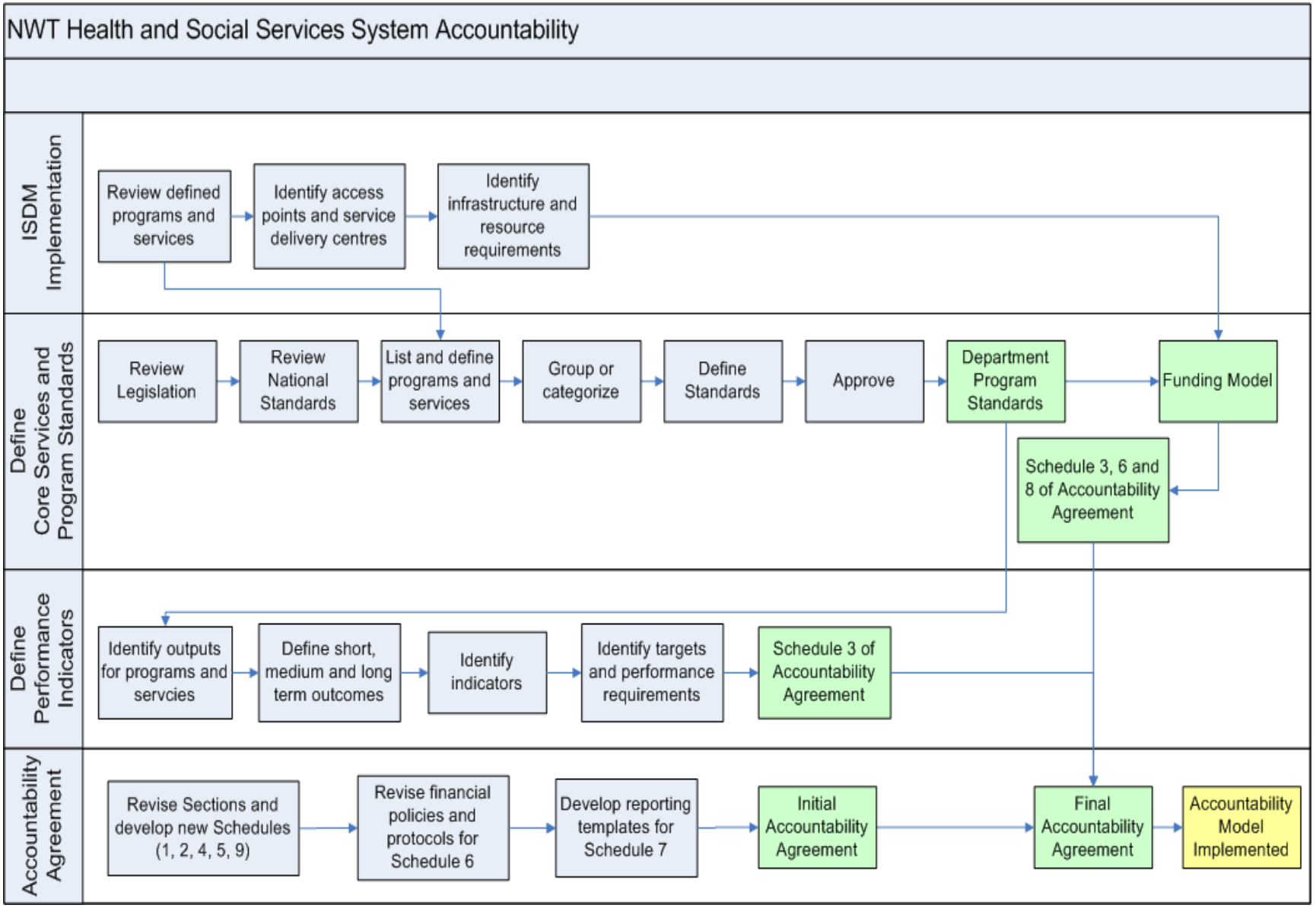
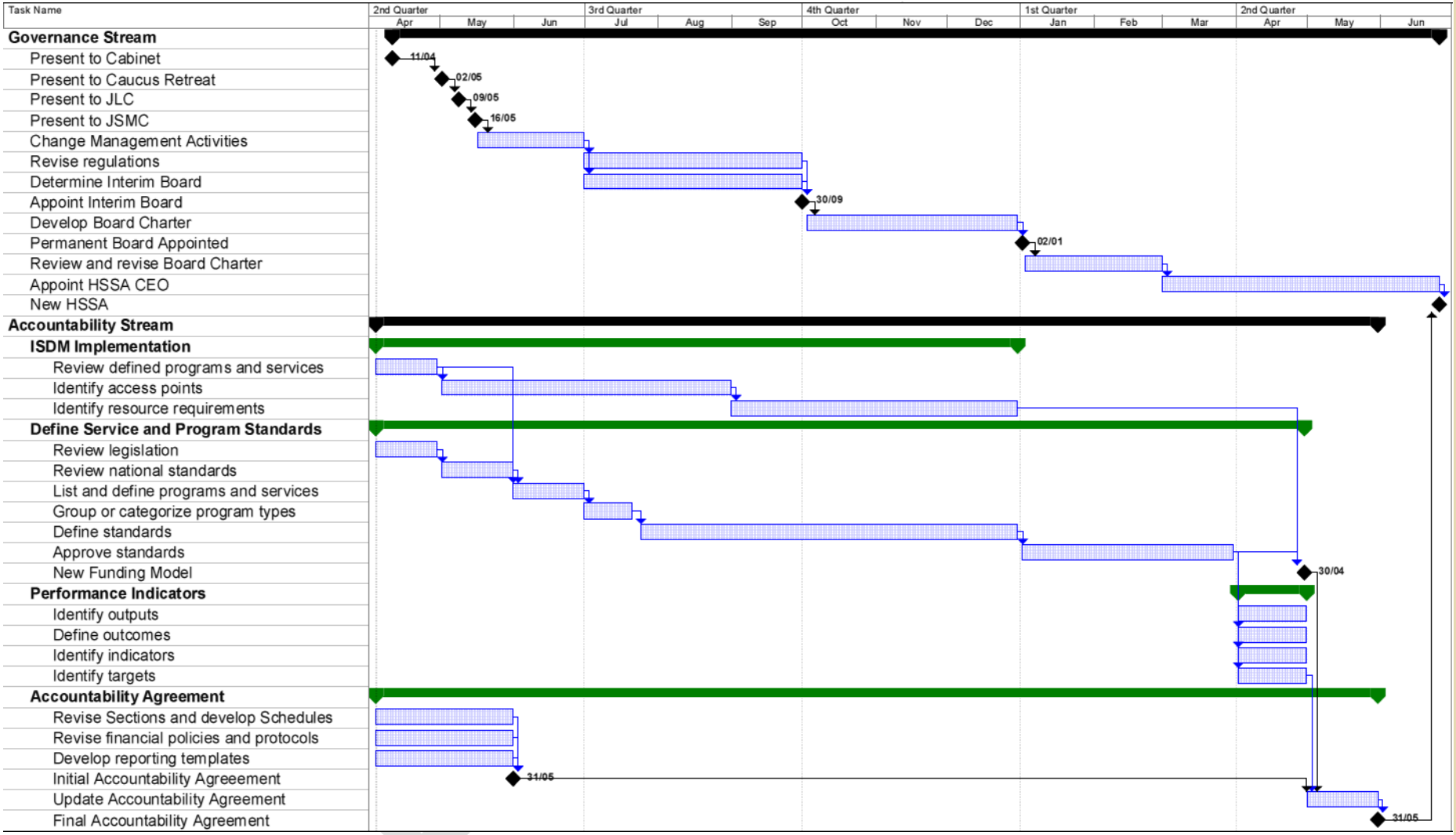


Figure 18: Gant Chart for Implementation of Change Activities



Change Management Considerations

In sections 3.0 and 4.0 we have made recommendations that represent significant change for health and social service governance that will impact all levels of the system. Accordingly we recommend that you employ a strong change management process to help ensure the implementation process is efficient and effective. This section is intended to provide:

- An overview of the change management process
- Identification and initial assessment of the stakeholder groups
- A definition of project stages and change management recommendations for initial stages

This section outlines a change management process and provides initial assessments and preliminary change management plans. Please note this represents change management activities only and would occur alongside the implementation planning or project management process.

Change Management Process

When initiating change it is important to both prepare for change and manage the actual transition. Table 44 summarizes a typical change management process.

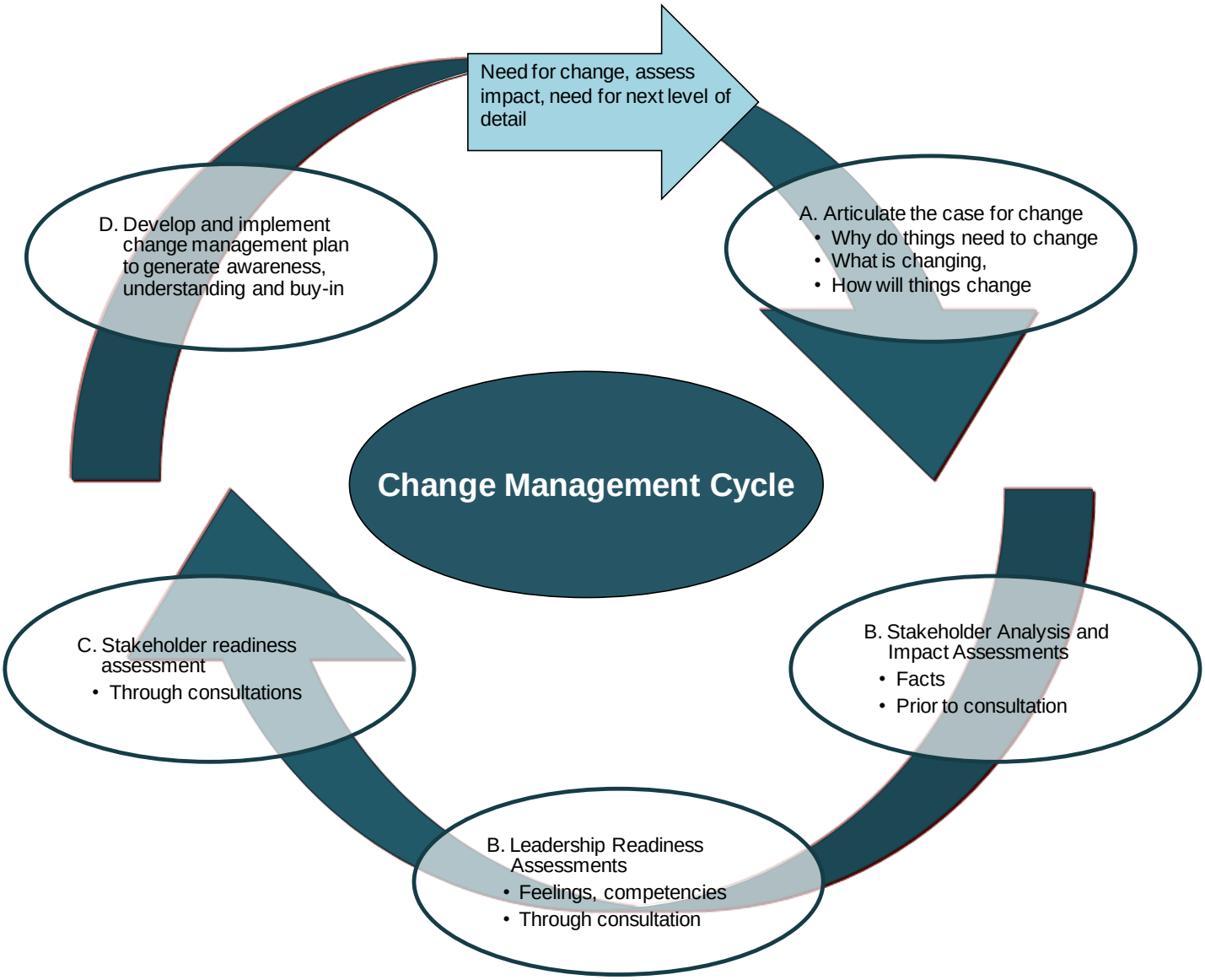
Table 44: Change Management Process

Change Management Process	
Preparation	Kickoff ✓ Get the leaders on board and involved ✓ Clarify the nature of the change and identify stakeholders Gather Information ✓ Gather information while providing opportunities for stakeholder input Identify Gaps ✓ Identify the stakeholders' level of understanding and readiness for change ✓ Identify the sources of resistance Plan the Transition ✓ Identify actions for introducing the change and overcoming resistance
Transition Management	Create Urgency ✓ Create a sense of urgency to eliminate complacency about the need for the change Create a Change Coalition ✓ Form a group to help lead the change Communicate ✓ Keep everyone informed ✓ Be continuously open to receiving questions and inputs Engage ✓ Find opportunities for meaningful engagement of stakeholders Identify Short-Term Wins ✓ Provide evidence of success and build momentum Anchor the Change ✓ Instill new approaches in the organization's culture

Change Management Cycle

Change management is a cycle that is repeated throughout the project design, implementation planning and implementation stages as changes get identified, explored and detailed.

Figure 19: Change Management Cycle



Appendix B – Implementation Plan and Change Management

Change Management Plan

A Change Management Plan will need to be fully developed and should address the following areas:

- **Readiness** – the history of change initiatives and situational factors that impact the magnitude and readiness for change.
- **Vision** – the vision, business and organizational implications of the future state, personal implications of future state, business and performance goals.
- **Overarching change infrastructure** – existing or other change efforts, integration elements.
- **Communication** – existing mediums of communication and their effectiveness.
- **Leadership capacity and stakeholder commitment** – understanding of the change process; leadership roles and behaviors to support change; leadership team competencies; existing training; commitment to the change.
- **Organizational design** – organizational structure, roles and responsibilities, performance goals and measures, rewards and recognition processes.
- **Individual and team capacity** – understanding of the change and the change process; sources of resistance to change; skills gaps and learning needs, equipment, coaching requirements.
- **Culture** – behaviors and values required to successfully implement the change.

Stakeholder Groups

An initial analysis to identify stakeholder groups for the current engagement was conducted with the Steering Committee. The intent was to identify the following stakeholders:

- **Primary** – those individuals or groups of individuals who would be directly involved in designing and implementing the changes.
- **Secondary** – those individuals or groups who would need to be consulted regarding what should change and how it should change.
- **Other** – those individuals or groups who would need to be informed about the changes.

Figure 20: Stakeholder Groups

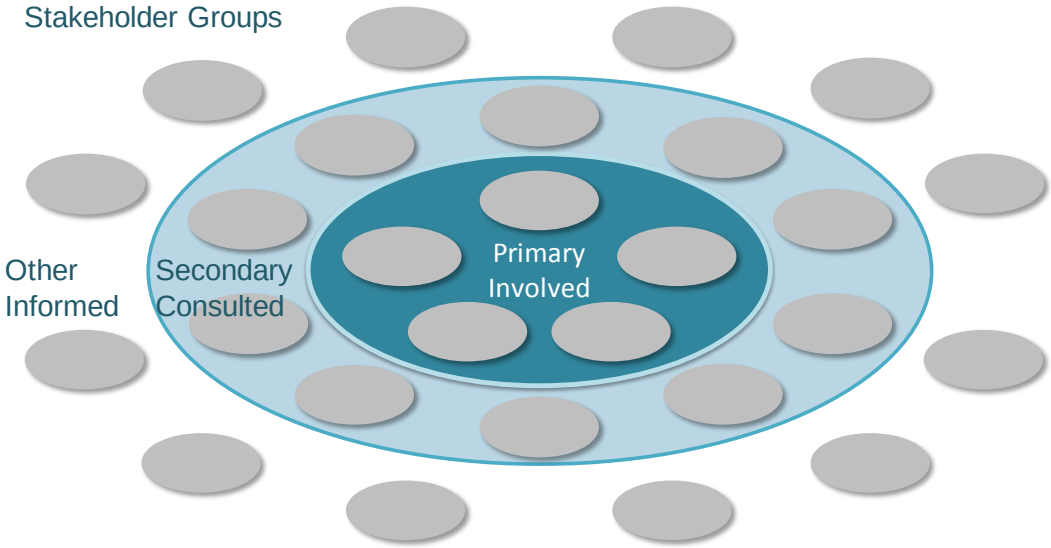


Table 45: Identified Stakeholder Groups

Primary – will need to manage or lead implementation
• GNWT – Premier, Minister of Health, MLAs • Department of Health and Social Services: Senior management • Health and Social Service Authorities: CEOs and Boards • Other GNWT departments
Secondary – will need to adjust daily tasks
• Health and Social Service Authorities: Finance and Administration • Department of Health and Social Services: Finance and Policy • Other GNWT Departments: Finance, Human Resources, Public Works (Technical Service Centre) • Non-Government Organizations and other Delivery Agents
Other – will need to be informed and aware
• Health and Social Service Authorities: Staff • Department of Health and Social Services: Program administrators • Aboriginal organizations and Bands • NWT residents • Unions

Impact Assessment

A complete impact assessment should consider the following elements:

- Number of stakeholders involved in the process
- Impact on core competencies
- Number of people impacted by the change
- Number of people who have to learn new skills or change specific behaviours
- Degree of required simultaneous changes to processes, technology and skills
- Degree of required cross-functional collaboration and involvement
- Timetable to implement change
- Link between performance results and change effort

Primary Stakeholder Groups were identified with the Steering Committee and an initial impact matrix was developed that identified the impact of change for identified stakeholder groups for each of the areas of change. Impacts have been defined as Low (L), Medium (M) or High (H).

Table 46: Stakeholder Impact Assessment

STAKEHOLDER / CHANGE	8 to 1 Board	One Territorial Health Authority	Acts & Regulations	Policies & By-Laws	Program Standards	New Contribution Agreement	New Accountability Structure	New Funding Structure	Back Office Support Consolidation Clinical
Cabinet	L	L	M	L	L	L	M	H	L
Standing Committee	L	L	M	L	L	L	M	H	L
Minister	M	M	M	L	L	M	M	H	L
GNWT DHSS Senior Mgmt	H	H	H	H	H	H	H	H	H
Authority Boards	H	H	H	H	L	H	H	H	L
Authority CEOs	H	H	M	H	M	H	H	H	H
Other GNWT Depts	L	M	L	L	L	L	L	L	M
MLA's	M	L	L	L	L	L	M	L	M
Aboriginal Boards	M	L	L	L	L	L	M	L	L
Aboriginal Organizations	M	L	L	L	L	L	M	L	M
Union	L	H	L	L	L	L	M	L	H

The DHSS senior management, HSSA Boards, and HSSA CEOs stakeholder groups were identified as being the most impacted by change. Change management efforts for this group will be to ensure they understand how their roles and responsibilities will change. In addition, it will be important to ensure there is the required capacity and capabilities within these groups to take on any revised roles and responsibilities. This group may also require competencies for championing the change and helping their staff to transition to the new model, process and/or responsibilities.

This analysis, however, does not assess what level of impact stakeholder groups will have on the success of the change initiatives. This analysis is provided in section the following section, Stakeholder Assessment.

Stakeholder Assessment

A stakeholder assessment was undertaken to identify each stakeholder groups' ability to impact the success of change, what they would need to commit to the change, what the challenges may be to getting their buy-in, whether their commitment is required, and who or what they have influence over. This assessment is done to understand the importance of getting certain stakeholders "on-board". Those stakeholder groups identified as having an impact on the success of change combined with an ability to influence a significant group will also be targets for change management. They are targets for change management, not because the change will have any direct impact on them, but because they are important to ensure the success of the change efforts.

Table 47: Assessment of Stakeholders' Ability to Impact Success

Stakeholder Assessment						
Group	Impact on Change	Success Criteria	Key Challenges	Commitment		Influence over
				Current	Required	
Cabinet	H	Understanding and commitment to need for change and resulting system benefits	Non-partisan government	M	H	HSS Minister and MLAs
Standing Committee	H	Understanding and commitment to need for change and resulting system benefits	Non-partisan government	M	H	HSS Minister and MLAs
HSS Minister	H	Understanding and commitment to need for change and resulting system benefits	Non-partisan government	M	H	DHSS, HSSAs
DHSS Senior Mgm	H	Understanding of change and system benefits	Concern regarding system capacity and capability to plan, implement and manage change	M to H	H	HSSA staff
HSSA and Tlicho Board Chairs	H	Understanding of benefits to system and all NWT residents	Personal impacts of change may influence buy-in	L to M	H	HSSA CEO and community members
HSSA and Tlicho CEOs	H	Understanding of benefits to system and all NWT residents Ability to acknowledge and	Personal impacts of change may influence buy-In Concern regarding	L to M	H	HSSA staff and community members

Stakeholder Assessment						
Group	Impact on Change	Success Criteria	Key Challenges	Commitment		Influence over
				Current	Required	
		support self government	system capacity and capability to plan, implement and manage change			
Other GNWT Depts	L	Understand impact of change on their departments and whether sufficient resources are allocated	No significant hurdle	M	M	Own department staff
MLAs	H	Understanding of benefits to system and the NWT residents from their region Concern regarding losing jobs in smaller communities	Non-partisan government History of taking all issues directly to Cabinet or Minister	L to M	H	Community members
Aboriginal Organiza-tions	H	Understanding of benefits to system to all NWT residents Concern regarding losing jobs in smaller communities	Have considerable political power and need to be on-board to change	L to M	H	Community members, cabinet and standing committee

Readiness Assessment

A readiness assessment should be completed through consultations with impacted stakeholder groups. This was not within the scope of this engagement but is a key initial step to ensure a successful change process. A readiness assessment will examine the elements listed in the Table 48.

Table 48: Stakeholder Readiness Assessment

Knowledge
Understanding of current issues and potential solutions
Satisfaction
Satisfaction with current situation and specific areas of concern or dissatisfaction
Benefits
Perceptions regarding the need for change, the likelihood for success, and the areas of change that are viewed as positive
Resistance
Sources of resistance, issues around which resistance surfaces and how the resistance is expressed, possible suggestions for addressing concerns such as information or training
Communication
Communication methods and messages that are typically well, and not well, received
Leadership
Aspects of project leadership and sponsorship which, in the past, have been appreciated or have not been viewed as helpful
Culture
Aspects of each stakeholder group's culture, such as employee attitude, past experience with change, levels of trust and teamwork that would help or hinder the groups' ability to embrace change

Project Stages

The overarching stages of the project have been identified in the following visual. Stages one and two are essentially complete, and change management plans for stages three and four are defined in this section. It is recommended that change management planning for stages five through seven occur following this engagement as recommendations are approved and changes are implemented.

Figure 21: Project Stages

Change Management Strategy for Stage 3: Socialize Recommendations

During this stage, recommendations regarding system design will be communicated and feedback will be gathered from key stakeholder groups.

Table 49: Change Management Activities for Stage 3: Socialize Recommendations

Change Management Strategy – Project Stage 3						
Activity	**Purpose**	*****	**Description/Deliverables**	**Audience(s)**	**Timeline**	**Responsibility**
Round Table Sessions (3)	Introduce categories of change and intended benefits	C	Facilitated session where progress to date on areas of change and system benefits are communicated and discussed. Resistors and supporters are identified and assessed for potential impact and mitigation strategies.	Board Chairs HSSA CEOs MLAs	Early February	Deputy Minister (DM) Assistant Deputy Minister (ADM)
Change introduction meetings	Introduce categories of change and intended benefits	C	Reasons for change and intended benefits are clearly understood. Identify any unintended impacts of change Resistors and supporters are identified and assessed for potential impact and mitigation strategies.	Community Leaders Cultural Leaders	Early February	DM and ADM
Change enablement meetings	Identify areas of resistance and concern	E R	Ensure benefits of change are clearly understood. Understand whether concerns are justified or related to personal impacts.	Resistors (if they can be identified and someone has a level of influence)	Late February	DM and ADM
Change enablement meetings	Identify and engage supporters	S E	Establish where benefits are clear and which supporters have a level of influence over other stakeholders.	Supporters	Late February	DM and ADM

* (C) Communication (E) Stakeholder Engagement (T) Training
(S) Sponsorship (R) Resistance Management (F) Follow-up Support and Reinforcement

Change Management Strategy for Stage 4: Detailed Implementation Planning

During this stage, implementation activities will be further identified and planned with relevant technical experts.

Table 50: Change Management Activities for Stage 4: Detailed Implementation Planning

Change Management Strategy – Project Stage 4						
Activity	**Purpose**	*****	**Description/Deliverables**	**Audience(s)**	**Timeline**	**Responsibility**
Round Table Sessions	Confirm and discuss main project streams	E	Ensure technical experts and potential resistors are consulted regarding the major activity streams. Clearly identified and detailed change streams and identify realistic timelines, dependencies and resource requirements.	Technical experts • Legislation • Standards and policies • Board governance • ISDM design • Org design	Early March	Project and Change Managers
Change Newsletter	Keep stakeholders informed	C	Correct information and messaging is communicated to all stakeholders regarding progress and next steps.	Key Stakeholder groups	Bi-weekly	Project and Change Managers
Question forum	Provide all stakeholders with a non-threatening mechanism for queries and suggestions	E	All questions or concerns are addressed and consistent responses are communicated to broader group through newsletter.	Key stakeholder groups	On-going	Project and Change Managers

(C) Communication
(E) Stakeholder Engagement
(T) Training
(S) Sponsorship
(R) Resistance Management
(F) Follow-up Support and Reinforcement