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Western Regional Health Authority

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Honourable Ross Wiseman, MHA

Public Accounts Committee

Chair: Jim Bennett, MHA

Vice-Chair: David Brazil, MHA

Members:

Sandy Collins, MHA
Eli Cross, MHA
Eddie Joyce, MHA
Christopher Mitchelmore, MHA
Kevin Parsons, MHA

Clerk of the Committee: Elizabeth Murphy

Appearing:

Office of the Auditor General
Terry Paddon, Auditor General
Sandra Russell, Deputy Auditor General
Scott Walters, Audit Manager (A)

Western Regional Health Authority
Susan Gillam, MD, President and CEO
Devon Goulding, Vice-President, Finance and Decision Support

The Committee met at 9:00 a.m. in the House of Assembly Chamber.

CHAIR (Bennett): We are now on camera, and this is a good time for all of us to silence our telephones or other devices that might make a noise.

Good morning.

This is a meeting or hearing of the Public Accounts Committee of the Province of Newfoundland and Labrador. For the benefit of our newcomers who have not been here before, or people who may have tuned in, the process that we follow is, first of all, all of the individuals here introduce themselves, say who they are and why they are here, and the witnesses are sworn. After that, we do a question and answer, and the question and answer is done in nominally ten-minute segments. It starts with a member of the Opposition, and it alternates back and forth between a member of the Opposition and a government member.

When I say nominally ten minutes, that is the time we have decided on; however, if somebody is involved in some particular subject matter then we try to let them finish that, instead of having it more disjointed. That may run over a little bit. If we have had some discussion about a procedural point or some sort of issue, so that particular member who was questioning at that time is not disadvantaged, we let it run a little bit longer so they get at least a relatively fully complement of ten minutes.

Today we have a review of the Auditor General's report related to the Department of Health and Community Services, and in particular the Western Regional Health Authority. I am, first of all, going to ask the Auditor General, Mr. Paddon, to introduce himself. If he has any comments, we are happy to hear them. It is not necessary to have comments, but –

MR. PADDON: No. My name is Terry Paddon, Auditor General of Newfoundland and Labrador, and I think for this hearing I will probably dispense with my comments. I think the report is fairly straightforward, nothing that I think I really need to elaborate on.

CHAIR: Next.

MR. WALTERS: Scott Walters, Office of the Auditor General.

MS RUSSELL: Sandra Russell, Deputy Auditor General.

MR. GOULDING: Devon Goulding, the VP of Finance and Decision Support with Western Health.

CHAIR: D-e-v?

MR. GOULDING: D-e-v-o-n.

CHAIR: How do you spell your last name?

MR. GOULDING: G-o-u-l-d-i-n-g. 'Goulding' if you are on the mainland, 'Golding' in Newfoundland, I guess.

CHAIR: I am sorry?

MR. GOULDING: I said, 'Goulding' if you are on the mainland, 'Golding' in Newfoundland.

CHAIR: Okay, thank you.

DR. GILLAM: Good morning.

Susan Gillam; and I am the CEO of Western Health.

MR. BRAZIL: David Brazil, Vice-Chair.

MR. S. COLLINS: Sandy Collins.

MR. K. PARSONS: Kevin Parsons, Cape St. Francis.

MR. CROSS: Eli Cross, Bonavista North.

MR. MITCHELMORE: Christopher Mitchelmore, The Straits – White Bay North.

MR. JOYCE: Eddie Joyce, Bay of Islands.

CHAIR: We will start with Mr. Joyce, but before we do we would like to offer Ms Gillam or Mr. Goulding if you want to – I am being reminded by the Clerk we need to swear witnesses, but then we would like to offer you an opportunity, if you want to give some background or review so you do not start off without any sort of context. That tends to frame the issue or issues better.

Swearing of Witnesses

Mr. Devon Goulding
Dr. Susan Gillam
Mr. Scott Walters

CHAIR: We will wait for Ms Murphy. She is probably attending to something technical we have overlooked or overseen. Anything from lighting to, it could be doors. Earlier, back in the summer, there were renovations underway and there were jackhammers and various devices on the go outside, regrettably we were not able to do much about that.

The reason not all individuals have been sworn is that they have been previously sworn. This is an ongoing process, so it is not necessary in our view to re-swear individuals who appeared before us previously or within this particular period.

Ms Gillam, if you would like to, if you have any comments, or Mr. – either one of you, then we would be happy to hear from you before the committee members start to ask you questions.

DR. GILLAM: Thank you, Mr. Bennett.

Good morning, everyone. I would like to thank the Chair and Vice-Chair and the members of the Public Accounts Committee, also the Auditor General and the representatives of the Office of the Auditor General for giving us this opportunity.

On behalf of Western Health, we are pleased to have the opportunity to address the Public Accounts Committee today regarding the Auditor General's findings and recommendations. We believe that today's discussion will provide further clarification of the issues raised in the 2012 Auditor General's report and the update provided to the Public Accounts Committee on June 28, 2013.

Western Health was formed on April 1, 2005, and it brought together two predecessor organizations, Western Health Care Corporation and Health and Community Services Western. Western Health covers a geographical area that extends north to Bartletts Harbour, to Jackson's Arm on the eastern boundary, to Grey River and François in the south. We serve a population of approximately 78,000 people and we offer a full continuum of health and community services including: long-term care, acute care, and community health services.

Additionally, Western Health has responsibility for unique provincial programs, including Humberwood, which is an inpatient addiction treatment program, the provincial cervical screening initiative, and Western Regional School of Nursing. We provide those services in twenty-six medical clinics and twenty-six community health clinics, four health centres, two hospitals, and two long-term care homes. We have approximately 3,200 employees, 160 physicians, 1,300 volunteers, and three foundations which support the work we do. The vast majority of our funding is spent in the direct care for the people of our region, approximately 73.5 per cent.

Upon the establishment of Western Health, we inherited approximately $31 million in accumulated debt from the two predecessor organizations. Since that time, we have balanced our budget with a slight operating surplus in six of the eight years. This allowed Western Health to reduce the accumulated debt from $31 million to $11.4 million, a 63 per cent decrease. We are proud of Western Health's financial performance.

Western Health has taken the Auditor General report 2012 and the recommendations contained in the report very seriously. We have viewed the report as an opportunity to continue to improve our organization. We have continued to address the recommendations, established

audit processes, and develop policies and procedures. Furthermore, a working group was established to oversee the implementation of the recommendations in the Auditor General report, comprised of senior executives and Chaired by the CEO.

Changes were underway with many of our processes prior to the Auditor General review and we were forthright in sharing this information with the officials of the Office of the Auditor General. This included the development of a health human resource information system, alignment of policies and procedures, and improved internal controls over our assets, such as cellphones.

We have continued to move forward with implementing a number of changes to existing policies and procedures, and internal controls, based on the findings and recommendations as outlined in the Auditor General report 2012.

I am confident that today's discussion will demonstrate our commitment to strengthening Western Health. Western Health is committed to the prudent use of organizational resources, achieving our mandate, and realizing our vision of the highest level of health and well-being for the people of our region. We are committed to providing quality health and community services to the people of our region.

Thank you.

CHAIR: Thank you.

I think you are more appropriately addressed as Dr. Gillam?

DR. GILLAM: Yes, thank you.

CHAIR: Mr. Joyce, would you like to begin to ask questions of Western Health?

MR. JOYCE: First of all, thank you very much and I thank the Auditor General again for the report on Western Health. I thank the people today for appearing to discuss these issues.

As you can see, a lot of the issues in the letter that was written to you by the Chair and the Vice-Chair, a lot of the questions have been addressed and have been brought to your attention. I will just go through, as I usually do, the Auditor General's report, just a few things to see if they have been rectified.

On page 209, Recruitment, "…external competition file did not have the required hiring checklist completed and filed in the successful candidates' personnel file." Has that been changed now to ensure that the procedure does include having the checklist and all the documentation on the personnel file?

DR. GILLAM: We have taken action to ensure that the recruitment files contain appropriate information. We have developed a documentation checklist. We have also provided our HR staff with recommendations and processes regarding the contents of our files, and we have received documentation from the Public Service Commission relating to what should be contained in a recruitment file. We have identified and created an audit checklist and audit processes.

So, we have gone so far as to determine what we need to contain in our audit and we are planning to look at the months of July, August, and September, and start the audit in terms of do the audit files contain the information they are intended to contain. We are going to continue this process as we go through to ensure that the competition files have the correct information.

MR. JOYCE: Was this started before the Auditor General's report, or has this come up since the Auditor General's report?

DR. GILLAM: After the Auditor General provided the review, we then developed the processes to ensure the competition files were correct. Some of the issues related to misfiling, but we certainly decided that we needed to look at an audit to ensure that all of our competition files and recruitment files are up to date.

MR. JOYCE: In a lot of hearings we have had, the Auditor General noted that there is a lot of

documentation missing like this when you do hiring and recruitment. Sometimes it is just missing or it is just not put in the right place, so you do need that, too.

Just on the next sentence down, "…was hired based on their skills and experience in their previous position with the Authority." It just shows where applicants were accepted, but in it, it does not show why the person was selected, the reasoning. "Without interviews and ranking of the candidates…." Will that be included in your audit now?

DR. GILLAM: Yes, we have implemented a process that we will require interviews and selection processes for all of our competitions. We agree that without interviews and ranking of candidates we have to demonstrate that our hiring processes are fair and objective. So that is what we are doing. These were two incidents where people were in temporary positions, but we have taken steps to rectify that.

MR. JOYCE: Okay.

On page 210, this is an issue that, as we all here, has been in the media lately: confidentiality. It says here, "3 of 28 files did not contain a confidentiality form". Is that being rectified now?

DR. GILLAM: Yes, absolutely. Confidentiality is very important to Western Health. What we have in terms of our process, as of yesterday, 97.83 per cent of our staff have signed confidentiality oaths. The remainder of staff that are incomplete are some people who have not worked and when they return to work, we will ensure that they have the confidentiality oath signed. We also not only keep a copy in the competition file, we have a listing computerized database of our staff that have signed oaths of confidentiality.

MR. JOYCE: Before or since the Auditor General's report, is there some kind of audit, internal audit, to ensure that this is complete?

DR. GILLAM: Prior to, during, and after the Auditor General report, we have been taking steps to ensure that we have and are fulfilling our mandate according to the Personal Health Information Act.

MR. JOYCE: I will just go to the next line, "…3 of the 28 files did not contain up-to-date documentation related to the employees' qualifications…." Is that also part of your new hiring documentation?

DR. GILLAM: Yes, that is part of the audit checklist to ensure that all of those things are in place, including educational documents, licences, and so forth.

MR. JOYCE: If you go on to the next page, 211: Non-compliance with the Government Classification Policy. Has that been rectified now to ensure that the authority is within the government guidelines for classification?

DR. GILLAM: We have implemented a classification job offer policy that provides guidelines to ensure that we classify all of our positions in a timely manner. We implemented that policy on February 8, 2012 and this is being utilized to ensure that all positions are classified appropriately by the Human Resource Secretariat.

MR. JOYCE: Was this again in motion before the Auditor General's or after?

DR. GILLAM: We had a Hay classification committee and a classification committee within Western Health. Some of these items of non-compliance were one-off items, but we are going to ensure that we do follow the classification system. We have our policy, and we are going to ensure that that is implemented.

MR. JOYCE: Will there be some type of internal audit system whereby just to have a review, just a random review of –

DR. GILLAM: We did an audit to ensure that all of our positions were receiving the appropriate salary. We completed that late spring of this year and they were all on the appropriate step and/or receiving the appropriate salary scale.

MR. JOYCE: Okay.

Page 212, step progression policy, has that been initiated?

DR. GILLAM: We have made major gains. What we are doing, we have developed and are in the process of implementing an automated scheduling system, and also linked with our Health Human Resource Information System. That will ensure that people do not have to request their step progression, but we are waiting for the actual implementation of that Health Human Resource Information System. So it is in progress, but it is not completed.

MR. JOYCE: When do you expect it to be completed?

MR. GOULDING: I am not sure the exact date when we –

CHAIR: I have to interject. I did not mention this before. When you speak it is important to say who you are for the people who do the transcript. It will be relatively easy in this case because we have only two individuals. It will be easy to determine, but sometimes it is not as easy for the person who prepares the official record. That was my oversight.

This is Mr. Goulding.

Thank you.

MR. GOULDING: As I indicated, I cannot give you the exact time that the Health Human Resources Information System will be complete. That is a part of a larger project we are doing with the other three regional health authorities across the Province. It is being staged across all four of us; hence, I cannot give you an exact time.

The scheduling system Ms Gillam referred to, we are hoping to start rolling that out within our organization within the next months, and I would say hopefully complete by the end of this fiscal year, March, 2014.

MR. JOYCE: Okay, thank you.

The next page, page 213 – which is very rare to see, we have not seen where there was an overpayment and the overpayment was repaid. Is there a policy in place now about housing allowance at the top? Where now if someone was overpaid, or to ensure that housing allowances are paid within the policy?

DR. GILLAM: Our policy is and our process, if we under or overpay our staff, we look at that on a case-by-case basis. In terms of – I think there were six items identified there. We did recover that and the payment was repaid.

What we are doing around our housing, particularly with our physicians, is working with the other health authorities so that we have a consistent housing policy and we are paying people consistent benefits.

MR. JOYCE: Okay.

I will just go to the bottom of that page, 213. The step progression of an employee, 25, and their pay scale with the authority invoiced based on step 24. Is there a procedure in place now to try to ensure that whatever you invoiced the Department of Health for is within their –

DR. GILLAM: Absolutely. I think what we have initiated is a double check of when we submit an invoice to the department. Two people within Western Health would review it to ensure that we were not either over or undercharging any of our third party organizations for payment. This was simply an oversight.

MR. JOYCE: Were these new reviews put in place since the Auditor General?

DR. GILLAM: The review process was put in after the Auditor General's report as part of our working group looking at ways to improve our internal controls.

MR. JOYCE: Just as a general question, as you can see in the Auditor General's report, do you feel it was beneficial to the organization to have a more internal view, step by step look at the operations?

DR. GILLAM: Absolutely. I respect the work of the Office of the Auditor General. We have taken it very seriously as an organization. We have been very committed to auditing processes and strengthening our internal controls prior to the AG report, but it is very important we have an external review of your processes, and then it helps give you movement forward. I think we have demonstrated that through the work we have undertaken. I do appreciate, and I think it has been very worthwhile.

MR. JOYCE: Can I ask the Auditor General: How did you find – when you were dealing with Western Health, with some of the issues that you found when you were dealing with the Western Health –

MR. PADDON: You are asking how – it is probably the wrong way to phrase it, but the relationship between our offices?

MR. JOYCE: Yes.

MR. PADDON: I think it was – I would probably ask Scott Walters to jump in after I finish, but my sense is that the relationship was very positive, very cordial. There is a process of back and forth to make sure that the items we uncover, that there is nothing missing, and that process worked very well. I do not think I would classify it as adversarial by any stretch. I think the sense of the work was taken in a positive sense, but I will just ask Scott to add to that.

MR. WALTERS: Yes, I second Terry's comments. Once again, it was very open communication, very professional staff. Being a small area of Corner Brook, you get to know the people as well. So that assisted as well, but very professional, very open, answered all of our questions, very forthright.

CHAIR: Mr. Joyce, we will move on to a government member.

MR. JOYCE: Okay.

Thank you.

MR. BRAZIL: Welcome to the Auditor General and his staff, particularly Dr. Gillam and Mr. Goulding.

I want to thank you on three fronts. First of all, for appearing, we appreciate that. It gives us an opportunity to address the issues here. Second of all, and by far in my opinion, the most professional detailed response we have had to the nineteen questions that the Committee put forward. I appreciate that, but particularly for your statement at the beginning and also your statement now to my colleague about admitting and acknowledging the role that the Auditor General plays, but particularly what he is outlining, that there are concerns regarding the operations, particularly around Administration when it comes to Western Health.

That is indeed a positive thing to start off these hearings because there is nothing more annoying to me, and I think my colleagues too, when agencies, line departments or organizations come in and all of a sudden go on the defensive that this is why and why. The fact that you have acknowledged, and that is evident here, there were some inconsistencies, there were some challenges in how you operated, and there is no doubt that there were some flaws, but what you have outlined here to me is phenomenal on how you proceed forward.

I do have a couple of questions. I am going to ask a general one around – because it is three months later since you responded. I would like to get a real update as to how things have progressed. I do take into account and do understand the summer months, but what you outlined there I would have thought would have been a normal progression.

A couple of questions here; you have done a costing here at this point where you wanted to look at the feasibility of compiling and maintaining a capital asset ledger. Have you looked at the costing? Is it an exorbitant amount of money or is it something that can be done fairly easy or built into the existing mainstream?

MR. GOULDING: We have not done a detailed costing; however, based on our

knowledge of the information system we are running, the Meditech information system, which is a consolidation of financial and clinical data that is well established within the health care sector, we do know the module in that is extremely expensive. I would not put a price tag on it at this point in time because it does change, but not only that, it is fairly labour intensive to keep it maintained when it is in place.

What we have done in the meantime is we do have a maintenance tracking system. While not all, and far from it, not all of our equipment is identified in that in terms of furniture, desks, chairs and some of the smaller stuff, we do have a fairly detailed record of all of our major medical type equipment, and beds and stretchers, for example, anything that requires any type of maintenance on it. The major stuff, and especially stuff we need to track for other purposes, we do have a good listing and a good record of.

MR. BRAZIL: Okay, great.

MR. GOULDING: Sorry, if I can just add to that – we also, since the AG report, and I cannot say categorically if it was started before, during, or after, but we have also implemented a system to improve the tracking of our computer type equipment.

MR. BRAZIL: Okay, perfect. I am glad to hear that because one of the concerns I had originally when the Auditor General's report came out and we knew there were concerns about Western Health, the first alarm is about quality of health care. That is my first, primary concern there. When we get into administration, it is still a concern and it is still a very valid issue for the Auditor General and for the Committee itself, but to make sure it does not have an impact on the quality of health care.

When I read through your responses, that was my worry about the ledger, the maintenance records, knowing that an MRI machine does not go down or an X-ray machine does not go down because it has been maintained and people can look at the responses there. I am glad to hear that and a compliment to you guys for maintaining that.

I do encourage you guys to move to where you want to go, that there is a full ledger. There may be an attached cost and there may be a human resource that is necessary. I know while everybody reviews efficiencies, there are certain things that need to be put in place so that the quality of health care is not compromised. Again, I compliment you on that.

A question around a key capital asset that you do have, some of the residences and the properties that are owned by Western Health: Off the cuff, is there a dollar figure? Has that been assessed, of what properties that you could dispose of if necessary?

DR. GILLAM: We formed a residential committee to look at our residences and to look at the occupancy of the residents that we have. Some of the residences are kind of unique. We have houses in some rural communities, but then we have houses in a larger centre that may have five bedrooms that we rent out to five individual tenants. They could be medical students, physicians, locums, or other staff. We are looking at our occupancy and then we are going to look at if there are things that we can dispose of. We will certainly be exploring that in the months to come.

MR. BRAZIL: Okay.

At this point, are all of those occupied now, or are there still some that right now are vacant?

MR. GOULDING: Are they all occupied right now? I cannot answer that categorically. I do not have a detailed occupancy list in front of me.

When you look at our occupancy list, and I guess it is something I am struggling with because that is an area of responsibility I have, for example we have one house in Corner Brook that has five rooms in it. The main purpose of that house is to provide accommodations for medical students and resident interns, which we are obligated to provide. Some months there are two in there, so I have 40 per cent occupancy in

that house. It does not sound very good, but it is two bedrooms out of five. Sometimes the occupancy rate is a bit misleading. I am not saying it is not an issue, but again, I struggle with what is a better measure to really show that.

We are in the process of updating the occupancy on our residents for the past year. I am hoping to have that information available to me within the next two weeks. At that time - while I think your question was: do we have a dollar value on the properties that we may be able to dispose of - I would not be able to give you a dollar value here. I do think we have some properties that we will be disposing of. When that time comes, that process will be done through an open market call, so the dollar value will depend on what the market in the various communities will allow us to get for those properties.

MR. BRAZIL: That is reasonable. I am glad that you are being proactive versus – and again, I know stats, as a former civil servant, that 40 per cent might look bad at that point but then, all of a sudden, if you give up three of those rooms and now you have two medical students and two nurses and the market out there is 400 per cent more, you will get chastised for not being proactive. I compliment you guys on that, and I would suspect so would the taxpayers as they go through the process.

As I mentioned at the beginning the fact that we are almost three-and-a-half months since you wrote this, I would like a general, if you could, Dr. Gillam, update as to how things have progressed and you do not have to give me detail question to question but general concepts and the concerns that the Auditor General had around some of the administration and some of the activities, please.

DR. GILLAM: Sure.

Since June 28, our committee has met four times; that is the working group to review the Auditor General report. Each time, we look at each item and we do an update and a status report as to where we are. Some of the issues are a little bit more complex, like the residential properties. We have our occupancy rate from January 2012 to March 31, 2013. Mr. Goulding will be doing the assessment for March 31 to present, and then we can make some informed decisions. That is a little bit more complex. We need to take our time in terms of making any adjustments to our processes and our programs.

We have moved forward with our auditing, we have moved forward with our review processes, and we put new policies and procedures in place. I see this and the auditing process as a continual process. I do not know if we will ever be done. We will have these pieces completed, but I think it will point us into the direction of other things that we want to go to improve our internal controls.

I am comfortable with the work that we have completed and that we are going to continue to complete. Some things were very easily rectified; other things are a little bit more complex, and it takes time. We would not want to make a decision that we have disposed of a property prematurely and then incurring a lot of cost for housing, because we do have arrangements with Memorial University around our medical students, our residents, and our interns. We will be doing that very cautiously.

I am pleased. We are not there yet, but it will always be something that we are working towards. Our committee will continue to take this under advisement. Then, the results of our audit processes will lead us in other directions, too.

MR. BRAZIL: Perfect, thank you.

Well, Mr. Chair, as I said in my opening statement, going through the detailed response and understanding what the concerns from the Auditor General are, unless something pops up from one of my colleagues asking questions, I am fairly comfortable with the answers I have gotten. I will turn it over now to Mr. Mitchelmore.

CHAIR: Mr. Mitchelmore.

MR. MITCHELMORE: Thank you, Mr. Chair.

It is very refreshing to hear the response thus far from Dr. Gillam. The Western Regional Health Authority is a very large organization, and I think the Auditor General's report really sheds a bit more light on the complexity of such an organization beyond the delivery of health care; that it does include a much more broad spectrum of other things that need to be dealt with when it comes to human resources and having control and management of staff, and also the equipment and capital assets, the Public Tender Act, and these types of matters.

When the general public may think of health care, we generally think of the nurses, the doctors, and the general staff; but there is a much broader operation. The Auditor General's report certainly had findings of systemic problems in a variety of areas; but, in the response that Western Health has taken thus far, it seems like there has been much effort made to rectify a number of the issues.

I do have questions. It is on the recruitment files. You may have touched this on Mr. Joyce's earlier questions. In the response you gave us, June 28, you said that over the next five weeks there would be additional auditing and things happening. Did that happen? Basically what you had said to Mr. Joyce is the extent of what has been done with these files?

DR. GILLAM: What we have identified is the process. We have identified the sample size, and we have identified who will be doing the audit. We decided to go with three months and then to continue that on an ongoing basis, depending on what that audit showed; if there were issues we would look at that further than the sample size that we have identified. We are hoping to have that completed – we will be starting that process next week, actually. We have the checklist developed and we have the processes in place, so that will be starting in the very near future.

MR. MITCHELMORE: These types of checklists and policies that you have now developed, were they always in place because, generally, it would be a standard policy to have a checklist when you are hiring an employee? Has there anything new been added, or it is looking at enforcing past policy?

DR. GILLAM: We had a previous checklist, but we have revised the checklist. We consulted with the Public Service Secretariat around what they see as important in the checklist, so to look at standardization and consistency. We have modified the checklist. Now the further step is the auditing to ensure that it, in fact, is done. Checklists are very important around safety and also around quality and processes, so that will help us to ensure that it is being done and then taking corrective action.

MR. MITCHELMORE: You have an internal compliance auditor on staff who will be taking over these duties?

DR. GILLAM: What we have – and I am really proud to say – is that we have staff and managers who are really committed to audits and auditing processes.

MR. MITCHELMORE: Okay.

DR. GILLAM: Many audits are very familiar, as you talked about earlier, in the client-resident-patient field. We do not have an internal auditor, but we view auditing as the role of senior managers, managers, directors and staff, so that is the approach we will be taking.

We have, on occasion, brought in external auditors. An example, I guess, would be a financial audit that happens every year with the Auditor General's office, and then we have also brought in external auditors to look at areas that we have wanted to delve a little bit further in.

This will be part of the work that we will be doing within our various branches and departments.

MR. MITCHELMORE: You feel you have sufficient staff to be able to meet these goals?

DR. GILLAM: Yes, because we are going to make this as part of the way we do business.

MR. MITCHELMORE: Okay.

Mr. Joyce had asked about the confidentiality forms for the specific files, three of twenty-eight. In your response you had said that 97.01 per cent back in June, and then you increased that number to 97.83 per cent.

DR. GILLAM: Yes.

MR. MITCHELMORE: If the number of employees remained as it was in June that would mean about seventy-one employees would not have confidentiality forms signed at this point.

DR. GILLAM: Right. We have seventy that are incomplete.

MR. MITCHELMORE: Okay.

DR. GILLAM: We have some people who are call-in relief who have not been called in. So, when they are called in, we will get them to sign the confidentiality oath. We have other people who may be on some form of leave of absence, so when they return. We also wrote the employees, the seventy, or at the time there were ninety-eight, and we advised them that they have to sign their oath before we would either recall them or before they return to work. It is critical.

MR. MITCHELMORE: Absolutely.

DR. GILLAM: We take it very seriously and we have made great efforts in getting this done. All new employees, before they start work, they have their oath of confidentiality signed. Our Board of Trustees have an oath. We have taken it throughout our entire organization.

MR. MITCHELMORE: Right.

Seventy still seems like a higher number and I like the measures that have been put forward by Western Health that people will not be recalled to work until this is complete. What about people who have left and may never come back to this organization and patient confidentiality could potentially be at risk or the litigation could be quite high? Are there additional steps the organization is willing to take if it comes to that measure?

DR. GILLAM: Prior to the Personal Health Information Act, all employees signed an oath of confidentiality. With the change in the act, that necessitated a new signing of their oath. I am confident that the previous employees did have an oath of confidentiality that I signed when I started work a number of years ago.

In terms of the seventy, we need to do a little bit more work on that and review their letters and find out exactly where they are and if and when they plan to return to work. We are committed to get rates of 100 per cent; that is our goal.

MR. MITCHELMORE: Okay.

The performance appraisals not being complete are concerning. In your response to the AG, you said that performance appraisals have been identified as an excellent tool for providing feedback to employees to support their continued growth. Your letter on June 28 notes just over half were done by that date. Has that work been completed now? If not, what percentage is left to do?

DR. GILLAM: The work is ongoing. We view the performance appraisal as very important for staff development. All of our senior executive have annual performance appraisals and they are up to date. I have a yearly appraisal that is up to date. Our Board of Trustees, they do an annual evaluation.

Right now, we have increased our rates. It is still not where we want it to be; it is 55.72 per cent. We have made some modifications regarding the processes. We have simplified some our forms because some of the forms were quite complex. We are going to continue to make this as a priority with our organization. We are going to increase that rate higher than 55.72 per cent.

MR. MITCHELMORE: I guess since you see this as such an important tool and certainly getting feedback as well from employees make for a more dynamic organization and can lead to efficiencies –

DR. GILLAM: Absolutely.

MR. MITCHELMORE: Obviously, you have identified that forms and complexity of reviews can be a barrier. Are there are other barriers as a human resource barrier to actual completing the other 45 per cent, because there would likely be competing interests? What would not get done if this becomes a greater priority?

DR. GILLAM: I think one of the priorities was simplifying the form because that lessens the time that is required to complete the form. Senior executive is more extensive. Some of our front-line staff, the form may be modified, depending on what peoples jobs, roles and responsibilities are.

One of the issues was time, so we looked at that and said what can we do differently; and one was modifying the form. Understanding we do have staff on shift work, people work a twenty-four hour schedule, but we are committed to making advances in that area.

We did stratify and look at what were some of the priorities and one of the priorities obviously was our leadership team to ensure that we had performance appraisals; but I think it is very important for our staff, it is very important for people to get feedback, to acknowledge the good work they are doing. That is something that we are very committed to improving.

MR. MITCHELMORE: Were these forms revised in consultation with the Human Resource Secretariat or with health authorities? Do you know if there is some standardization in this process?

DR. GILLAM: Originally, when the form was developed, we worked with a group from Memorial University to look at the development of our forms appraisal system. Then with integration of the health authorities, we adapted that process. This work was done internally through our employee development branch. They did look at what was happening with other organizations, looking at best practice, looking at the research, how we adapt and revise forms.

From my understanding, there is not a standardized performance appraisal tool used throughout this Province, but we have looked at learnings elsewhere in terms of modifying and adapting that.

MR. MITCHELMORE: Good.

I am pleased to see the work that is being done to address the issues the Auditor General uncovered regarding incorrectly calculated compensation; that is important. In some cases, we have seen overpayments and things be repaid.

DR. GILLAM: Yes.

MR. MITCHELMORE: There seems to be compliance in the organization, once an issue comes forward, to take course and correct it. I guess for me the concern is what conditions actually led to these kinds of errors.

CHAIR: Mr. Mitchelmore, before you pursue that avenue, we should go on to Mr. Goulding. I guess this is sort of a natural break, and it is about eleven minutes or so – I am sorry, Mr. Collins. I am confusing the witness. Maybe the witnesses would like to ask the government members some questions.

MR. S. COLLINS: Thank you, Mr. Chair.

Just to echo some of the comments that have been said earlier, of course, thanks for coming in today. In my brief experience with Public Accounts, normally we ask the questions and the responses we get back sometimes are a little bit lack lustre or they leave a little bit to be desired, and of course this process allows us to have the back and forth.

What we have here, I think in large part are very concise answers. The information that has been provided is fantastic, actually. We have not always been able to say that, so kudos to you folks for putting this together.

There are a few little things I want to ask. With regard to the questions put forward, the response to number twelve. Have there been any instances of failure to call for tenders for goods

and services costing more than $10,000 in the first quarter of 2013?

I am just wondering, you go on to say in your response: any instances where a good or service is in excess of $10,000 that could not be tendered, corresponding Form B has been completed. I am just wondering: in how many instances do you see that take place? Can you give us some examples of that? Is it a common thing that that would occur or is it very specific instances?

MR. GOULDING: I would not be able to put a number on it. I probably should have, but I do not have it. There is a number available because they all come in here to the House and tracked, but I do not have a number myself.

Is it a common instance? It depends on the type of thing. If we are going out and looking just for a good or service, no, it is not a common thing because the vast majority of those are acquired through a public tender call. If you are talking about maintenance and services on some of our equipment, it is a common thing because that service agreement – for example, on the MRI, we prefer that the manufacturer of the MRI do the service. In those cases it would be Form B.

In some instances that is part of the original purchase agreement, at least for a five-year term. That is where most of your Form B's are in those, or sometimes it is a very specific piece of equipment or implant for prosthesis or something like that. So the answer is kind of yes and no. It depends on which good or service we are referring to at the time.

MR. S. COLLINS: By the very processes in place, you have, obviously, a great level of comfort with the practices being followed.

MR. GOULDING: At this point in time, I am fairly confident that the vast majority – I would never say all because there are always mistakes in the human system, but I am very comfortable that we have a good compliance with the Public Tender Act either through the tender call and/or the completion of the Form B's.

MR. S. COLLINS: Okay, thank you.

Moving down to the next one, question thirteen. Has the authority implemented a formal process for tracking recording computer equipment over its life cycle? I think somebody had touched on this earlier, but I am just wondering – because I read down through your response and it seems complete almost, if I could say, compared to what we do here in provincial government and what I am familiar with tracking assets and whatnot.

I am just wondering, what remains to be done, as you see it, or is this process complete now? Because it says Western Health has continued to make improvements and refinements in tracking computer equipment over its life cycle. I am just wondering, is there anything left to be done?

MR. GOULDING: There is always something left to be done.

The main action here is complete. We have implemented a system that helps us keep better track of our computers. Basically, what we do is we run reports on a regular basis that will tell us if a certain device has not connected to our main system for a specified period of time.

MR. S. COLLINS: Okay.

MR. GOULDING: I have my laptop here with me today. I will not be back in the office until Friday. If that report gets run on Thursday, it will probably flag that my system has not been connected to the network for about five days. That will then prompt the staff in Information Technology to contact me, because they know that particular asset is assigned to me, to find out where the computer is.

MR. S. COLLINS: Okay, thank you.

It is interesting.

DR. GILLAM: Just as an example of some of the small but large improvements. I needed a memory stick last week. I had to sign off approval and my responsibility, should I receive the memory stick, and it was itemized and

tracked. That is one of the new processes that we brought in place.

MR. S. COLLINS: Okay. It is impressive.

Finally, just one other question or point. Question 14, with regard to the implementation of policies and procedures designed to strengthen internal controls related to the use of motor vehicles and fuel credit cards. I think every time we have sat around here at Public Accounts, this has been something that has been brought up.

I am just wondering if you want to go into a little bit more detail with regard to the steps that have been taken, and have those steps been successful thus far?

MR. GOULDING: This is one of the items where we are not as far along as we would like to have been. Shortly after the AG review and report, and during it, we had started developing our own internal policies with respect to the vehicles, the use of vehicles, the tracking and fuel. Those policies are still in draft.

Over this summer, as a result of the strategic procurement process that government undertook provincially, we were involved in that as well. A part of that process was looking at procurement cards, gas cards, and because of that we kind of held on a part of ours, because we were a part of the strategic procurement process. That has not been finalized as of yet. I think an e-mail I seen last week; hopefully, it will be rolling out within the coming month or months. Hence, we will be a part of that process at that time.

MR. S. COLLINS: Okay.

With that, no further questions. It has been very helpful, and like I say again, thank you for the work that has been put into this. It is clearly reflected in the answers.

Thank you.

CHAIR: Mr. Joyce.

MR. JOYCE: Thank you.

As usual, I am the one with all the questions in the Public Accounts. I am sorry for that.

I will just go through, again, some items to give you the opportunity to respond to it. On page 214: Payments not consistent with Government policy. Let's see, we have nurses' collective agreement, eliminate the payment of car allowances to people. Can you respond, if those policies now are being put in place to insure that the payments are being followed?

DR. GILLAM: Right. One example was the payment of a car allowance to employees, and we continue to pay a physician a car allowance. That has been discontinued.

The issue around educational allowance paid to certain management employees, although the education requirement is part of the position requirements and they would have already been included in the pay scale, there has been no decision made on that. We have had discussions with the Department of Health and Community Services and the other regional health authorities. A decision has not been made on that issue yet.

MR. JOYCE: Okay.

DR. GILLAM: We have made the payment of in-charge pay - that has been discontinued because we were paying that to employees in bargaining units other than nurses. That has been discontinued.

MR. JOYCE: Okay.

Once again, is that because of the Auditor General itself to report and doing a review that highlighted some of these issues?

DR. GILLAM: Some have been part of the Auditor General's review; others were part of our own internal processes. For example, the educational allowance and the in-charge pay, we have had discussions prior to and a decision had been made around not paying that benefit to

people if it is not covered by their collective agreement.

MR. JOYCE: Yes.

Now, Dr. Gillam, I am going to ask you a tough question. Did the minister renew your new contract since 2012?

DR. GILLAM: Yes, I have a contract that was signed in February of 2012.

What I would like to say is that, no different than what happens with a unionized employee when the contract is finished and there is negotiating for a new one, all the terms and conditions would stay in place until a new contract is signed. With that process, I just want to assure everyone that the conditions of the previous contract stayed in place until a new contract was signed. It was just the ability to give the CEO the permission and the authority to carry out the roles and responsibilities of that office; that is why it was signed by our board Chair.

MR. JOYCE: We can see here: the physician contract issues; there are some issues about signing bonuses. Are there guidelines in place now for this?

DR. GILLAM: Yes, there are guidelines in place regarding the benefits paid to physicians. I am confident that the concerns that were identified around signing bonuses, that has been discontinued. That was important for recruitment and we did have success, but I am pleased to say now that we are working with the Department of Health and Community Services, and the other health authorities, to have a consistent program of sign-on bonuses and processes that will enable all of us to have a sufficient supply of physicians for our organization.

What we are working on right now is consistency of housing allowance for physicians across our four health authorities. That is the goal around standardization of our processes.

MR. JOYCE: Is there a standardization of bonuses across the Province now, or is it each authority on their own?

DR. GILLAM: What we do is we would be working with the Department of Health and Community Services to look at any market incentives offered to physicians and we do that in collaboration.

MR. JOYCE: Okay.

On page 216, in the middle of the page, it is talking about other employees with a provincial government pension being hired by the authority; Cabinet approval was not obtained. Has approval been obtained for these employees?

DR. GILLAM: The vast majority of the people who provide casual work to Western Health, who are in receipt of pension, are nurses. We only call the employees into work when there is no other person available to do that work, so there is no one else on that list. It is important to have casual employees and we value their contribution, because they enable us to provide care and also they enable us to not have to pay high sick leave and relief costs.

What we are doing is we have an internal form developed so if it comes up that someone is to be hired that they are in receipt of a pension, there is a process that they have to go through.

Since the Auditor General review, we have not hired any permanent staff that are in receipt of a government pension. We do have some casual staff that are in receipt of a pension, but they are only called back when other people have their work completed.

That is what we have done, and we have a process to monitor and review that. We have extended that to memos to our management staff advising them of the policy, advising them of the process, and we are going to continue to audit and maintain that direction.

MR. JOYCE: This is just more of an information question for myself. You see here a

lot of nurses who are retired being called back, which keeps the system running, and I understand that. Is it because of the lack of qualified nurses or specialized nurses in the Western Region? You hear a lot of cases of younger nurses who are looking for work and –

DR. GILLAM: Right. We have been very successful in the recruitment of nurses, registered nurses and licensed practical nurses. Sometimes there may be an incident coming up unexpected in a specialty area that we have to bring in a casual nurse with that expertise.

I do not feel it is related to lack of employees. Sometimes it may depend on schedules; it may depend on specific skill set that you require. Many of our new nurses want to work in permanent positions, so they work in a permanent position and we have smaller flow pools of casual employees. Many times that is what employees would prefer would be full-time work.

Sometimes when we have to call people in, it is related either specialty areas or something unexpected happens that we require people to provide that.

MR. JOYCE: Most of those ones who you are called in, who are retired, do they need to have authorization from the minister or is it just do a list and say here is the people who are on our list?

DR. GILLAM: Maybe I need to kind of explore that. It is my understanding that what we do and we are required to do is to look at our list and ensure that there are no staff that have the qualifications, they are not on that list and they are not available, and then we can fill on a casual basis. We would require further permission if it was a permanent employee.

MR. JOYCE: My understanding with teachers, what they do is they get permission from the minister, if you need substitutes. You could always have this list approved in advance so that if you were in an area and there is no teachers and these teachers are retired, then there is a list that is already set up in advance.

DR. GILLAM: That is something that we will look at as we go forward. Maybe that would be a solution, the same process that education is using.

MR. JOYCE: I do not know if the Auditor General ever came across that. For example, with teachers, I know in some areas where they cannot find substitutes but there are retired teachers, so they do up a list and they get permission from the Department of Education to be able to use people on that list because there is no one else in the area. Would that satisfy the requirements?

MR. WALTERS: I guess it would have to take a legislative change to do that. I think what you are saying is correct with the teachers, but it is also in the legislation as such – but it works.

MR. JOYCE: Okay.

MR. PADDON: I will just add a comment as well. At the end of the day, whatever you put in place has to be practical. You are not going to not call in a nurse, for argument's sake, while you are waiting for Cabinet approval. Really, you need to have some kind of a practical mechanism in place to be able to accommodate this. With the teachers, that is what it is designed to do. For instance, there are special provisions in place for remote or more rural schools and those sorts of things.

Maybe there needs to be something here that – we all know what it is designed to do. It is to ensure that people who are not in receipt of a pension have a reasonable opportunity of employment, but it should not be designed to encumber the normal operations of an organization. Really, something should be in there to practically accommodate both sides of the equation.

MR. JOYCE: Yes. That would help out the authority to do its job and also ensure that these are certain –

MR. PADDON: Our point here, you have a Cabinet directive which requires something. From a strict interpretation of that, clearly they

are not onside; but, from a practical perspective, you have to operate. We understand that. We are not naive.

MR. JOYCE: It would be nice to find some way to get a compromise where the authority could have that in place and follow the guidelines in place, as they do with the teachers, the teaching profession. It is just a little comment on that.

I will go to page 218. Recommendations: "The Authority should: ensure compensation and recruitment practices are in accordance with Authority and Government policy; maintain adequate documentation in competition and personnel files; have all job positions approved by Human Resource Secretariat; and calculate employee compensation accurately."

I will just give you a minute, Dr. Gillam, to respond on the recommendations and what work has been done to date to bring that up to the recommendations of the Auditor General.

DR. GILLAM: Thank you so much for that question. I am pleased with our progress in this area. For example, our recruitment practices are in accordance with government policy. We have revisited those. We have also done an audit in terms of our compensation to ensure that our staff were being paid appropriately. We are in the process of doing an audit to ensure we have documentation on file, on our competition and personnel files. We have the hiring checklist developed, and we will be monitoring that.

We have our job positions approved by the Human Resource Secretariat through both our internal Hay committee and then through the job classification process with government. The other point is, as I said, we went back and did the review of our salary details to ensure that they were correct, and we are ensuring that all of our positions are classified by government.

MR. JOYCE: Okay.

DR. GILLAM: So I feel very comfortable with this process.

CHAIR: We should go to Mr. Parsons now.

MR. JOYCE: Pardon me? You are very comfortable with it?

DR. GILLAM: Yes, very comfortable with this process, but our role now is to ensure that we continue to monitor and audit these processes, which we are committed to do.

CHAIR: Mr. Parsons.

MR. K. PARSONS: Thank you very much, Mr. Chair.

Again, I am going to say what my Committee has already said, that this is probably the best report that we have come through, the Auditor General, with our Committee with Public Accounts. I would like to congratulate you guys on the work you have done already, and the work it seems like you are continuing to do. It is a great example of how the Auditor General's report can work to improve what – the idea of the Auditor General's report, obviously, is to bring out the things that need to be improved, and this is a great example of how it is.

Especially when you look at Western Health, and Western Health's priority number one is patient care. Understanding that there is a lot of, when you look at what you guys have here, your geographic from one end to the other is interesting, and to keep all those people, over 3,000 people, and to be able to do the job you are doing, you are doing a fantastic job.

I just have some questions here now; they are general, and I am going to touch on something that Mr. Joyce just touched on that time: health professionals. Right now in our Province we have more doctors than we have ever had before. We have more nurses than we have ever had before. What kind of difficulty are you finding in recruitment of health professionals for the remote areas, like you have in your geographic areas? Is it difficult? I understand when I read there that there was one person paid $110,000, and a person given – is that something that has to be done in order to attract these professional people?

DR. GILLAM: We have been very successful with our recruitment of positions, both physicians and nurses; but we do have some unique challenges, like many organizations, and we do have some hard-to-recruit positions. The sign-on bonuses that were paid did help shore up some of our services.

As an example, I am really pleased to say for the first time since prior to 2005 we have a full complement of psychiatrists. I am pleased to say that by moving forward with the Department of Health and Community Services and the other three regional health authorities to look at recruitment and to look at whether you call it incentives or bonuses collectively, I think that will be for the good of our entire Province.

We have been very fortune in terms of our recruitment, but we do have some difficulties in some hard-to-recruit positions and we are looking at some unique ways to try to address them. For example, for nurses, we introduced a new model of nursing care, so that looks at helping nurses and working with them to reach their full scope of duties and responsibilities; and that satisfaction does help retain our staff. They are some of the things that we are doing.

With our physicians, we introduced a new physician leadership structure and that has helped with our physicians being supported by their colleagues and that also helps with the recruitment process. They are some of the things that we are doing.

MR. K. PARSONS: Okay.

In the remote areas you are still finding some difficulties. For example, like I just said a minute ago about nurses and doctors; we have more today than we ever had before. Like you said, you have a full complement of psychiatrists right now.

In the remote areas, are you finding that you have the adequate resources that are needed in those areas? How are the resources that are supplied to Western Health in the last number of years?

DR. GILLAM: In some of our remote areas, some of the recruitment is ebbs and flows. You may have a very stable workforce for five years and then people may choose to leave. We have had some success in our rural areas with recruitment of our nurses, for example. I know of one for Port Saunders several years ago we had some issues with recruitment of needing more nurses. We worked with the Department of Health and Community Services to look at what incentives can we provide to have the nurses and to attract nurses to come to work with us, and that was successful and that worked.

Some of our clinical psychologists often are hard to attract, some of our very unique health professionals, and some our specialists in terms of physicians.

MR. K. PARSONS: I know here in St. John's in the last week or so we heard of some issues in our long-term care facilities with people off on different sick leave with different issues, with bad backs and all kinds of different things. Are there any policies in place that you are looking at? I know it is a real issue when it comes to leave with sick leave and then trying to get the people in to cover off – are there any policies in place that you are looking at to improve this situation?

DR. GILLAM: We have several things, and I think what I would like to start off with is what we try to do on the preventative side. On the preventative side, we look at how we provide a workplace that helps prevent workplace injuries.

For example, with the new Corner Brook long-term care home we have ceiling track lifts. The purpose of the ceiling track lifts would be to reduce injuries of our staff. We also have an early and safe return to work program for staff. So, knowing that if a staff person gets injured or a staff person is off on sick leave, what can we do to either modify the work environment or what can we do to help them come back to work earlier so that we can provide the service that is really necessary to our patients, our clients and our residents.

We also have an attendance management program because with sick leave costs, we want to reduce our sick leave costs and to be accountable for that expenditure. We have an attendance management program that works with staff so that if staff are sick, we want the staff to stay home; if staff can be brought into work safely, we want them to be at work.

They are some of the things that we are doing in terms of how to manage our sick leave and how to ensure that we have an adequate supply of staff to provide quality care to our residents.

MR. K. PARSONS: Okay.

Again, last year my dad was in long-term care, and the man was 270 pounds, and to just watch how professional they were when moving him and stuff like that; but, when you are lifting somebody that heavy, injury is very common. I believe in there also that was a major issue with staffing, that a lot of people were off, like I said, with the bad backs or whatnot. It is important that we make sure that we take care.

I just want to go through a couple of little things here. Can you explain to me your cellphones, what policy you have now in place to attract your cellphone policy? I know that when you look at an organization like yours that cellphones can become an issue because of the vast area that you are dealing with and everybody there. What policy do you have in place now on your cellphones?

DR. GILLAM: I can start off and then I know Devon would have lots of detail. I just want to say that we are really committed to ensuring that we follow government policy around cellphones and that cellphones are very important when you are working in rural areas. We have our staff out working in homes, in schools; and not only is it a communication tool for staff, it is also very important, sometimes, around safety for people who are working alone.

When the review started with Western Health, that was one thing we did go to the Office of the Auditor General and say: we have issues with our cellphones, and there are policies, procedures and processes that we need to put in place to improve our internal controls over our cellphones. I am really pleased with the work that Mr. Goulding and his staff have completed around our cellphone processes.

I will leave that to Mr. Goulding to explain more the detail of what we have done.

MR. GOULDING: Thanks.

Yes, when this review started, or slightly before the Auditor General review started, we acknowledged we had a problem with cellphones. It was one of those things that got away from us. Not unlike, I guess, a lot of the cellphones got away in some of our homes as well, just through the times. We did identify the problem, and thanks to the AG we received some information from them, some information from other agencies. I think right now we are in a lot better place than we were. We are not perfect, far from it, but we are making progress.

In terms of cellphones, as Dr. Gillam said, they are multi use. I have one because I am on call at times. We also have staff who are travelling out to a client's home, because some of the home support and other services we provide. They use them as a means of communicating with their office to find out where their next appointment is, or somebody called in saying they are not going to be home so they do not need to go there.

They also have them as a safety means, because under Workplace Health and Safety we are required to provide a safe work environment for our staff. That is a means of them checking in on times so we know they got into a client's house and got out safely, or as a means of them contacting if they have issues and need support and that type of thing. There are multiple uses for the cellphones.

The practice and policies we have right now, before any employee gets a cellphone it is required to be approved by their manager. We have an electronic database that tracks who the holders of the phones are. We distribute the bills electronically to people to review on a

monthly basis. As well, to acknowledge each and every month – when I get my cellphone bill in an electronic format there is a part of that which requires me to acknowledge having received it and acknowledge that I have reviewed it, and ensure that I am in compliance with organizational policy.

We review that from time to time to ensure that people are reviewing their bills and acknowledge them. We just recently did an audit and identified a number of staff who were not compliant. We followed up with each of them individually in writing and gave a certain period of time to improve the practices.

We also do audits, I will say, on a regular basis, but some of the processes you have to acknowledge are just starting. For example, on what our individual usage is to ensure we have the right plan for people and we are not paying more than we should. We work with Bell Mobility. They do some tracking for us as well and do some automatic adjustments as to the plans that people are on.

We also do random audits to look for any use that might not look proper, and follow up with individuals so they can give an account of that. We just recently did an audit on our top twenty users to find out who is using the cellphones the most. Those reports, just last week, are gone out to senior managers for them to sit down with the specific employees, review the bills and say: Is this appropriate? Are there other means? Sometimes it is the type of work an employee does that requires them to be higher users of cellphones than the norm.

We have implemented, I believe, a much improved system from prior to when this review started and during the review. Perfect, no, but I would say tremendous progress.

MR. K. PARSONS: I say there are families who have issues with cellphones out there too, and different packages.

MR. GOULDING: Yes.

MR. K. PARSONS: It is a changing thing that will evolve. There are packages and everything else that can make it a whole lot – but other than that, okay.

CHAIR: Thank you.

Mr. Mitchelmore.

MR. MITCHELMORE: Thank you.

I am really impressed, actually, to hear the response around cellphones and the action that has been taken. To see an organization look at the top twenty users and to have that dialogue, to the adjusting packages, it is proactive.

When I last had the opportunity to ask questions, it was around the – just the array of different compensation calculations being incorrect. It has been a very systematic problem. That goes on page 212 and 213. There were things where there were CPP and EI incorrectly paid to locum doctors, the interest rates were not paid for deferred salaries, things of that nature.

I will just ask, what actually led to these types of problems? Was it a staffing issue, was it training? What would have led to such errors? Because we are talking of relatively a small sample in the Auditor General's report. If this is happening on a small sample, you have a lot of employees that on a broad scale there could be a number of concerns that were not uncovered.

MR. GOULDING: I am just looking through to make sure I cover off all the points you raised.

The one with the physician improperly paid CPP, EI; I am relevantly comfortable that was a one-off. It was a locum doctor, and locum physicians are paid differently than regular salaried physicians. This doctor was put in the system wrong and it was corrected. We did not go back through Canada Revenue Agency and try to file amended T4s for all those periods of time. I think the dollar value we would have used to that would have exceeded what we would have recovered.

With respect to the physician, he would have gotten his CP and EI back when he did his annual returns, the same as you and I. I do believe that was a one-off. Again, we alerted our staff to be more diligent as they are processing. They need to ensure that it does not happen again.

The second part of that question had to do with the interest, I believe, on staff who are on deferred salary. That was an honest oversight on our part. We were not doing the calculation of interest on staff who are on deferred salary as per the agreement. It was an honest mistake. One individual who was on deferred salary brought it to our attention and we did a review of the situation. At that time we made a conscious decision where we went back and looked at all the staff who had been on deferred salary and did the appropriate adjustments. The system is now in place where that is done on an annual basis.

MR. MITCHELMORE: Are staff who are on deferred salary at different interest rates for their deferral based on when they went on a deferred salary? What would be the ranges of the –

MR. GOULDING: We use the interest rate we get on our normal bank account during that period of time. There has not been much change in recent years, as you are aware.

MR. MITCHELMORE: Right. Okay.

On page 215, I have a question around the CEO contract. Not in particular to the fact that – you have explained the process that there is a new contract now, but it had talked about the contract expired January 24, 2010, but the board Chair amended the contract, deleted an expiry date and replaced it with extending the expiry date indefinitely.

Just as a question of governance: Does the Chair of the board have the authority to do that? Does this come up in a board meeting where there is a discussion, and would minutes reflect that due process in terms of governance and the board were followed, or if the board Chair has that authority individually to do it, I guess is the question.

DR. GILLAM: The CEO contract is a three-party contract between the Chair of the Board of Trustees, the CEO, and the Minister of Health and Community Services. This letter was simply a letter that enabled the CEO to act while a contract was being negotiated. It gave the CEO the authority to have and act, in terms of roles and responsibilities.

To my knowledge, there is not a board minute that reflects that, but the board Chair, in order to have the CEO work the next day, would be to sign that letter saying that they were extending the expiry date until the new contract could be reached. Not changing the terms and conditions of the contract or any benefits paid, but extending the expiry date until a contract could be reached, the third-party contract.

MR. MITCHELMORE: Right. I certainly understand that, but the contract had expired in January and the board Chair amended it in April. Basically, between January and April, it was not accurate. I do not know what –

DR. GILLAM: It was a verbal understanding with the board Chair, yes.

MR. MITCHELMORE: Okay. It was verbal at that time?

DR. GILLAM: Yes.

MR. MITCHELMORE: There was no approval by the board to take this action.

DR. GILLAM: Not a written board minute, no, but the board members were certainly aware of this and they had received a copy of the CEO contract prior to.

MR. MITCHELMORE: Right.

I certainly see the importance of this; I am just wondering if due process was followed. We have seen this at boards where there is not written documentation showing the action. Certainly, you need to have the CEO in a

position, and the contract, during that negotiation process.

DR. GILLAM: Sure.

MR. MITCHELMORE: It just seems very questionable if the right process was followed from a governance perspective, and that is why I asked the question.

DR. GILLAM: Simply, this was an interim measure until the contact could be negotiated, without any change of benefits or terms of the contract.

MR. MITCHELMORE: For me, I guess, I wonder if the board could have maybe done something better in terms of holding an emergency meeting or holding a meeting, discuss this, vote on it and have it written and documented for accountability measures.

DR. GILLAM: I think that would be a suggestion I can certainly bring back to our Chair.

Thank you.

MR. MITCHELMORE: I have a question on page 217 regarding the benefits not in compliance, "Government policy requires that employees who accept lower paying positions as a result of the redundancy policy be treated in accordance with the voluntary demotion policy, in which case the salary would be reduced to the maximum of the lower paying position."

Has this matter been taken care of?

MR. GOULDING: If memory serves me correct, that was one individual who was missed during the transition process when the two boards came together in 2005; the former Health and Community Services Western, and Western Health Care Corporation, to create, for example, Western Regional Health in 2005. There was one employee who slipped through the cracks, out of many, through that process. So, again, it has been rectified, but it was a one-off.

DR. GILLAM: We have changed our policy to reflect that.

MR. MITCHELMORE: Okay, thank you.

On page 219, relating to leave, has there been any changes made when it comes to the leave policy as to making sure that when leave is approved that it is actually taken, and that we are not seeing things like where an employee was going to take two days, no documentation, so the authority adjusted the leave by adding two days, and other places where there was not documentation and issues. Is there improvements made to the system to deal with leave?

DR. GILLAM: I can start by talking about what the plans are, and then Devon can talk a little bit about the interim measure.

We are developing, and have developed, an electronic scheduling system which will make it very easy for staff to submit their leave request for their manager to approve the leave request, and this would be done electronically. So that has been developed and is being implemented in the coming weeks to months.

In the interim, we have a process that Mr. Goulding's staff are undertaking in terms of if leave slips are sent and they are not completed correctly, there are processes to catch that and correct it at the time. We have implemented that process and we have sent direction to our managers and to our staff that leave slips have to be filled out correctly; they have to be approved by your supervisor. If that is not done, then we have a second step of it is caught, so to speak, by the staff in Devon's branch or people doing payroll, and then there is a discussion back to the individual staff member and/or manager about the process.

The new electronic scheduling system will be very beneficial in being user-friendly and moving this forward and also increasing our accountability. It is very easy to track, audit, and measure.

MR. MITCHELMORE: It sounds excellent.

MR. GOULDING: As Dr. Gillam said, we have done a couple of things to improve the process and I think the electronic scheduling system is going to greatly improve it. Sometimes, I guess, we make mistakes by trying to be nice. There are times, yes, we might know that Jane was off on leave but the leave slip was not signed. So, rather than Jane getting paid seven-and-a-half hours short on a particular day, we put it through and got the form signed after. It does not make it right, but it was things that we did. We have tightened that up.

Right now, if there is no approved leave slip, there is no pay. That process has been put in place since the AG review. We were off to a couple of rocky starts the first payday, but staff soon became aware that they have to take ownership in making sure that they have their leave request filled out and managers soon became aware that they have to take ownership ensuring that staff have the leave slip filled out and they have it approved in a timely manner.

We have greatly tightened up our controls and process around that. I believe the system we are designing and implementing is going to add an added level of accountability to that process, and efficiency.

MR. MITCHELMORE: It certainly sounds like –

CHAIR: We should move to Mr. Cross and then take our morning break. We will take about a ten-minute break in ten minutes or so when Mr. Cross concludes.

MR. CROSS: (Inaudible) I have to echo many of the comments already said. In your opening comments, you referred to taking this report very seriously. From your answers and from even the calm demeanour in which you are answering the questions, there is absolutely no adversarial type of approach or defensive type of approach to this. That is not just words; I think your actions are speaking for you as well.

The changes in the processes lead from a systemic problem as opposed to a personal problem or something that you have identified in a corporation that needs to be taken out of it.

The other term I really liked that you referred to is with regard to commitment to strengthening Western Health is that this is a continuum. There is no final part to the process. There is always growth. You move the file ahead; but, by the time you think you get close to the end, then there are changes and these changes happen.

I have several areas where I wanted to ask questions, but being the eighth horse in a six-horse race many of these have been touched on. I am quite comfortable with some of the answers, but there are two or three areas that I did identify that I will jump into.

This may sound very disjointed, but again it is just to touch on some things. I do not really want to get you to repeat things that have already been identified with regard to pensions, cellphones, and things like that.

On page 216, I did have a question about the double-dipping and the pensions, but that was covered. Just below this are temporary management positions. I guess the operative word here may be temporary; but, having a temporary position that does not have Treasury Board approval, I guess that is not a problem these days?

DR. GILLAM: I can assure you that was a one-off, and that was a true temporary position. The person is no longer in that position. What the process and the policy is currently and what we have been doing since that date is that Treasury Board approval is required for all positions before they are created, even temporary management positions.

MR. CROSS: Okay.

I am going to jump to page 229. Again, this is just a very brief question. It sort of caught my eye when I was reading through this more so in the sense of how to spend your money wisely on preventative things. Municipal tax discounts not taken: It referred to actual tax bills being paid

two weeks after incentives were in place; and others, in fact, where there was an incentive in place, but it did not get monitored or tracked. So how has this been fixed or rectified?

MR. GOULDING: Again, I do not want to say one-off because if you went back another three years, you might find one more. I think it was certainly the exception, close to a one-off. Since that time we have notified the various communities and internally within our organization that all municipal tax bills are to come into one individual within the organization and that individual is tasked with reviewing them in terms of the list of properties that we have. Not only that, that person is also tasked with scanning down the list of properties to ensure that we have received the tax bills prior to the deadline for them to be paid, and hopefully that will not happen again in the future.

MR. CROSS: Okay, that answer is fine.

Back to page 218-221 range. Mr. Mitchelmore asked questions about leave and about documentation and recording accurately. I sensed – and maybe it was because I was just jumping over things to try to get prepared, because that was one of the questions I wanted to ask. I got to the point with monitoring there; but, the actual compliance, how is this now totally in compliance with all leave policies across, say, the whole Province?

MR. GOULDING: Well, in terms of unionized staff, what leave they are entitled to and the process, a lot of it is outlined in the collective agreement. So, by virtue of there being provincial collective agreements, that would be consistent as to whether you ask for a doctor's note on day one or on day three – I am not going to speak to specific collective agreements because I do not know them in that detail, but in most cases the requirements for leave slips, how far in advance you have to grant it or request it, or whether it is doctors' notes, all of that is outlined in the collective agreement.

In terms of non-unionized staff then yes, we would be following the normal government policies for those things.

MR. CROSS: Just to jump really back and forth again, page 231, if you are following – and I do not know if you can follow this, the way I am jumping around. Provisions of the Public Tender Act not always adhered to: In reading this, purchases totaling $607,000, although the authority determined that this was a sole source purchase, the required Form B was not completed.

In just the paperwork, it seems as if it is not tendering when tendering is possible, but, in some cases, where there are sole source purchases and these Form B's. How is the monitoring on the program now fitting that everything does, I would say, come up to acceptance for the Auditor General's office with regard to public tendering and these Form B's and exceptions?

MR. GOULDING: I think the biggest thing was probably in education with the people in our purchasing department, the manager and director, to, again, reiterate with them the requirements of the Public Tender Act and the requirement to do the Form B's in a timely manner. Part of our process is that if, for example, in one of the cases there was a service agreement that the Form B is done as a part of that process. When the service agreement is authorized and signed, the Form B is done right at that point in time with it.

Again, hopefully, by changing the process where Form B's are done at the time versus going back and doing a review subsequent that we have tightened up the process greatly.

MR. CROSS: When Mr. Parsons was asking the question about nursing and challenges and things like that, Doctor, you were referring to the model of nursing and I guess it is sort of connected to this because again through the model of nursing there are some savings and some efficiency created.

My district is in Central Health and they are implementing, I assume, the same Ottawa model of nursing. Are you ahead or behind them in this implementation, and maybe a quick comment, if it is in order, as to how the satisfaction – because one of the big arguments from nurses, and I am talking about the RNs now in Central, is that the true scope of practice for the LPNs is that the training factor is probably not there, and the comfort level with clients.

DR. GILLAM: I can speak to Western Health's implementation of the model of nursing care or what is commonly referred to as the Ottawa model.

For the most part, our staff have really embraced it. The Registered Nurses saw it as an opportunity to work to the full scope of their ability, to look at control over their work life; our Licensed Practical Nurses, the same way; and then, Personal Care Attendants, in the areas that we had them. It is more of a team-based approach looking at individual problem solving at the unit level and, really, in giving people the autonomy to act.

I think the benefit of that has really been around retention and job satisfaction, but our experience has been positive. Of course, with any implementation, there are adjustments as you go along, and we have made those as appropriate.

At the same time, we also introduced what we call COD or Clinical Online Documentation. So not only are we looking at the model of nursing care, but people are now doing documentation on-line. For the most part, our staff have really embraced that also. They see the benefit for their patients, their clients, and their residents, but also making sure that we have really current client charts that are based on the electronic models. So overall, the process has been very positive. Not without adjustment, but that is expected any time you implement any new program or process.

MR. CROSS: One sort of further follow-up to that, and again, it is economic, I guess. If the true satisfaction is obtained in the job and the stress is reduced, it may lead to less leave requested for leave that is related to the stress. Is there a way to monitor that, after full implementation?

DR. GILLAM: It is a good question. There is an evaluation component of the Ottawa model, but I will certainly go back and look at that. We do monitor, on a regular basis, our sick leave, our overtime, those types of statistics.

MR. CROSS: Okay. Again, thank you for your straightforwardness; I appreciate it.

DR. GILLAM: Thank you.

CHAIR: If we could take a morning break right now for roughly ten minutes or so. I am going to canvass with the Committee whether we think we will need the second half of the day.

My sense is at the rate that we are proceeding, and it is a compliment to the witnesses being very well prepared and having this covered, I do not see us going into the afternoon. I see us concluding before lunchtime, even if we needed a few extra minutes before lunch to do so. There would be little advantage to go into the afternoon, come back at 2:00 p.m. and run through for twenty minutes, and then come back again (inaudible) that period. That is my feeling.

I have concurrence with the Committee. I think if the witnesses want to plan their afternoon in accordance with that, or Mr. Paddon's office, please feel free to do so.

Thank you.

Recess

CHAIR: Okay, we are ready to resume. We are back on air, so to speak.

We will go back to you, Mr. Joyce.

MR. JOYCE: Thank you, again. I just have a few more questions that I am going to go through.

On page 223 of the Auditor General's report, overtime for the fiscal year March 31, 2011, you can go through it there with the nurses and the CUPE workers. Down below in the next paragraph, "Five nurses were paid overtime ranging from $25,000 to $50,000 annually for the past two fiscal years in Corner Brook."

Is it that there is a shortage of nurses, or shortage of specialties in different fields? From my understanding, too, it is an issue still in Corner Brook; there are some nurses getting up to $40,000, $50,000 and then you hear the younger nurses saying that we are looking for a job. Would you like to comment on that?

DR. GILLAM: Sure.

We have taken overtime and reduction of overtime very seriously. Some of the things we have completed and we are looking at would be some scheduling changes to reduce overtime. So, if we know the work is starting at 10:00 in the morning, we will change people's shifts to 10:00 a.m. instead of coming in at traditionally 8:00 a.m. or 8:30 a.m. That has helped reduce some of the overtime cost.

The other thing we have looked at with overtime, we have put in some new policies and we have put in some new monitoring processes, signed by supervisors or managers, and really tightened our controls. We have had a significant reduction in our overtime cost from the fiscal year 2010-2011 to 2012-2013. I think the cost reduction was about a little over $700,000 by putting in those types of controls.

We are committed to continuing to do that, and also reviewing, for example, maybe in some instances we need to hire more staff. We have, in fact, done that in some cases because of the overtime payment. It is something that we are committed to monitoring, but we have made steps around our policies and procedures and our processes.

We have looked at such things as some of our callback processes in some of our rural areas, for example. So, instead of having to pay people call-back cost, is it more fiscally responsible to have people on an actual shift? There are some of the things that we have tried to do, but we are going to continue to do them and monitoring our overtime is very important to us.

MR. JOYCE: In the five nurses – and I do not know who they were – were they in a specialized field?

DR. GILLAM: I do not have the areas here with me that the nurses worked. Sometimes you may be an intensive care nurse, so it may be a speciality area, or emergency room, so you may be incurring overtime payment because of that.

I do not have the breakdown of those five nurses with me today, but I can provide that later.

MR. JOYCE: No, that is fine. If you have it, just if there are speciality nurses and if it is being looked at.

The other thing I am going to bring up – and I think that it was discussed before – is on page 231 about the Public Tender Act. The only two or three notices on the Public Tender Act are lack of compliance with some documentation, but everything else was in place, except for $121 went over on a roofing job.

I ask the Auditor General do you feel – and I know we have done a lot here where public tendering has been a major issue; but, obviously, from your report here, it looks like the public tendering, except for some documentation, has been in compliance.

MR. PADDON: I think it is fair to say that given, I guess, what you see in the report, if you look at 4A on page 230, we looked at about thirty items and twenty-four of them we had no problems with and the rest was, by and large, documentation. I think it is fair to say that with the Public Tender Act issues, there was not really a big issue there.

MR. JOYCE: Okay.

You notice on page 235: Motor Vehicles and Fuel Credit Cards. Can you explain what steps have been taken?

MR. GOULDING: As indicated previously, this is one of the ones where we have not progressed as much as we would like to. During the subsequent to the Auditor General's review, we reached out to other health authorities, other government agencies, looking for their policies and practices with respect to the control of motor vehicle use and credit cards, specifically, for gas. We have developed two to three draft policies related to this.

Unfortunately, those policies are still in draft and kind of got put on hold midsummer as government embarked on the strategic procurement program, provincially, for all government agencies across the Province. We are working with them. Hopefully, within the next month to two months, as the process gets finalized, we will be rolling out the procurement card system that will be achieved through that process.

MR. JOYCE: Okay.

I will just go on page 241, the recommendations of the Auditor General about some of the information concerning capital assets, vehicle expenditures, and credit cards, some of the things you already mentioned, and adhere to the Heating Oil Tank Storage System Regulations. Would you just like to comment on that? What steps have been taken?

MR. GOULDING: Okay, with respect to the fuel?

MR. JOYCE: The fuel one, capital assets….

MR. GOULDING: Capital assets: We do not have the full capital asset ledger. As indicated previously, I do believe, though, we have a good system of tracking our major medical equipment. All of the equipment that requires any type of regular scheduled maintenance, we have tracked in our maintenance tracking system as to the location, the life, the conditions, whether the services are done and that type of thing.

The fuel tanks: I think they were a one- or two-off that got missed in the fuel range of all the fuel tanks that we have. Once they were pointed out, action was taken immediately to ensure that they were registered, inspected, and in compliance with the proper legislation that is in place with respect to fuel tank monitoring.

MR. JOYCE: Okay.

Mr. Chair, I am finished with the questions for now. If you want, I can make a few comments now or I can make them later – I can make a few comments now.

It is very reassuring when you come in to a Public Accounts and there is not this conflict between the Auditor General, the authority that was reviewed, and the Public Accounts. Very seldom do you get people coming in viewing the Public Accounts. This is the way it is supposed to work: Have it reviewed by the Auditor General so that you can improve the system, then have the Public Accounts review the report and discuss the progress on it so that we can give assurances to the people of the Province.

Very seldom – and I have to give both witnesses today a lot of credit – do you come in say we missed it. Usually you try to find a reason to justify it and say that is not correct; but, very seldom, do you come in and say we just missed it, human error, we missed it, but we will put safeguards in place.

To the Auditor General: thanks again. We went through it ourselves, and I said it before, it is always an experience to reflect inward to see how you can better put procedures and policies in place, and we all went through the process. Thanks again for the work that was done on this.

On the public tendering, as we said, except for a few documentations of some rent – I think it is $121 which needed to be done right away from the public tendering – very seldom do you ever see that itself, that the public tendering is adhered to so good.

Thank you very much for your frankness. Thank you very much for your open and very upfront, very forward information that you gave all of us. I think it is refreshing to the Public

Accounts Committee, and I am sure everybody can speak for themselves, that it is nice that we all can work together to ensure to the general public that yes, we are doing our job and that the Auditor General's report is being taken seriously and being looked at.

Thank you very much for appearing and for your answers here today, and for at least saying yes, there are some things that we need to strengthen, there are some things that slipped, but all in all it is a work in progress that we are doing. I thank the Auditor General also.

CHAIR: Thank you.

Mr. Brazil.

MR. BRAZIL: I have some concluding remarks also. I am good on my questions.

I want to thank the witnesses, great job and good openness – I appreciate that – and the Auditor General for his diligent work in identifying the issues here and the co-operation between the two.

I am just happy to be able to say that, in my opinion, Western Health is in good hands and it is moving in the right direction, that we, as the Public Accounts Committee, and I would hope also the Auditor General and his staff, can see that the accountability for the taxpayers' money is well in hand.

Thank you very much for that and good luck with everything else.

DR. GILLAM: Thank you.

CHAIR: Mr. Mitchelmore.

MR. MITCHELMORE: Thank you.

I still have some questions around the Residency Repayment program on page 218, which is referenced in the Auditor General's report. It basically seems like an employee or staff were under the assumption that this type of payment would be non-taxable, which it was taxable, and then there was additional monies paid to compensate the physicians under this term, under this agreement, which led to over $70,000 being paid out.

I guess I would like more information on this, why this had happened. It seems like a very basic matter, tax exemptions, and being able to understand them.

MR. GOULDING: Again, I will try my best.

Unfortunately, once again, we made a mistake. The tax issues around the residency loan, repayable awards, it is not as clear and succinct as you would think entering into the process. When we initially set this process up, we were of the understanding based on the people we had checked with – and I really cannot tell you who those people were because it was very early, or before my tenure with Western Health. Our understanding at the time is that when we advanced this money and it was forgiven over a period of time, as the physicians provided their return-in-service, that it was non-taxable. That was our understanding in how it was structured up and how it was communicated to the physicians we were trying to recruit.

As we went through that process, we became aware that we were incorrect in our understanding of the tax laws around it. As such, at that point in time, there were several physicians who had already signed up and had entered into it. We really felt it would not be right for them to be out-of-pocket for funds that we made a mistake on in our interpretation of the Canada Revenue Agency tax and that they had come to work with us of a misunderstanding.

So, we entered into agreement with them that we would work with the people we had on staff, our auditors, and their tax auditors to get an understanding of what the tax liability was to them as a result of that mistake and compensate them as such so that they would not be out-of-pocket.

As you appreciate, if you pay taxes this year and I compensated you for that, that, in effect, is carrying over to the next year and next year until

it finally gets resolved. So, some of those went on for a couple years.

As soon as we became aware of that, though, we changed the process, did some further investigation through the Canada Revenue Agency, through other organizations, and changed the way we were structuring the payments to the physicians to avoid that so that it was not taxable.

It was a mistake. It happened. It was made, at the time, with the best of intentions. As soon as we became aware of it we did take actions to rectify it, not only for us and for future physicians but for the ones who accepted the program under the terms that were not correct at the time.

MR. MITCHELMORE: This misunderstanding, I guess I can understand where Western Health would issue additional funds because they had entered into that agreement, but the additional funds then, if it is provided as direct income to a physician, then that is also taxed as well.

MR. GOULDING: That is right.

MR. MITCHELMORE: The income that was provided was, I guess, above and beyond what originally Western Health would have thought it would have to pay.

Do you have a dollar figure as to what these errors in terms of the Residency Repayment program and the Canada Revenue Agency has cost the organization?

MR. GOULDING: Not off the top – I do have it in files back in the office. I think it was two or three physicians at the time, but I would have to go back over the three- or four-year period and add up what that cost would have been in total.

MR. MITCHELMORE: Is that something you could provide to the Committee?

MR. GOULDING: We can, yes.

MR. MITCHELMORE: Okay, great. I certainly think that from your response there has been appropriate action taken.

I had questions here on page 223, around the overtime. I guess it was reported recently in the news around an efficiency review and how Western Health, like other health authorities, were going to be saving money, the same way it looked at doing things as appropriate use of overtime and different things like that as to well, if we pay out a high amount of overtime maybe there is justification to have a staff person there and we could save money.

I am just looking at a situation here around the three laboratory and X-ray technicians at a site outside of Corner Brook who were paid an average of $80,000 in total for each of the past two fiscal years, basically, in overtime.

Is there a reason why there would be so much overtime in those circumstances? I understand that if somebody gets called in, and has to make a call, even if it is an X-ray, and drive for fifteen minutes, the amount of working time may be quite significant. Are there things done to maybe extend lab, X-ray services in rural and more remote clinics?

DR. GILLAM: One of the issues we looked at was – the issue you are talking about is callbacks, when people are called back after hours.

MR. MITCHELMORE: Yes.

DR. GILLAM: According to the collective agreement, people are eligible for a certain payment. What we have looked at are some of our scheduling issues in the rural areas, particularly around the laboratory technologists, and how do we better manage that.

MR. MITCHELMORE: Okay.

The answers that you provided under the HR, leave, looking at tracking severance, paid leave, step progressions, and sick time – have you purchased new software and who is the company?

DR. GILLAM: I think there are two components and maybe I will let Devon talk to that because that has been part of his branch.

MR. GOULDING: There are two components to that. One is what we refer to as the Health Human Resources Information System. That is the title, but I cannot tell you the company for sure. That is the system that we are working with the other three regional health authorities in the Province, and it is going to be a common system across all four when it is done. It is currently in the process of being implemented.

In addition to that, some of our in-house staff have developed and are fine-tuning a scheduling system that we will use for scheduling the staff; and, through that process, hopefully, have better control of who is coming in, not calling people back who have worked their regular hours and entitled to overtime when there is somebody else there. So that is an in-house design and built system that we are currently finalizing and hoping – well, we are starting to roll it out now into some smaller departments, with smaller numbers of staff, just to test it. We are hoping to have it rolled out throughout the organization by the end of the fiscal year.

MR. MITCHELMORE: Okay, great.

It is a work in progress. At this point you would not be able to provide us with any tangible evidence to show that this type of system is currently working, that it is effective, but it will be monitored and I am sure your working group will be evaluating it at some point?

DR. GILLAM: Yes.

MR. GOULDING: Yes, it is a work in progress. The early indications are – and you have to realize that of course we start with smaller sites, departments where schedules are not as complicated, to test it; but the early indications are it is much more efficient.

As you can appreciate, I am sure, if staff have the ability to go on-line, check their schedules, do out their leave forms on-line and the manager sign it off, it is more efficient and it will give us a better tracking of who is scheduled when.

MR. MITCHELMORE: Great.

I will not go into any details around the public tendering and the cellphones because that was covered by my colleagues. I would like to ask a question, though, around the database of computer equipment being incomplete, those particular assets. Why would the cost not be complete, to be able to reconcile your financial statements to show that you do have an asset, you know what the cost of it is, then you can do your write-down of that asset over a period of time, just so that Western Health understands its true financial position?

MR. GOULDING: In terms of full capital asset ledger or the computer equipment? I am not sure I got your question correctly.

MR. MITCHELMORE: No, well, I guess that would go into the broader question, but my colleagues have asked about your capital asset ledger, and I can understand the complexities of doing it and the cost associated can somewhat be a bit restrictive, depending on your human resource means. In terms of dealing with basic monitoring of equipment, especially those that can be mobile, like cellphones and computers, laptops, things like that, certainly should be tracked and accounted for.

MR. GOULDING: Okay.

MR. MITCHELMORE: Because they could be easily disposed of.

MR. GOULDING: I will try to address each one probably, if I may. As indicated previously, we have done significant work in tracking of our cellphones, the whole approval process, and bills going out monthly to individuals who are then required to acknowledge electronically that they have received and reviewed the bills. That, in itself, is a control that people are acknowledging that they still have the phones.

In addition, we review the total cellphone package on times to monitor if a particular

phone has no use. Now, we do have some phones that do not get used on a regular basis. We have phones, for example, in each of our facilities that are there as backup should our main telephone system go out, which does happen from time to time. Again, there is a particular manager on that site responsible. So, through the process of monitoring the cellphone bills and usage and no usage, we do keep track of our phones in that way.

In terms of computers, equipment, as I said, the system we have in place improved logging of computers from the time we order them to we receive them, and where they are stored until they are actually deployed to individuals. Once they are deployed and set up there is software on them that communicates with our main servers, and we will run reports periodically to identify computers that have not been connected to our main server for a specified period to time. Then, people in the Information Technology department do follow-up with the individuals that these computers are assigned to, to find out why they have not been connected to our network.

As I indicated earlier, mine is here – I am not going to be back in the office until Friday. So if they run the report in that time, they will be looking for me to find out why my computer has not been attached to our system for a specific period of time.

In terms of our major medical equipment, we do monitor it on a reasonable basis through our maintenance tracking system.

MR. MITCHELMORE: Okay.

MR. GOULDING: Again, as to the location, the age, the condition, the amount of service that is required, or whether it has been serviced according to the manufacturer's recommendations. What we do not have is all of that integrated into a full-blown capital asset ledger.

Now, in my mind, a capital asset ledger is a system where each and every asset is identified on an individual basis as to its original purchase cost, its estimated life, and how much it has been depreciated over time. We do not have that. When will we get it and how will we get there? I am not sure. In an ideal world yes, we would. We are not there. I cannot really tell you when we will get there. We will keep adding it or trying to get it on that priority list, for the scarce resources that are there, and hopefully before we come back here again, we will be able to answer yes to that question.

MR. MITCHELMORE: Great.

CHAIR: Mr. Mitchelmore, we should move on to Mr. Collins.

MR. MITCHELMORE: Sure.

MR. S. COLLINS: (Inaudible) no further questions for myself. I will just simply say thank you for all the great work you have done and will continue to do. That is everything for me.

Thank you.

CHAIR: Mr. Parsons.

MR. K. PARSONS: Yes, I am just going to say it is obvious that Western Health and people in the Western Region of the Province are in great hands. What we heard here this morning and how you are on top of things, and again, from the Public Accounts Committee's view, it is refreshing to have someone like yourselves come in who have addressed the issues of the Auditor General in such a way that you have.

I am looking forward in the next – I guess it is only going to be a year now that the Auditor General will be back in, do a review, and see where you have progressed. It is going to be interesting to see, and I am sure that the Auditor General is going to be pleased with what you have done so far. I know that from a Public Accounts Committee perspective, I think you are going to be on track with what needed to be done.

Again, thank you for coming this morning. I really appreciate your frankness and keep up the good work.

Thank you very much.

CHAIR: Mr. Cross.

MR. CROSS: I will just echo and say I could not have said it much better, so there is no need for duplication.

CHAIR: Mr. Joyce, do you have more questions or are you finished?

MR. JOYCE: I am finished now.

CHAIR: Mr. Mitchelmore.

MR. MITCHELMORE: Okay, just a couple of more questions that I have. I believe the answers to the motor vehicles were provided and the issue around the fuel cards, but I did want to ask questions around one particular – some of the purchases that were provided certainly stood out there, but I think you have said that it is being addressed.

I wanted to go on page 239 and get some clarification. It may be similar to the property taxes being paid by one person. It talks about insurance premium overpayments where two residential properties, the insurance premiums were paid, but they were not even being leased.

MR. GOULDING: That did happen. As a result of this, we have tightened up the process around people who are responsible for our residential properties, and the ones who are responsible for the insurance, to ensure there is better communication between them as to when new properties are coming on and are going off to ensure that insurance is updated.

The extra premium we paid was one thing, but the other thing equally important is to ensure that the insurance is added to properties on a timely basis in case a loss did happen and end up with an uninsured property. So, we have improved the timing around the communication between these areas.

MR. MITCHELMORE: I know that we have talked a little bit or some of my colleagues have asked about the rentals on the housing piece, and I can understand why an authority would have a certain amount of housing stock. There are two questions I have.

One: You had talked about how you are going to try to create a uniform policy for physicians, but is there going to be a grandfathering process as to what people are paying? Will people see a significant change that are currently renting or leasing a property, in terms of their rents?

DR. GILLAM: In terms of what we provide would be for new physicians, but that would work its way through the process and then we would not offer that or change the terms of the offering to any new people. So that would not impact on current, but it would be more as we continue on our path.

MR. MITCHELMORE: Okay, that is great.

MR. GOULDING: Sorry, I think you had a second part to that question, in terms of what people pay for the facilities.

MR. MITCHELMORE: Not necessarily as to what people pay, because there would be varying amounts, and I would understand that. I just wanted to know if this is on a go-forward basis, which it is, to have a standardized policy, which makes sense, it seems, for housing.

I wanted to know – my second part was around the properties; some of them being vacant. Is there something more dynamic that can be done to bring in some revenues, even on a short-term basis? The authority knows that it has certain contracts, certain physicians coming, that some may be vacant for quite some time, to even do short-term lets and things like that. Are those options being pursued?

DR. GILLAM: We have not explored that, but when the residential committee meets, that is something we can provide for their consideration in terms of what is practical, what can we do; and we need to really, I think the first step, continue doing our occupancy review and

then what are the decisions that are arising out of that. Then, if we are, in fact, reducing any of our properties, what will that impact on the current vacancy or occupancy rate. So we will continue that as part of that entire review.

MR. MITCHELMORE: For example, maybe where you are responsible for the Western nursing school, basically, there may be a semester where if you have students where you have interns staying in rooms, maybe there could be nursing students who could fill the remaining rooms for a semester to deal with the housing. There is a significant wait-list when you talk about Grenfell, when you talk about Corner Brook, in terms of student housing as well, so there may be an option for future health professionals.

It is just an idea, something to look into; it might not be practical. It might only be something that could be implemented on a small scale or very short term.

I do not think I have any further questions for the health authority. I think you have been very forthright in saying, from the Auditor General's findings, there were some things that were not done correctly, and there were errors and some oversights and ways to improve and embrace that, and have taken progressive action to see results.

My only other question that I could ask would be around this working group, as to who sits on this working group. Is it a management issue or is there a member from the Department of Health and Community Services there? Are there subcommittees of that working group?

DR. GILLAM: This working group is Chaired by the CEO, and the members include the VP of Finance and Decision Support, the VP of HR, our VP of Medical Services and Patient Services, and the Director of Regional Communications. At this point in time, we have met nine times; but we have limited to really actioning but most of the work then would go to other people within the organization.

At this point we do not have a subcommittee structure, but we are going to continue, obviously, to exist and then we need to maybe change, maybe modify, what that committee looks like. We felt this issue was very serious. We took the commitment very seriously, and we felt that this would be one way to demonstrate our accountability to internal controls and, really, the environment of improvement. We work very diligently and we will continue to do so.

MR. MITCHELMORE: Certainly, for me, as a member here of the Public Accounts, I look forward to seeing those additional progression of steps, the Auditor General will be doing a follow-up review, and I am sure we will see more things implemented in greater compliance at that time, as we have already seen since the initial release of this report in January, that there has been improvements made and changes from this hearing.

I do not have any further questions, Mr. Chair. I thank all the witnesses for their time. It has been a very productive hearing.

CHAIR: I have a few questions.

When you were referring to housing allowances, I think you said you needed them for physicians for residence or maybe it is for locums. How does that work? Do you use that as a recruiting tool, or is it more of an educational support? How does that work?

DR. GILLAM: Our houses that we have, the residences, we offer them to our medical students, our residents, our interns, who come and do rotations with us; so that is part of the work that we do with Memorial University and other universities.

There is also a housing allowance as a recruitment incentive for new physicians that we recruit to our organization. That is the piece that we are continuing to review and to ensure that we have provincial consistency and standards.

CHAIR: You indicated earlier that some time ago there was an issue with recruiting nurses in Port Saunders.

DR. GILLAM: Right.

CHAIR: That is close to me, obviously, because the St. Barbe district is in Port Saunders and my personal physician is in Port Saunders. One of the issues, and I suspect that smaller rural communities will be similar, that it is difficult to recruit nurses, for example, because the whole family unit needs to move or maybe it is not seen by single people as having a very exciting social life available.

Do you use housing allowances as an incentive to recruit non-physicians to rural communities?

DR. GILLAM: We have, on occasion, looked at our residences in terms of our occupancy and allowed staff members to transition and live there based on market rent, but I would really like to say that one of the really positive things has been working with the Department of Health and Community Services with recruitment of new nurses. We do an assessment of do we have a difficult to recruit position. They have been very supportive of offering a bursary or sign-on bonus for those individuals.

CHAIR: Also, in some areas there is a concern about the availability of physiotherapists, particularly. The complaint of some people is if we have to go so far as Corner Brook from wherever, I have a two-hour drive, I am already injured or need physio, I have physio and then I drive back, and maybe it is not as effective as if it were nearby. I do not know if that is a hiring issue, or maybe there simply is not enough demand to warrant having somebody in these locations.

Do you have any thoughts on physiotherapists, particularly away from Corner Brook and maybe away from any major centres?

DR. GILLAM: I acknowledge that for some communities it is an issue. Particularly, what people are looking for are private physiotherapists in communities. What we have done is hire, for rural sites, physiotherapy aides; so looking at skill mix so they provide support under the direction of a physiotherapist.

For our communities, we have travelling physiotherapists and/or we use Telehealth in order to do some of the consults and discussions using the physio aide on site. Many of the communities we do not have the private, fee-for-service physiotherapy offices; they are only in several of our communities in our region.

CHAIR: One of the issues facing our Province, particularly by the business community and the small business community – and you did discuss your safe and early return to work policy through workers' compensation – is that if people are able to access early and aggressive physiotherapy, they can get back to work more quickly. This Province has, for more than the last twenty years, the highest rate for workers' compensation, the highest premium for employers.

My question is: Have you had any consideration to collaborating possibly with workers' compensation or employers' groups and maybe cost-share or to make physiotherapy more available in more rural areas?

DR. GILLAM: We have had discussion with workers' compensation; but, to date, we do not have a program cost-shared as you are suggesting. We are committed to looking at innovative ways of doing things.

One of the things we have tried, which has been successful, is around dental services. We do not employ dentists at Western Health, but we had communities that were concerned – they did not have access to a dentist. What we did was, with the municipality, put an ad in the newspaper to try to recruit a dentist, a fee-for-service dentist, and we provided the space. That has worked very well.

We are very open to any suggestions and any opportunities to partner with, whether it is the private sector or other government departments, to look at innovative ways of doing things. By all accounts the dental program has been an

overwhelming success, but there are other ways we can move and we will certainly look at other things we can do as a partnership.

CHAIR: When you refer to fee-for-service, I recall a very recent news story from another Province whereby fee-for-service physicians were charging for multiple specialities simultaneously; and, in fact, they were being compensated very huge amounts of money. Do you have that sort of exposure, that sort of an issue whereby a physician who may have been on call claims to be on call for two or three specialities simultaneously and is paid for all of them? Is that an issue here?

DR. GILLAM: That has not been my experience, but I would require more details and exploring to see if that was, in fact, an issue for us.

CHAIR: My final issue that I would like to raise with you is with respect to risk management, risk management generally for the organization. How do you handle a risk management? Do you have a committee, group, or person? By risk management, I mean everything from malpractice to slip and fall to fire insurance, wherever your exposure might be.

DR. GILLAM: We have a VP of quality management and risk. She has staff consisting of some risk managers. She has a director of risk management. We have a patient safety advisory committee and we also, as an organization, have as one of our strategic directions a goal around reducing patient risk, improving patient safety.

We operate very much from that model. We have policies and procedures in place. We have, for example, disclosure. We very much follow those best practice and the standards. We do regular reporting to our board through a balance score card, talking about our risk areas. Then, we also look at what are some of our higher risk areas and then what do we do to address them and how do we work on preventing that issue. We try to be very proactive but our quality management risk staff very much take risks seriously.

Our board has a committee called board planning for safety and quality, and they take it very seriously. So, we try to thread patient safety and quality and risk management throughout the organization. It is critical.

CHAIR: Thank you.

Do any of the members have any further questions?

Mr. Paddon, do you or any of your staff have any questions, observations, or commentary?

MR. PADDON: I have no questions. I will just make an observation based on, I guess, the discussion here today and the responses that Western Health have provided to the Committee over the last little while.

It would be my expectation that when we go and do our follow-up review, roughly a year from now, that we would expect to see that the majority of our recommendations we will see some fairly good progress. Certainly, based on what I hear, I do not think there is any doubt that we are going to be fairly pleased with the outcome.

I am certainly quite content with what I have heard here today.

CHAIR: Thank you for coming.

If you have any observations, feel free to make them. This will be your last chance, if you want to leave.

DR. GILLAM: I do.

I would like to thank the Chair, Vice-Chair, and members of the Public Accounts Committee, really, for their commitment to public accountability and also for the environment of continuous improvement, because that is what I heard on the other side of the House today. I really want to thank you for that. I want to thank you for your questions. They were thought provoking and I think will help us as we move forward to the next steps.

I would also like to thank the Auditor General and his officials for their review and their recommendations and their willingness, because we had a good working relationship and the willingness to work together. We look forward to the one-year review.

I would just like to say in closing that we are committed to quality improvement, we are committed to the recommendations in the report, and it is something that we take very seriously and we are going to continue to make progress in this area. Some things do take time. We have had to prioritize and strategize.

I would like to thank everyone for your questions today and thank you for your input; I think it will help inform our next steps.

Thank you so much.

CHAIR: Thank you.

We have minutes.

MR. BRAZIL: I make a motion that the minutes from Tuesday, October 15, be adopted.

CHAIR: A seconder?

Moved by Mr. Brazil; seconded by Mr. Parsons.

All those in favour, 'aye'.

SOME HON. MEMBERS: Aye.

On motion, minutes adopted as circulated.

CHAIR: Motion to adjourn?

Moved by Mr. Parsons.

On motion, the Committee adjourned.