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2019 Annual Report, Auditor General:

Ministry of Health

Ontario Health

Ontario Hospital Association

1st Session
42nd Parliament

Wednesday 2 June 2021

Chair: Taras Natyshak
Clerk: Christopher Tyrell

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Ministère de la Santé

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Mercredi 2 juin 2021

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 2 June 2021

Mercredi 2 juin 2021

The committee met at 0900 in room 151 and by video conference.

SUBCOMMITTEE REPORT

The Chair (Mr. Taras Natyshak): Good morning. Welcome back to public accounts. It's great to see everyone. Welcome back to our Auditor General. It's great to see her and her team, as always.

The first item of business this morning on our agenda is the consideration of the report from the subcommittee on committee business dated May 30, 2020. Would someone like to read the report into the record and move its adoption? Either Madame Gélinas or MPP Parsa? Can we get either one of you to read the report in? Anyone else? There we go. MPP Hogarth. Thank you.

Ms. Christine Hogarth: Sure. Your subcommittee on committee business met on May 14, 2021, and May 31, 2021, and recommends the following:

That the following sections of the 2020 Annual Report of the Office of the Auditor General of Ontario be reviewed by the committee:

—Value-for-Money Audit: Condominium Oversight in Ontario (2020);

—Value-for-Money Audit: Electrical Safety Authority (2020).

The Chair (Mr. Taras Natyshak): MPP Hogarth, can you move adoption of the report?

Ms. Christine Hogarth: I move adoption of the subcommittee report.

The Chair (Mr. Taras Natyshak): Thank you very much. Is there any debate on the report? Seeing none, are members ready to vote? I believe they are.

All those in favour? All those opposed? I declare the motion carried.

Thank you very much. We'll now move into closed session for report-writing.

The committee continued in closed session at 0902 and resumed at 1232.

2019 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH

ONTARIO HEALTH

ONTARIO HOSPITAL ASSOCIATION

Consideration of section 3.01, acute-care hospital patient safety and drug administration.

The Chair (Mr. Taras Natyshak): Good afternoon. I'd like to call this meeting of the Standing Committee on Public Accounts to order. We are here to begin consideration of acute-care hospital patient safety and drug administration, section 3.01 from the 2019 annual report of the Office of the Auditor General of Ontario. Joining us here today are officials from the Ministry of Health, Ontario Health and the Ontario Hospital Association.

You'll have 20 minutes, collectively, for an opening presentation to the committee. We'll then move into the question and answer portion of the meeting, where we'll rotate back and forth between government and official opposition caucuses for 20-minute intervals, with some time for questioning for the independent member. I'd invite each person to introduce yourself for Hansard before you begin speaking.

Just prior to us getting going, I'm going to ask those who aren't primary presenters to possibly shut their video off, just for technical reasons here. We have a 30-inch monitor, so for those primary presenters, if you can stay on, and then those who are assisting, we'll call on you or you can call on them at any time.

With that, the floor is open. Anyone who would like to begin can begin. Please identify yourself. Ms. Angus, welcome back. Thank you very much.

Ms. Helen Angus: Thank you very much. I'm Helen Angus. I'm the Deputy Minister of Health. It's a pleasure to be here again. It's been almost a week, so nice to see you. We're here to talk about the 2019 audit on acute-care hospital patient safety and drug administration. As the Chair mentioned, I'm joined here by colleagues from the Ministry of Health, Ontario Health and the Ontario Hospital Association. As always, I'm going to thank the Auditor General for her careful work on this audit. Hopefully we'll have a productive session today as we explore the themes in her report and our progress today.

I want to talk a little bit about the last year. When the state of emergency stemming from COVID-19 was declared on March 17, 2020, the Ontario health sector took, I think, unprecedented action to ensure patient needs continued to be met during a time of uncertainty. As everybody in this room knows, new public health and infection prevention and control measures were initiated while the province waited for vaccines to be rolled out.

Over the last almost 17 months, extraordinary measures have been enacted by Ontario's hospitals in response to the challenges faced in delivering patient care to balance

critical health human resources supply in a constantly changing environment. Again, as everyone knows, to manage this influx of patient care needs under the Emergency Management and Civil Protection Act, hospitals were provided with directives which authorized them to reduce or delay non-emergent surgeries; to create alternate health facilities, such as mobile health units, to deliver patient care in non-traditional hospital settings; and to provide assistance to long-term-care facilities, which certainly experienced challenges in the first and second waves of the pandemic. They were authorized to transfer ICU and acute-care hospital patients to other hospitals in order to balance beds and make best use of finite hospital resources and do the best for patients in the province. Finally, they were authorized to redeploy hospital staff to other hospitals to address critical human resources challenges.

I would say that in spite of these extraordinary measures, which required hospitals to go above and beyond routine operations to manage patient surges brought on by the declared emergency period, the Ministry of Health has made some progress in advancing the recommendations of the Auditor General in her 2019 report.

I would just say that on the issue of patient safety, the Ministry of Health is committed to working with our health system partners to mitigate the risks associated with health care delivery. I believe that we've taken important steps to strengthen patient safety in hospitals across the province, but of course there's still more to do. We also believe that the risks to patient safety are more important than ever. As we look forward to what kind of care is going to be delivered in Ontario hospitals going forward, we look at the medical technologies and treatments that are becoming more complex; we look at patients who are presenting with multiple comorbidities, multiple conditions and increasingly complex needs, given the aging of the population; and certainly, we look towards specific safety threats such as antimicrobial resistance and new viruses like COVID-19, which are increasingly prevalent. The work on patient safety is more important than ever, and I hope by the end of this session you get a sense that we're seized with the work and implementing most of the recommendations of the Auditor General.

I'll just talk a little bit about roles. The ministry does play an important oversight role in ensuring that important safeguards are in place to protect patients from harm. But we can't do this work in isolation, and so there are a number of key actors who contribute to our collective work on patient safety. You'll hear today from the newly formed Ontario Health, which brought together expertise from a variety of crown agencies under one roof, and its role in sharing best practices in advancing the quality and safety of care that Ontarians receive.

I would just say that advancing the ministry's progress in patient safety concerns within hospitals also takes cues from other reports and guidance that are found in other sectors, such as in long-term care. I would just reference briefly the 2019 report of Justice Gillese, the public inquiry into the safety and security of residents in long-term-care homes. That certainly has also provided an ambitious road map for the Ontario government to improve the long-term-care home system to avoid similar tragedies. So we look to that. Although the health care system is different, we look at the staffing, medication management, oversight of the institutional patient death record and the coroner's investigation processes as guideposts as well for the work.

While the inquiry, as I mentioned, was focused on long-term care, it has helped with patient safety and quality in hospitals. I would just cite an example where the College of Nurses of Ontario, in their response, has been actively educating its members about the possibility the health care worker may deliberately cause harm to a patient. Also, to enhance the investigation process, the College of Nurses of Ontario has also created a standard list of questions for investigators to use when interviewing employers who have raised concerns about a nurse's practice.

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Now, a word about our partners: Certainly improving patient safety requires an environment that is transparent, committed to reducing harm, as well as encouraging of collaboration with many stakeholders, including patients and caregivers. In addition to the collaboration with key patient safety partners, the ministry leverages their work, such as reports and data, to inform and improve patient safety in Ontario.

Ontario Health specifically—and I believe Matt Anderson is here, as well as members of his team—has a mandate to help the government achieve the vision of improving the patient experience, journey and outcomes in the province. They have a mandate to execute against government policy and strategy, to oversee health care delivery, to improve clinical guidance and to extend and strengthen quality and performance capacity across a full continuum of care.

With regard to patient safety, Ontario Health does provide leadership on patient safety through the public reporting of data and the development of clinical standards and quality standards for patient care and safety. As you probably know, the former Health Quality Ontario is now embedded in Ontario Health and has been an adviser to the Ministry of Health since 2011 on health quality. With that function embedded, Ontario Health oversees, as I mentioned, health care delivery and does improve clinical guidance, enabling better care for patients.

Through the former HQO website, Ontario Health does provide the data—the system performance information—not only to providers, but in an interactive way that is publicly available through an online platform. The data that they put out there has a wide variety of system performance information. Hospital patient safety is one of them, but it also includes information about wait times, surgery procedures, diagnostic imaging and other aspects of care. Monitoring and public reporting on critical aspects of patient safety and health system performance makes Ontario one of the most open and transparent jurisdictions and is helpful to the cause of improving the quality of care.

On the patient safety agenda specifically, we have developed a multi-pronged approach to mitigate the harms associated with the delivery of health care. Based on

emerging patient safety literature, expert input and changing safety priorities, our approach will continue to evolve. It will also have regard, of course, for the recommendations of the Auditor General. We've focused so far on three key areas, and I'll talk a little bit about these. One is strengthening patient safety legislation and regulation, then making public reporting of patient safety indicators mandatory and, third, investing in patient safety training for health care providers.

I'll dig into the patient safety legislation and regulation a little bit. It signals the importance of patient safety and creates an environment where system priorities are clear. Linking health system safety objectives with organizational accountability plays an important role as well. The ministry has also enabled learning following critical incidents. Then creating a just and learning culture: We're leveraging opportunities to learn and improve following incidents and believe that this is the critical part of the agenda.

When I look across the legislative and regulatory instruments that guide the work of public hospitals, obviously, first and foremost is the Public Hospitals Act, which has a number of tools for government to intervene with hospitals to address patient safety and quality issues, including the issuance of directors and the appointment of inspectors and supervisors. It also sets out requirements for hospitals regarding reviews, disclosures and analyses of critical incidents. Those requirements suggest that as soon as practical after the incident, the hospital reviews, with patient input, every critical incident and discloses those incidents to the hospital's medical advisory committee, the hospital administrator and the affected patient and/or their substitute decision-maker.

More recently, the Excellent Care for All Act requires all public hospitals to establish quality committees to investigate and report on quality issues, to develop and publish annual quality improvement plans, to link executive compensation to the achievement of targets set out in those—we call them QIPs—and carry out regular patient and care provider satisfaction surveys.

The Excellent Care for All Act also requires public hospitals to have patient relations processes in place for receiving, reviewing and responding to complaints from patients and their caregivers, and public hospitals are required to record, monitor and analyze the data on the complaints they receive and, most importantly, on their resolution.

The identification of quality improvement plan priority indicators is also an opportunity to create a focus on quality and safety issues. It's important that the indicators that are using those QIPs are meaningful and relevant to the current state of health system delivery and are actionable so that they can actually be improved at the organizational level or through collaboration with other health care providers. The minister has the authority to require indicators for hospital QIPs, including those related to patient safety, but I would say that activity this year remains paused as critical resources have been redirected to address the COVID-19 pandemic.

Finally, the Quality of Care Information Protection Act enables care providers to have protected quality improvement discussions while helping to improve patient safety and make sure that patients and their authorized representatives have access to the facts around critical incidents.

The next area would be the public reporting of patient safety indicators. Going back a long time, not even in the middle of my career, in 2008 the ministry introduced public reporting of hospital quality care indicators. Certainly the data on these indicators is an essential component of patient safety efforts. They are used to look at benchmarking performance to prioritize improvement efforts, to help system leaders and policy-makers make evidence-based patient safety priorities and also to help patients, families and caregivers make informed choices about care options. The Public Hospitals Act does require a hospital to disclose information concerning these minister-specific indicators of the quality of care they've provided and it must be disclosed on the hospital website.

Ontario Health also reports health system data, as I mentioned, on an interactive online platform, and that does include safety indicators for long-term care, acute care, home care, primary care at the facility and provincial level.

I'll just talk a little bit more about some of the targeted interventions and then I will hand it over to Anthony Dale, CEO of the Ontario Hospital Association to give a few remarks. I think the safety approach I've described really emphasizes a systems view that creates a strong foundation that can be adapted to address a variety of safety issues, but there are targeted interventions that are in response to existing emergent patient safety concerns, and they can be implemented in regard to a specific type of harm, like infections or a contributing factor like what might happen at the transition points in care. So we are supporting the National Surgical Quality Improvement Program. We might talk a little bit about that later, but it allows affiliated hospitals to compare their post-surgical outcomes with 700 hospitals around the world.

We've also provided funding for infection prevention and control practitioners who have specialized expertise and training in that area, and work with all departments in an organization to prevent health-care-associated infections. It has never been more important, certainly, than during the time of COVID.

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In conclusion, I would say we very much appreciate the comprehensiveness of the audits conducted by the Auditor General. We welcome the recommendations in the report. We share the concerns about patient safety. It is a responsibility shared by providers, organizations, health system associations and the ministry, and we certainly recognize that there is a need for continued improvement. While steps have been taken to strengthen patient safety, I'm certainly looking forward to the recovery phase of this COVID journey and being able to spend more time on this important work.

Perhaps, with that, I might ask Anthony to say a few words as well.

The Chair (Mr. Taras Natyshak): Thank you very much, Ms. Angus.

Mr. Dale, welcome. You have two minutes and 45 seconds on the clock.

Mr. Anthony Dale: Hello, everyone. We're here in response to the committee's request that the OHA provide an update on the Auditor General's 2019 annual report. As you know, my name is Anthony Dale. I'm the president and CEO of the OHA. I'm joined by David Brook, vice-president of labour relations and chief negotiation officer, as well as Melissa Prokopy, our director of legal, policy and professional issues.

The OHA is the voice of the province's 141 public hospitals. We are an independent, not-for-profit corporation that has existed for almost a hundred years. We're governed by our own board of directors. The OHA is part of civil society and helps hospitals and their boards have a strong voice by advocating on their behalf and by providing resources and services in support of our membership and the wider health system.

The OHA appreciates the Auditor General's work to enhance patient safety in the hospital sector. We have always co-operated and voluntarily worked with the Auditor General's team on audits involving our sector, despite the fact that our organization itself does not fall under the mandate of this office.

Patient safety remains the most important priority for Ontario hospitals. All across the province, every effort is made by boards, management teams, clinicians and other staff to ensure that patients and clients receive the highest quality of care possible.

As you know, hospitals are independently governed by their boards of directors, which play a leadership role in identifying organizational priorities and developing preventive programs to enhance patient safety. Over the past decade, boards have been working continuously to embed a culture of quality and safety within their organizations, and as you may know, hospitals have dedicated board committees that monitor quality and performance and provide oversight of quality improvements. Hospitals also work very closely with Accreditation Canada and others—especially HQO, now Ontario Health—to implement best practices.

Since the creation of HQO, hospitals have made significant changes to high-priority areas like organizational culture, incident disclosure and management, medication reconciliation, surgical checklists, infection prevention and control, and risk assessment. They've developed and publicly shared annual quality improvement plans that provide measurable targets. Most importantly, hospitals have routinely completed comprehensive reviews of patient safety and critical incidents.

During this time of crisis, hospitals have transformed and adapted like no other part of the health care system. But while foundational progress has been made, hospitals recognize that there is more to do. The recommendations included in the 2019 Auditor General's report provide an opportunity for leadership in hospitals to reflect further on improving safety within the context of the ongoing pandemic and beyond. Ontario hospitals have committed to reviewing the recommendations at the board level, to determine whether improvements are needed to elevate the culture of safety within each organization in the province—

The Chair (Mr. Taras Natyshak): Thank you very much, Mr. Dale. I have to stop you there.

We will move to our first 20-minute rotation, to the official opposition. Madame Gélinas? Madame Bell?

M^me^ France Gélinas: It's MPP Bell.

The Chair (Mr. Taras Natyshak): MPP Bell.

Ms. Jessica Bell: Yes, MPP Bell. Hey. Thank you so much for being here for the Auditor General's chapter on acute-care hospital patient safety and drug administration. It's fascinating, it's important, and some of the elements of it were a little concerning. Like anyone, when I go to a hospital or my parents or parents-in-law go to a hospital, I want to make sure they come out with no additional injuries or sickness compared to when they come in.

The questions that I have focus on some of the issues that the Auditor General raised around "never events." The one thing I noticed is that there are still some instances where never events are taking place, like foreign objects left in patients after surgery, the wrong spot on a patient's body is operated on, the wrong blood is given to patients or there are bed sores—and these are clearly all preventable events. The Auditor General made some pretty clear recommendations around setting targets to eliminate never events and ensuring that all never events are tracked and reported to the Ministry of Health, which they are currently not.

Can you speak to the Auditor General's recommendations that she has made and if there are any other measures you're looking at taking to reduce never events to zero? It's certainly something that I think anybody in Ontario would want to see.

Ms. Helen Angus: I might lead off. There's a reason why we call them "never events": They shouldn't happen. Unfortunately, sometimes they're human error; sometimes they're systems that need to be improved. Certainly from the ministry perspective, we want to have those fully investigated and shared, so that every never event is a learning opportunity to make sure that it doesn't happen again.

As always, I might ask whether the OHA or Ontario Health want to jump in here and just talk a little bit more about how the work on never events has been systematized in the sector.

Ms. Jessica Bell: Okay. Just before you do that, the one specific request that the Auditor General had was around the Ministry of Health tracking never events, which I sense falls more in to your authority than Mr. Dale's, so it would be good to hear what the ministry's position is on tracking never events and reducing never events to zero.

Ms. Helen Angus: I think that we probably need to do some sort of policy work on the "never event" question, in terms of probably wanting to get that information more in aggregate than to get specific patient information, and to be able to use that to set priorities. I don't know whether it coming in one at a time makes a lot of sense, given the policy role of the ministry, or whether it's more appropriate for an organization like Ontario Health to compile

those, analyze them and then send them to the ministry in order to use whatever levers we have in order to ensure that they don't happen again.

And I would agree: We have levers. We have relationships with the regulatory colleges. We have funding levers. We have accountability levers. I've just talked a little about the directive authority of the Minister of Health. We can use all of those, but we're pretty far removed from an individual patient in an individual organization receiving care. I think understanding the larger patterns is probably where the ministry can be the most useful.

The Chair (Mr. Taras Natyshak): Mr. Anderson?

Mr. Matthew Anderson: Thank you, Deputy. For the record, it's Matthew Anderson speaking, president and CEO at Ontario Health. Thank you so much for the opportunity to come to speak with you today and to have this conversation, a hugely important conversation.

In follow-up to the deputy's comments around never events: I couldn't agree more with the recommendations coming from the Auditor General on the collection of this information. Just to drive home a little bit one of the points that the deputy spoke to, when a never event occurs, typically it's a failure of multiple systems. It's rarely a single thing that occurred, but in fact, most of the things we're talking about when we're talking about never events are a chain reaction, and it would take several safety steps to fail in order for a never event to occur. That's very, very important learning.

Again, to support the deputy's comments, we would never do anything that would compromise patient health information on the individual, but understanding how a never event could occur—what were the learnings? Generally, they are complex and I think that the recommendations from the Auditor General were very strong in pulling that information together and producing some kind of report. At Ontario Health, we're going to work through exactly how we would do this, but producing a report of learnings—because, hopefully, we can get never events to truly be never and we can work at the reduction of these so there aren't many in a year. It should not be an onerous task to do this. The only thing that we would have to really consider on the other side is, when you are in a world of never events, if the number is small, we have to protect patient confidentiality. But I'm sure we can find that balance, and we look forward to engaging in this work when we move through the pandemic.

1300

Ms. Jessica Bell: Okay. I'm sure my colleague will have questions about this later on as well, but having read that in the report, I can certainly say that I'm very interested in the Auditor General continuing her investigation into whether there are moves to identify targets to reduce never events, tracking them and having a plan to reduce them. It very clearly needs to be there, and I can clearly see a ministry role in that.

The second thing that really struck home with me when I was hearing about this report was around the fact that there is not real clarity around making sure that if staff, physicians and nurses have been let go due to discipline or incompetence, which is the word the Auditor General used—there's no real tracking to ensure that that nurse is not rehired in another jurisdiction or in another hospital, and the Auditor General had made some recommendations around that to ensure that those kinds of standards are kept.

I'm curious to know, what are the ministry and the hospital association doing to ensure that a nurse's work history is part of any hiring process?

Ms. Helen Angus: There are certain provisions under the Regulated Health Professions Act that require nurses to—there's a duty to report to the relevant college, and it has to be done in a timely way. Certainly, we are working with regulators to ensure that the best practices involving sharing of information between provincial and territorial nursing regulators happen. It will require interprovincial collaboration to establish the national system that would allow for the reporting of disciplinary actions against nurses in particular but against health professionals. So it's not unchallenging as a recommendation because there are various legal frameworks across the country, and it is complex.

I understand that the CNO and other Canadian regulators are committed to developing and implementing a national database to share nursing registration and discipline information. There are a number of projects under way. I don't know whether Sean Court might want to talk a little bit about that.

The interjurisdictional nature of a pan-Canadian approach adds complexity and time, but we are committed to trying at working through those issues to implement this recommendation.

Ms. Jessica Bell: Okay. I guess I could go to my third question, which is kind of related, which is around the issue of physicians also being hard to discipline, especially when, going by the Auditor General's report, we're in a situation where it's taxpayer dollars that are paying physicians to lawyer up in situations where they might have committed some activities that are very problematic.

I can give you an example of something that has happened in my riding: I was approached by a constituent who had been sexually assaulted by her physician when she was a teenager. He was eventually found guilty for committing those assaults, but his legal bills were paid for by taxpayers. That seems incredibly problematic.

When I look at the Auditor General's report, I see that the ministry's response at this point is to do a jurisdictional scan, which seems like a pretty nascent step in the steps we would need to take to ensure that physicians are properly disciplined in a cost-effective way and that physicians who are breaking the law or violating patient trust consistently are really held to account. I'd love to know what measures are you taking to ensure physicians are properly disciplined in a cost-effective way?

Ms. Helen Angus: That probably straddles two areas: one is the relationship that the ministry has with the Ontario Medical Association and the fact that—Patrick Dicerni may want to jump in here—the payments to the CMPA, the dues, are bargained with the Ontario Medical Association. So that's on the payment side, and Patrick can

probably provide a little bit more insight into that, knowing that we are in the middle of a mediation process with the Ontario Medical Association and there's a blackout on that. So that's fairly sensitive territory at the moment.

The other relates to work that may be ongoing with colleges to ensure the timely and effective prosecution of disciplinary matters. For that I would go to ADM Court to answer those questions. Maybe Sean can lead off, and if Patrick is on the line, he can speak to the CMPA relationship in more detail as well.

Mr. Sean Court: Hi. Sean Court. I'm the ADM of strategic policy, planning and French-language services division in the Ministry of Health. Thank you, Deputy. I think Patrick is not in this meeting today. We're going to rely on Tara or Sherif, potentially, to take some of the questions about the CMPA.

The time it takes to move through a discipline process can be lengthy, and there are a number of factors. I would say in the case you raised where someone had been the victim of a sexual assault, first and foremost, the correct place to go in those instances is to engage the police. That's not a professional misconduct. That's a criminal misconduct. So the correct place to go for those kinds of complaints is the police.

Oftentimes, police-related complaints involving or alleging crimes do ultimately end up in professional misconduct hearings as well through the college process. We do know that moving through the college process oftentimes involves people almost immediately lawyering up, and that can really increase the cost. It creates a significant barrier for some of the lower-paid regulated health professionals who are captured under the current regulatory college model. Oftentimes, there's a significant amount of procedural steps that people do undertake to draw those processes out.

I would defer to others on the call from the ministry about the CMPA payments and the use of taxpayers' dollars. But I think it's fair to say that the professional misconduct processes of the college do take a significant amount of time, and there are real issues that we, as a ministry, continue to monitor and to work with our college partners and other employers on about the appropriateness of the discipline in hearings processes of the colleges. So it's something that we continue to work on. It's not a definitive answer about solving it. It's a process and it's something that we're alive to and continue to work on with the colleges.

Ms. Jessica Bell: I just want to make a few closing remarks before I hand it over to my colleague MPP Gélinas. I do want to say, having read that report, the issues around tracking never events and having a plan for them, ensuring that all physicians and nurses are adequately trained and we're not hiring people who have been fired previously in another jurisdiction due to incompetence, and making sure that physicians are properly disciplined in a cost-effective way are issues that I would like the Auditor General to continue to investigate on. I'm going to assume and I certainly hope that the ministry considers those to be a priority as well.

1310

In the case of the woman who was sexually assaulted, she did go to the police. She's been following this case for many years. The larger issues I have here are less around the process being lengthy; I already know that. The real issue is around how we're going to make sure that we're not spending unnecessary taxpayers' money on defending physicians who really shouldn't be operating anymore. So I'm looking forward to continuing to work with the Auditor General on that. Thank you.

I would like to hand my time over to MPP Gélinas.

M^me^ France Gélinas: Chair, how much time do I have?

The Clerk of the Committee (Mr. Christopher Tyrell): There are three minutes and 20 seconds remaining.

M^me^ France Gélinas: Thank you. I will start by saying I am really proud of Ontario's hospital system. I know how much good work comes out of each and every one of our hospitals every day and how many people are helped because they reached out to our hospitals and they were helped. So reading a report like this just tears my heart apart, to see in black and white when the system has failed, when our hospitals have failed.

And then to look at: What do we do to make sure that we don't fail? Although we are successful for millions of Ontarians every year, there are thousands for which we fail them. How come, in 2021, there is still no mandatory reporting of never events? What's keeping us from making it mandatory to report those and have them collected? How come we're not there yet?

Ms. Helen Angus: Thank you, MPP Gélinas. I think that we've got some work ahead of us to implement the recommendations, particularly recommendation 2. I think that we've got to work with the sector to make sure that we do track never events and that the focus is on the areas that are really going to make the most difference for patients. I think that by the time we report back for the next reporting interval on this audit, we should have determined what is the most appropriate mechanism, how we would implement such a system and how we would make it easy for hospitals and provide the most relevant information for patients. We haven't done it yet, but I think that the intention is to move towards a better system than what we have today, for sure.

M^me^ France Gélinas: Mr. Dale, I would like to ask you—you saw the report: 26 unintended foreign objects left in patients following a surgery, wrong tissue or biological implants in 24 patients. Are there any hospitals that push back against collecting those mistakes so that we learn from them and we improve? Do you see this in a few?

Mr. Anthony Dale: Hi, France. No, no, of course not. When the report came out on the eve of the COVID crisis, obviously all of us in the hospital community and in health care took the findings extremely seriously. One critical injury, one critical error is one too many, and of course a never event is the most serious of critical incidents. No, there would be no pushback. It's really what the deputy says: taking the necessary time to design the appropriate

systems and solutions to support clinicians and the field to as great a degree as possible to achieve that target—

The Chair (Mr. Taras Natyshak): Apologies, Mr. Dale; I have to cut you off. We are moving to the second rotation, this time with the government members for 20 minutes. MPP Crawford.

Mr. Stephen Crawford: Thank you to the Auditor General for this report and to all the speakers here today—a very interesting topic and very serious topic.

I first want to start out by asking Mr. Dale—I know you didn't have an opportunity to finish your opening remarks; you were cut off. I don't know how much longer you had, but did you want to finish your remarks?

Mr. Anthony Dale: Well, I can just paraphrase by saying that the truth is the OHA and the system in general have been so absorbed in fighting the pandemic for 15 months that we simply haven't had the opportunity to devote the time and energy the report deserves.

That is an honest report to this committee. It's not through any lack of interest or lack of commitment; it's just that this has been, for the ministry and Ontario Health, a 24/7 undertaking, and it has been 15 months. We're in the final phase, but it is still as intensive as it has ever been. Perhaps that won't surprise you, but we wanted to ensure that is known to you. But we do absolutely intend to work with our very hard-working colleagues at the ministry and Ontario Health, once the health care system is stabilized, once the pandemic is in the rear-view, and do our best to appropriately reflect on and be able to implement the recommendations.

Mr. Stephen Crawford: Okay. I'm curious, since you're on the topic of COVID: How do you think, through the COVID pandemic, 15 months right now—has there been an effect on some of the issues like patient safety? I don't mean specifically COVID, but just in general. Has it been affected by the pandemic in a negative way? Is it neutral? Just your thoughts on that.

Mr. Anthony Dale: I will say to you that the pandemic, with its single-minded focus on infection prevention, control and safety of both patients and health care workers, has absolutely amplified and underscored the need for this to be an anchor commitment, an anchor strategy for every organization on an ongoing basis. I think Ontario's hospitals have shown remarkable resilience and leadership, particularly through infection prevention and control, with clinical leadership and administrative staff supporting front-line clinicians, physicians, nurses and other important health care workers on the front lines in dealing with the most unprecedented conditions we've ever seen.

People have to remember: We're speaking about this report, and everything about it is extremely important; this is also the most serious civil emergency in the province's history. I would ask all committee members to be patient with us as we finish our necessary work on the pandemic response, and then turn our eyes and ears and intentions toward these findings and, of course, all the other work that has to happen after the pandemic for the province's health system to recover, for the health care workers to recover so that they're in a position to continue to provide very high-quality care, very safe care to the people of Ontario.

I don't know, Helen, if you'd like to add anything to that, or Matt.

Mr. Matthew Anderson: Thank you, MPP Crawford, for the question. Thank you for the opportunity to address it, a great question. I couldn't support Mr. Dale's comments any more strongly in terms of what has gone on. And a huge thank you to both MPP Bell and MPP Gélinas for recognizing the great work that goes on in our hospitals and the challenges that we face.

Directly to your question, MPP Crawford: One of the recommendations that was in the report spoke to patient transfers and a coordination effort around patient transfers. We've seen patient transfers at a scale that we would never have imagined before. Some wonderful work has been done—just a quick acknowledgment particularly to CritiCall Ontario, who have done a fantastic job of managing the transfers and ensuring the safety.

The recommendations specifically spoke to initiatives to ensure timely care at the closest hospitals, and not only has that been a major feature of our response, but also, as I'm sure you all know, it's looking at where that safe spot in a hospital is for our patients and managing that, and load-balancing across the province.

Again, I thank the Auditor General. I think she, as usual, pointed out a critical element of our system, one we tend not to speak about quite as often: this notion of safe transfers. Certainly, we have seen that as a key part of our response. A particular shout-out to our colleagues at CritiCall, EMS and others—and Ornge, of course—who have worked together in a single system to provide that transfer capability. I didn't want to miss the opportunity to thank them for the work they have done in making sure that we have been able to provide a safe environment for our patients.

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Mr. Stephen Crawford: Yes, that's good to hear.

My next question is more geared to the ministry. I'm just wondering: What are some of the ways that investing in the quality of care patients are receiving has increased patient safety? How has that led the way to improve patient safety?

Ms. Helen Angus: Thank you very much for the question. I'll talk about a couple of initiatives, and then maybe if either Matt or Anthony wants to jump in.

I think some of these initiatives provide a road map. So think of them not only as areas of focus, but as the elements of the initiatives that actually make a difference to patient safety on the ground and what we're learning through those that could be applied to other patient safety challenges.

One would be the implementation. I think I mentioned briefly in my remarks the National Surgical Quality Improvement Program, NSQIP Ontario, which is now called the Ontario Surgical Quality Improvement Network. It's where affiliated hospitals are able to compare their post-surgical outcomes with 700 hospitals from around the

world. Then the surgical teams in Ontario use that information to inform changes in care that could be implemented across the province. We support the Ontario Surgical Quality Improvement Network to do that. Again, that's a network that enables the improvement of surgical quality. It uses clinical data through the American College of Surgeons National Surgical Quality Improvement Program. That has 46 hospital sites participating, including four pediatric centres and 11 provincial neurosurgery centres, representing 72% of all surgeries performed in Ontario.

Ontario hospitals that participate in that program report better outcomes, shorter patient hospital stays and fewer surgical complications. Here are the kinds of results you can get: In March 2019, at that point, we were able to see a 27% reduction in post-surgical infections among participating hospitals, a 51% reduction in the rate of post-surgical urinary tract infections and a reduction in opioid prescribing across all targeted surgeries. By that, we estimate about 650,000 opioid pills were not released and used by the public.

This is exactly why we set up Ontario Health: to bring together the data, the implementation capacity, the clinical leadership and the commitment to doing a better job for patients under one roof to be able to drive improvements like these initiatives.

There are many more in the cancer space as well. I don't know whether Matt wants to talk about the ingredients to getting traction and results like these. It takes that kind of effort, I think, across multiple sites and in multiple areas of practice. I see Matt has his hand up.

Mr. Matthew Anderson: I do. Thank you, Deputy. I think I will actually ask our Ontario Health chief nurse, Judy Linton, to make a couple of comments regarding this point on investment in patient safety and the comprehensive work we do.

Ms. Linton, I know that we're pressed for time, so you may want to just pick one or two examples of the things we do, whether it be cancer, renal or elsewise, in support of this and in support of the questions from MPP Crawford.

To introduce Ms. Linton to everybody, Judy joined us all of about 10 days ago, and then she's right in here. She is our first chief nursing executive of Ontario Health and also runs our clinical programs.

Over to you, Judy.

Ms. Judy Linton: Thank you very much, Matt. Thank you for the opportunity to address the committee. I am Judy Linton, chief nursing executive and clinical institutes and quality programs executive at Ontario Health.

I'll talk very briefly about some of the ongoing safety initiatives in some of our larger programs. I'll start with the cancer program. In the cancer program for chemotherapy systemic treatment, there is a system whereby physicians enter all of their orders using a computerized order entry system. That system has protocols and limits built into it so that we ensure the ongoing safe ordering and administration of chemotherapy. The e-claim system that actually then allows the hospitals to be paid for that delivery of chemotherapy also checks to make sure that the appropriate protocols have been administered. That's one example.

Sticking with cancer, our regional vice-presidents have a significant role in safety for all of the cancer programs across the province. They are accountable to notify Ontario Health of any potential safety concerns or incidents within their region, and then we identify reports and evaluate risks to the cancer programs and the cancer system, and implement local measures where possible to mitigate those. Ontario Health and Cancer Care Ontario have an issues and crisis management protocol that can be put into place to respond to any issues.

I'll also talk briefly about radiation safety. Since 2007, there has been a radiation incident safety committee. All of the radiation treatment programs in the province are required to report any and all safety incidents to that committee centrally. We have now become part of a national group that reviews all of those incidents and shares any outcomes from those incidents or anything that needs to change as a result of that.

I will just also say that a number of the ongoing safety processes and measures that Cancer Care Ontario and all of Ontario Health have in place have been modified as a result of COVID. One of the examples in the cancer system is making modifications to protocols so that patients did not necessarily always have to come into the cancer centre to get their chemotherapy. We have provided guidance to the centres as to how to do that safely.

Just switching briefly to the renal program, our renal program, through the Ontario Renal Network, has ongoing routine reporting of infection rates: peritonitis in patients who are on peritoneal dialysis; they also monitor catheter-related infections for patients who are on hemodialysis. They have extensive safety protocols around medications. There are medications that would typically be prescribed in primary care that may actually be detrimental to patients who are on dialysis, so there are protocols around safe administration of those medications or a modification of doses.

Again, there is ongoing conversation with the Ontario Renal Network around safety related to equipment, so there is an obligation of those programs to report centrally on any issues around equipment and supplies. There have been incidents where that happens, and then those are monitored and managed centrally through the Ontario Renal Network.

Just briefly, I'll mention the Trillium Gift of Life, our transplant program. There are extensive protocols in place to ensure the safety of organ and tissue transplants, including testing for infectious diseases in potential donors and screening through medical history and social questionnaires to ensure medical suitability for donation.

I'll stop there. Thank you.

Mr. Stephen Crawford: Thank you.

I know, Mr. Dale, you touched on best practices for patient safety. I just want to get a sense on what is being done to ensure best practices for patient safety. But also to

that question, Madame Gélinas talked about the never events. I'm pleased to see the ministry is looking at collaborating and tracking that in a more effective way going forward, but are we discussing those events as well?

What I mean by that is: For example, in pilot training, all pilots go through simulators and they go through scenarios where pilots made mistakes and accidents occurred. So it's not only best practices which are critical, but it's also important to show the medical professionals these never events that should never occur again. If I could get some response on that, I'd appreciate it. Thank you.

Mr. Anthony Dale: Thanks, Mr. Crawford. I'll start and then ask Melissa Prokopy from the OHA staff team to add to what I've said. But I think, maybe just pulling back the camera lens for a minute, I'd say that over the last 10 years the hospital sector in Ontario has gone through what is really akin to a revolution with its focus on quality-of-care issues, and that is founded in the passage of the Excellent Care for All Act, which created a legislative regime for the first time in the province to concentrate on quality of care, clinical matters, patient safety and so on. It really is a foundational piece.

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Creating a board committee for each hospital, alongside the medical advisory committee, to concentrate on quality of care, patient safety and clinical issues really has been the cornerstone of all the quality improvement efforts undertaken in individual facilities. I assure you that those are taken extraordinarily seriously. As the deputy also alluded to, I hazard to say that there is no other jurisdiction in this country—sorry, you'll have to forgive my dog barking in the background; it's a working-from-home thing. No other jurisdiction in the country reports publicly on quality and safety measures the way Ontario does. We're very proud of that transparency, and that's both at the provincial level and at each individual hospital level.

I'll ask Melissa to speak a little bit about critical incident reporting. It is a very significant question you're asking: How do we learn from and prevent major incidents like never events from happening again? There's a process and a methodology in place to facilitate what is, in effect, a safe, no-blame environment so that people, organizations and individuals can learn from and prevent this in the first place without people being penalized, unless of course there's wilful negligence. But I'll turn it over to Melissa to speak.

Ms. Melissa Prokopy: Sure. I'm Melissa Prokopy. I'm the director of legal policy and professional issues with the OHA and appreciate the opportunity to appear before the committee today.

Just building on Anthony's comments, certainly the process related to disclosure of and reporting of critical incidents is something that's been enshrined within hospitals for a number of years. This has been a twofold exercise. One has been to help families and patients who have gone through adverse events or incidents to understand the facts and the learnings behind those incidents, because in many of those situations, frankly, the goal of those individuals is to make sure that something similar doesn't happen to someone else. They want to really make sure that hospitals are undertaking actions to resolve some of the challenges.

But to Anthony's point, I think part of that exercise is also the hospital understanding the system factors that have been at play across the continuum of that patient's experience that have perhaps led to a critical incident. What happens is, there's a formal committee that's established that actually reviews each and every critical incident that happens at the hospital. It's an opportunity for individual staff to share, without fear of reprisal or sanction or punishment, their own reflections or opinions on what they feel went wrong during that specific situation. Then that committee comes up with a series of recommendations or options as to how they're going to create systemic improvements within the organization to prevent that from happening further.

That information is then formally required through legislative and regulatory oversight to be fed up through the quality committee of the board and, to Anthony's comments, then raised to the level of the board to consider exactly how those systemic recommendations are being acted upon on a go-forward basis. A lot of that does involve simulation and tabletop and discussions about processes. Many of these things are built of a series of complicated processes and involve a number of individuals, so looking at how all those pieces fit together is a huge part of that exercise.

The Chair (Mr. Taras Natyshak): Thank you very much, Ms. Prokopy. That is the end of the first round.

We will now move to the second round of 20-minute questions, starting with the official opposition. Madame Gélinas.

M^me^ France Gélinas: In line with what we have been talking about, it still puzzles my mind that—we've just been given multiple examples of where, when something goes wrong, it is reported. So, a radiation incident has been reported since 2008. Dialysis infections are reported, looked at; supply and equipment in the renal network; the Trillium Gift of Life, the example we were just given. But yet, when it comes to never events, there is no mandatory reporting of those. There is no mandatory learning from those. Why are they treated any differently? I guess that would be to you, Anthony.

Mr. Anthony Dale: Well, I don't know quite your meaning, France. The auditor's report is primarily about reporting, collecting, collating that information and then systematically introducing measures to attempt to achieve zero. I agree it is an absolutely vital priority, and we have to take the auditor's recommendations quite seriously and implement the measures to accomplish that goal.

The OHA, as one partner in this undertaking, would obviously work quite closely with the Ministry of Health and Ontario Health to support the field in implementing it. I'd ask you to bear in mind—and you know this very well—there is a huge array of quality of care performance indicators that are reported on publicly already, and they are taken extremely seriously, as Melissa has articulated and as I have, by individual boards, management teams and clinicians. Perhaps I'll ask Matt and Helen to add to what I've said.

M^me^ France Gélinas: Okay. Mr. Anderson?

Ms. Helen Angus: Before Matt jumps in, I might just—if that's okay, MPP Gélinas.

M^me^ France Gélinas: Sure.

Ms. Helen Angus: I think this is why Ontario Health was created. The examples that Judy just gave were areas where you've got a strong provincial program, so the cancer example, the renal example, the Trillium Gift of Life example. The policy intent was to bring the same discipline and the same ingredients, whether it's the data, the reporting systems, the performance management systems, the clinical leadership to other parts of the health care system that have been so beneficial for cancer.

I would just point out that in addition to the examples that Judy gave, certainly in my time and when Judy and I were working together at Cancer Care Ontario, we also embedded safety—things like fume hoods and other things, medication administration—into the clinical standards and then into the funding model for the administration of chemotherapy. When you have all those levers together, you can actually make big strides in improvement and quality, patient safety and otherwise.

Maybe Matt will want to jump in here, but I think that was why we didn't want to limit those systems that have been shown to work so well just to the cancer and the renal space.

Mr. Matthew Anderson: Thank you, Deputy, and I think you said it well. Madame Gélinas, just to say, building upon what Deputy Angus has said, taking those learnings and practices from parts of our system and expanding it across, to my mind, is exactly the mandate for Ontario Health. On the never events, I would like to say I'm as passionate as you and MPP Bell on this topic. It's a great example of where we can take those learnings and apply them in this kind of setting, just to support what Deputy Angus has said.

M^me^ France Gélinas: I don't want to put words in your mouth, Mr. Anderson, but you give me hope by what you just said. You make me really happy with what you just said. Can I take it that once the pandemic finally ends, those are the kinds of actions that we will see Ontario Health taking?

Mr. Matthew Anderson: Absolutely. That is absolutely right.

M^me^ France Gélinas: Okay. You give me hope. Thank you.

Following up on Mrs. Bell, the next question will be around nurses. I love most of them. They're all competent, but apparently there are a few of them, at least 104 anyway, as identified by the auditor, who are not competent but continue to work in our hospitals. It is my understanding that hospitals have performance evaluations of their staff on a regular basis. Why aren't staff who are incompetent either sent for more training or sent out the door so that they don't put our lives in danger? How come we're still there? And [*inaudible*] maybe?

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Mr. Anthony Dale: Sorry; that broke up there. But I see I've been unmuted, so I assume I'm being asked to comment. I'm going to ask David Brook, vice-president, labour relations, at the OHA, to take this. This is a complex question you're asking.

M^me^ France Gélinas: David?

Mr. David Brook: Hi. I'm David Brook, vice-president, labour relations, at the OHA. I think that, as Anthony alluded to, there is some complexity here. First of all, with the safety culture, the just culture that hospitals have, we do want to have a situation where people are free to examine and investigate any incidents of medication errors or other patient safety incidents that occur in a hospital, and to do it in a blameless way, in a way to identify the issues and to ensure that there are not things that are hidden from sight, because of the importance that we've all heard about of learning from them and understanding if there have been systemic issues that have come into play, and to properly investigate them and learn from those issues, if there are truly practice issues, training that needs to occur, learning plans for the nurse that may need to be put into place or system failures within the hospital that may need to be remediated through all the other interventions we've talked about.

Unfortunately, regrettably, there may be situations where there might be wilful misconduct or true incompetence after a number of different efforts that would actually occur. Hospitals take that seriously. They do want to balance the learnings and the attempts to address the issues, but if it comes to a point in time where it's clear that that's not possible and there is a situation of incompetence, hospitals will have to take the steps and do take the steps to take patient safety very seriously. There are disciplinary processes that are put in place. I think—

M^me^ France Gélinas: And how tough are those processes? What do they look like, how long do they take and who is successful?

Mr. David Brook: Those processes could be looking like progressive discipline. It could be looking like—up to the point of termination is very possible, and it could also require, as it would, reporting to the College of Nurses of Ontario for professional practice issues or concerns that need to be investigated from that body.

I think what you see is hospitals taking those issues very seriously. The complexity in working with the regulated health professional environment, with this kind of environment as well as with the role of the College of Nurses of Ontario—the Auditor General's report is talking about a bit more transparency and a bit more ability to get more information to employers, so that not only are they able to work in a timely way and understand how to work through these things in their own context, but if they do end up having to make the decision to terminate an employee, what does that mean for the next employer and how can they get information about that action that has been taken?

And so you can see that thus far it has been either reliant on the College of Nurses of Ontario to provide information—there are limits about what they're able to share with employers directly, and in some cases, if a nurse is applying for a new job, they're self-reporting where they have worked in most cases. There has been

some progress on this front following the recommendations from the Auditor General. The CNO now reports all the current employers, because a nurse may work for multiple employers. Of course, it will also provide a history of three years, which is already very helpful for an employer to have that information, to understand where they can go and talk to them to understand if there have been previous performance or professional practice issues, or issues of incompetence.

I think we've seen, and in the report it also talks about, how there are complexities dealing with highly regulated environments, other provinces, and getting that information from the College of Nurses of Ontario and working with the Ministry of Health on other sources of that information. So definitely hospitals treat it seriously when they are uncovering it and understanding those issues in their own environment. But also, some of the recommendations, I think, speak to some of the work ahead to be better informed if they make those decisions and when they're making hiring decisions going forward.

M^me^ France Gélinas: Do you see a value in the auditor's recommendations that criminal record checks be done on a regular basis for hospital employees?

Mr. David Brook: I think that is another area that speaks to the current complexity, because hospitals in the very large main, if not 100%, upon hire would do criminal reference checks. It's after the point of hire, because they're members within a college, where they are required to self-report to that college, that there is an interaction about whose role it is. Typically, absent in any other recommendation or intervention, the hospital really has to assume that they're still a member in good standing with the college.

So we definitely think that recommendation would be something that would change that story. It would have that ability for hospitals to provide that or to obtain that information if necessary.

M^me^ France Gélinas: Every regulated health professional has to renew every year, and when you renew every year, they ask you where you work and there's a list of questions that has to do with police intervention and charges and being found guilty and all of this. So the system works such that once the college knows about this, they may withdraw the licence. Once they withdraw the licence, then would you be notified that one of your employees has lost their licence, or do they have to notify you?

Mr. David Brook: I think that's the understanding, is that the college would be notifying. There are obligations of both the employee as well as the college to notify the employer if either of those situations have occurred. I think that's what the Auditor General's comments are speaking to, is the need to make that a bit more robust and make it a bit more clear so it is clearly understood as part of that annual process.

M^me^ France Gélinas: My next question also follows Ms. Bell about physicians and the CMPA. Do we have any idea how much hospitals spend trying to go after CMPA-paid lawyers for the physicians who do wrong in their hospital? How much does it cost our system to fight those lawyered-up physicians who have done wrong?

Ms. Helen Angus: I don't have that number. Obviously there is a process and there are resources on both sides. I don't know if somebody closer to that situation might have a sense to answer your question or not.

Mr. Anthony Dale: I think the Auditor General's report sheds a light on a very old historic process related to physician disciplining in hospitals. That's the nub of the issue. It is infrequently used, but when it does occur, it's typically quite a challenging and adversarial situation. And you're right, it can be costly; we don't have information for you on the aggregate costs for hospitals each year, but every tax dollar is important here.

I think what is important to emphasize here too, though, is that this is about a delicate question of rights and questions of due process for physicians, and it's not right to talk about that without the OMA and other physician organizations as part of that conversation. Again, because it deals with rights that are historic in nature and relate to due process, it's extremely important to handle this question transparently and in a constructive way. But Melissa, would you like to comment on your own perspective about this?

M^me^ France Gélinas: I see that the auditor has her hand up also.

Ms. Melissa Prokopy: Sure. I'll just add very briefly, I think to Anthony's point, that it's the culmination of the legal fees. It's both legal representation by the physician, and it's then legal representation that's required by a medical advisory committee and separate legal representation that's required by the hospital. So I think that although it's used very infrequently, when you start to add up all of the legal fees for the three parties over the course of a year or two years or three years, you can start to see the numbers getting quite high.

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To Anthony's point, it is part of a larger process and a larger discussion, I think, that's warranted to include the OMA, to think about how we continue to ensure that those due process considerations are kept intact, but at the same time creating, perhaps, a little bit less of a kind of quasi-legal process for organizations to manage those relationships more effectively.

M^me^ France Gélinas: Do any other provinces do that better than us?

Ms. Melissa Prokopy: I don't know, in detail, the other province's regimes, but my understanding is that we're really the only province that has this, I would say, historical process that has been in place for the better part of 40 years, with very little modification in terms of the privileging and appointments process specifically.

The Chair (Mr. Taras Natyshak): If I could recognize the Auditor General. She had her hand up.

Auditor, did you want to—

Ms. Bonnie Lysyk: Yes, I'll just point to our report and figure 15. I don't want to give the impression that this is rampant, but there are cases. So we cite a case in figure 15 in our report where one doctor, over the last seven years,

has had the situation come up where their fees are being paid by the organization that pays their legal fees, and the hospital itself was paying about $1.5 million, and the case was ongoing. Likely, if you say "reciprocal," you're looking at $3 million over a seven-year period, roughly, for the same legal case, and that's one example. I'll just leave it with you. That's the only one we cite in the report for physicians. Thank you.

The Chair (Mr. Taras Natyshak): Just over two minutes left.

Mme France Gélinas: To anybody: Are there best practices out there? Is there a role for government to change some of this 40-year-old historical process that is causing us to question a whole bunch of stuff? Why do we spend $3 million on liability insurance for physicians when we don't do this for dentists, for optometrists, for the other registered professionals? Why this cumbersome process? I will start with you, Deputy. Is there a role for the government to play to help this?

Ms. Helen Angus: Thank you for the question. Yes, for sure, there's a role for government. I think Anthony has correctly pointed out that this is a multi-party discussion that must involve the OMA since the insurance coverage is part of a bargained support for physicians. Right? That's the construct.

I've certainly had, in my tenure here, people come to me with: How could we streamline privileging? Does every hospital have to do it themselves? Some physicians practise at multiple hospitals. Could there be a central place to do that? We haven't had any discussions about it, again, for the aforementioned reasons. But when something has been in place for 40 years, it doesn't mean that it needs to be in place for 40 more years.

I think it should be incumbent upon good public servants to kick the tires of assumptions and orthodoxies every now and then in order to make sure they're actually fit for purpose. It feels like, through the Auditor General's report and other examples, there are parts of the health care system—this might be one of them—that aren't fit for purpose anymore, where we need to come up with collaborative solutions.

I'm certainly aware of other processes, even in the government, where the workplace harassment and discrimination policies don't—the processes are protracted. They don't seem to satisfy anybody. Are there ways to make improvements in those processes? Are there opportunities for mediation? Are there more collaborative ways of arriving at decisions and remedies rather than recourse to the courts?

Mme France Gélinas: I see Anthony has his hand up also—

The Chair (Mr. Taras Natyshak): Thank you very much, Ms. Angus. My apologies. We are out of time for that round. We will need to move to the next round, starting with the government and Mr. Barrett.

Mr. Toby Barrett: Thank you to the Auditor General and the group for looking into this. We reviewed some of the highlights of the report today. I appreciate the comments from the deputations that we have heard this afternoon.

My question I wish to raise is a two-part area with respect to best practices. Some of this is being covered, but I direct this to the Ministry of Health to just have a more fulsome or continued explanation of best practices to ensure patient safety. I think of the word "oversight" as well, and perhaps that leads into the second part of my question with respect to other major players or organizations in our health care system like, obviously, the Ontario Hospital Association, the OMA. I'm looking for information that would be of value for our Auditor General and for our committee in the report that we're writing.

But secondly, I'm an elected guy. I think of our office. Over the years, we are contacted by a patient or oftentimes by a family member when something has gone wrong. Well, who do we go to? We have to get some answers back to our constituents. We have a medium-sized hospital down in the riding of Haldimand–Norfolk, a great hospital, Norfolk General. We have three smaller hospitals that the majority of our people relate to. But as far as acute-care hospitals, we don't get a lot of complaints. Often, it's those who have gone for tertiary care in a neighbouring city in the Niagara, Hamilton, Brantford or London areas. Who do we go to? Oftentimes, we will contact the hospital administrator. Perhaps it's a department responsible for quality assurance and what have you. Of course, we pick up the phone and talk to the Ministry of Health and staff. We don't necessarily phone the OMA or the OHA.

So it's a two-part question. I apologize for going on a bit on this. But I wonder if we could kick off on those two threads, if you will. Thank you.

Ms. Helen Angus: Thank you for the question. In terms of the best practices, I think we've talked about the legislation. Obviously, it is an important underpinning, and we talked a bit about the Excellent Care for All Act. But in addition, it is the partnership with Ontario Health, associations like the OHA, OMA and the colleges and the partnership with front-line providers that really make a difference for delivering reliable care to patients. I think that it's when all those things work together that we can see measurable improvements in patient care. Maybe Matt wants to talk a little bit more about on the ground.

On the patient complaints processes—and again, maybe Matt and Anthony want to talk about this—I think the best solution is really for there to be a discussion between a patient and their care team when something goes wrong. I think there's a body of literature that says when those discussions can happen in a constructive and patient-centred way, often the need for litigation and escalation really reduces substantially. It isn't always the case, as you would know from your constituency office. I know from my day-to-day work that we get complaints from patients, and so that's why hospitals, for example, will have a designated person to deal with patient complaints and try and solve those. Anthony can talk about that.

1400

As you know, there's also a patient ombudsperson. That's an important role as well, and that is when all the other systems don't work and there's a really complex set of facts. That office has its own independence. Minister

Elliott was, as you will know, the Patient Ombudsman in a previous life. The office has its administrative home within Ontario Health. So maybe the next best place to go to is to Matt, and then maybe Anthony can give you a hospital perspective on that as well.

Mr. Matthew Anderson: Great. Thank you, Deputy. Thank you, MPP Barrett, for the questions. Maybe, from an Ontario Health perspective, we'll address the first question around the work that we're doing with respect to patient safety and how we work together as a system, and I'll leave to the OHA the second question around specifically within the hospitals.

On that first question, if it's okay with MPP Barrett, I'd like to introduce Anna Greenberg, who is our chief of strategy and planning at Ontario Health and has done a considerable amount of work, particularly through our older agency, Health Quality Ontario. Some of the work that she's been doing most recently is around best practice and how we ensure the sharing of information around patient safety and best practices across the system.

Ms. Greenberg, if you wanted to take it from here.

Ms. Anna Greenberg: Thank you very much. I'll start with the evidence-based practices we've used, and then I'll also mention some of the public reporting we've done, because I know that's been a theme in the conversation. Having come together as Ontario Health, we actually have some strong and long-standing capacity from the program in evidence-based care at Cancer Care Ontario and the quality standards program at Health Quality Ontario, and the ability to influence best practice and stay up to date with the evidence and enable the system in that way.

Over the past several months of the pandemic, we've targeted that capacity towards a COVID response. I'll just give you some of the examples of the work that we've done to guide the system as evidence in an unprecedented way was emerging. We had directed that capacity towards providing timely guidance on procurements, extended use of PPE, expired PPE and limited reuse, remembering the state we were in as a system in terms of personal protective equipment and the ability to quickly synthesize the evidence, which we had previously done for particular conditions or for key processes in the health system, and directing that towards the evidence in light of the pandemic.

We also provided to the system recommendations on how to manage with critical care drug shortages early on in the first wave of the pandemic. We worked on providing guidance on infection prevention and control as we came out of wave 1, in terms of restarting scheduled surgeries and procedures during COVID. We provided clinical guidance, as Judy mentioned, during COVID for how to support front-line workers in terms of addressing the needs of cancer patients, chronic kidney disease patients, palliative care patients and also the continuity in diagnostic imaging services through the pandemic.

We also supported partners in terms of providing timely guidance related to antimicrobial stewardship. That group had been looking at not only antimicrobial stewardship but also dosing and chronoecologic considerations for both approved medications for COVID and then also medications that were under investigation for COVID. All of this capacity that we've used previously for other types of conditions we were directing over the past 15 months towards COVID-related issues.

At the same time, and to be responsive to other non-COVID issues, we also just recently released in March new quality standards focused on medication safety. These quality standards are concise statements based on the best available evidence and provide support across settings for how to deliver best practices, to the MPP's question about how we are guiding best practices and synthesizing the evidence.

This includes quality standards for front-line providers, but then also supplements that with a patient guide so that any patients who would be interested in, for example, this topic of medication safety could understand what it means for them, as well as providing the latest available data on that particular standard. For example, in this case we looked at where there was unwarranted variation in medication safety practices and medication reconciliation review and then also where, across the board, we were seeing low levels of that.

The last thing I'll just mention is, throughout this period, in addition to an enormous amount of reporting on metrics and quality related to the pandemic and the performance of the system, we continued our reporting on hospital patient safety, on patient safety in long-term care, in primary care, as well as all of our quality reporting across all sectors of the health system.

The Chair (Mr. Taras Natyshak): Ms. Hogarth?

Ms. Christine Hogarth: Thank you, Chair, and I just want to thank the AG for this report and for the briefing this morning. I also want to thank the deputy and all who are on the call for their hard work. I appreciate, Anthony, you mentioning that there is still more work to be done. We understand that we're in an emergency situation—it's a pandemic—so I appreciate all your time and the work you've done. We know that there is more work to be done on this report.

Something that bothered me when I was reading this, and I know MPP Gélinas touched on it, was a statement by the AG about hospitals we visited that rehired nurses terminated elsewhere who continued to show incompetence. Out of the 104 nurses, there were 62 that were still active and working in hospitals and long-term-care homes and other facilities. As someone who represents a community, we always want to make sure our hospitals are safe places to be. We always hope we have the best of the best and we like to say we have the best of the best.

If you can elaborate a little bit more on what the ministry is doing to ensure that prospective employers obtain more complete records of nurses' employment, their history and, perhaps, their performance measures in the past so people can make some well-informed hiring decisions. Also, how are the ministry and the college ensuring this information is complete but also updated in a timely manner? Thank you.

Ms. Helen Angus: Thank you very much for the question, MPP Hogarth. I'll just say as I start, you may want to

hear from Sean Court and I'll ask Anthony whether you want to hear from David Brook as well.

From a ministry perspective, it's important that there are clear and effective health human resources practices and transparency between, for example, nurses and employers such as hospitals. We've worked with the college of nurses, as mentioned, and employers to add information about nurses' employers from the past three years on the college's public register so that employers have a reliable way to obtain employment information about nurses. It really helps them get a more complete picture and reach out to additional employers, if needed, to obtain more information on a potential hire. There is an onus on the hiring organization to actually go and check and do that work.

Maybe I'll reference the Regulated Health Professions Act, which requires every nurse, as we've talked about, to file a report in writing with the executive director of the college of nurses if there is any finding of professional misconduct or incompetence by another body that governs that professional inside or outside Ontario, unless there's a publication ban, which I would assume is a somewhat rare event. The intention of that, as I mentioned in my own remarks, is that this has to be filed as soon as is practical and reasonable after the nurse receives the finding made against him or her, and it is to be reflected on the online public register, which employers have access to.

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The college of nurses has also worked to include all current employers on the public register. Many nurses have more than one employer, so we want all of them there. That gives, again, a more accurate picture of a nurse's employment.

There's also work under way to link information in better ways. The college of nurses has partnered with nurse employers to establish an employer reference group. Its intention is to identify areas to support employers' needs relating to nursing regulation. I think that dialogue will be important to make improvements going forward.

We are working with the College of Nurses of Ontario to look at best practices and the sharing of information between provincial and territorial nursing regulators. As I mentioned, that's a bit of an uphill battle in terms of a whole pan-Canadian approach, but I think we're up to the task, and we will pursue that.

I think, to highlight some of the work that has been done, the college of nurses and other Canadian regulators have committed to implementing a national database for sharing nurse registration and discipline information across jurisdictions. Nursys Canada is a national project under the joint leadership of the BC College of Nurses and Midwives and the College of Nurses of Ontario. So you've got two sizable jurisdictions working together and they've partnered with the National Council of State Boards of Nursing to develop an electronic repository for Canadian nurse registration and discipline information. This system will enhance public protection by allowing all nurse regulators across Canada to review and exchange relevant information needed to make sure that it's safe to permit a nurse to work across provincial and territorial jurisdiction. Our intention is to continue to work collaboratively across the country as well as with our American counterparts to ensure the full implementation of this recommendation.

But I'll look to my colleagues to see whether they have a different line of sight into your question that might be thoughtful and contribute to the conversation today.

Mr. Sean Court: Thanks, Deputy. It's Sean Court. I'm the ADM of strategic policy, planning and French-language services division.

I think the important distinction is that there's a fairly robust regime for people who are following the rules and are not trying to hide information to participate in a system that is increasingly transparent. The work that the college of nurses has done in terms of employment history, working not only with nursing groups but also with an employer reference group, shows that it's possible to build out our capacity to share information with the public and with employers about nurses. But the backstop is really that obligation on individual nurses to make reports and share information with the college of nurses, either at the point of re-registration or registration or off that cycle if things happen.

The Chair (Mr. Taras Natyshak): Two minutes, Mr. Court.

Mr. Sean Court: Thank you. But I think one of the fundamental issues is that, at the end of the day, it's an employer who's doing reference checks, an employer who's doing their due diligence on an employee entering into the provision of health services within their institution or place of employment. There's only so much that can be done if someone wants to intentionally not share information about something that has occurred in their past employment or in their employment here in Ontario.

I think we've put in place a number of things that are intended to capture good actors and people who are committed to following the rules, but there's always going to be a small group of individuals who potentially are not going to follow the rules, are not going to report proactively. I think the backstop there really is the due diligence that individual employers are doing at the point of hiring into the system, and then they're the ones who are closest to the day-to-day performance and actions of an individual clinician, in this case a nurse, and making sure that they're monitoring what's going on in the workplace.

Ms. Christine Hogarth: How much time do I have left, Chair?

The Chair (Mr. Taras Natyshak): Thirty-four seconds.

Ms. Christine Hogarth: All right. Well, I probably don't have enough time for a question, but I just want to thank everybody for their work. I know, Deputy, you've been here all last week and you've been in meetings constantly. So I just want to thank everyone for what they're doing, and I look forward to further follow-up on some of the questions that the AG was waiting for.

The Chair (Mr. Taras Natyshak): Thank you very much. We'll move to the final round. It will be a 14-minute round. Back to the official opposition: Madame Gélinas.

M^me^ France Gélinas: Thank you. I'd like to start at the back of the report, when the auditor looked at the effect of hospital overcrowding that limited the transfer of critically ill patients. She talked to us about how 784 life-or-limb patients were denied inter-facility transfer: 10 of those patients died awaiting a transfer; 5,400 non-critically ill patients were denied inter-facility transfer. This was all way before the pandemic. The report was written in 2019.

I will open it up as to where are we now with hospital overcrowding and what do you think our hospitals will look like once the directives that limit surgery—those are gone, but once the pandemic is gone and people are back, wanting to have their surgery, their tests, their procedures, how are we going to deal with overcrowding? I'll start with Anthony.

Mr. Anthony Dale: Thanks, France. I think you're hitting at a central issue in our hospital and wider health care system. Back in the early part of this century, the early 2000s, successive governments asked hospitals to continue to absorb a very significant amount of inflationary pressure, hold the line on costs and become ever more efficient in order to push resources into other parts of the health care system. We agree in principle with that objective. It's essential that we build capacity in the home care sector and in the long-term-care sector.

Coming more toward the current day, I think, empirically, evidence is here that the sector has probably gone as far as it reasonably can—I'm talking peace time conditions here, pre-COVID—to keep absorbing that kind of inflationary pressure. The current government has made significant investments. The previous government did make significant investments also, at the end of its term, to start to stabilize hospital capacity. But I think the pandemic has taught us that because Ontario's bed capacity is so low compared to the rest of the OECD, we have some choices ahead of us in terms of holding onto the capacity that has been created because of the pandemic to allow for that flexibility. The OHA will be making submissions and working with the government and anyone interested on that question.

At the same time, though, it's absolutely not about hospitals alone. We've made multiple submissions to the long-term care commission.

Interjection.

Mr. Anthony Dale: That's my glass of water because I'm glued to this chair. Thank you, my wife, for bringing me that.

We have to make sure that our long-term-care capacity is resilient and that we have a way of caring for our frail seniors that's appropriate for the acuity that so many residents of long-term care so clearly have. Again, that is an area where we will work with long-term care and our partners to accomplish that objective.

The third, of course, is home care. Home care has endured some very heavy pressures in this pandemic. The truth is, most people who need care—they certainly don't want to be in a hospital for very long, and they certainly don't want to be in an institutional setting, if it can be avoided; they want to be at home. So I think those three areas are crying out for renewed leadership when this pandemic is over.

One final comment: This pandemic has taught health care providers a huge amount about what we can do when we work with leaders like Helen and Matt Anderson, who understand their capabilities, their leadership and their technical capabilities, their operational skills and certainly their clinical skills. We want to find a way not to rebuild our health system, but to build a new one that is better focused around the needs of patients, particularly our frail elderly.

That's a kind of high-level response to your question, France, but I'll perhaps turn it over to Matt and Helen to comment further.

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M^me^ France Gélinas: Mr. Anderson, if I can continue with that line of thought, there was a call for CritiCall to look at a province-wide command centre. You talked about how inter-facility transfers just exploded when our southern Ontario hospitals were overcrowded with COVID patients. They even came to Sudbury. I'm just wondering if you can comment as to: Are we changing our CritiCall to the command centre that was mentioned in the report—or any other ways, for that matter?

Mr. Matthew Anderson: Great. Thank you very much, MPP Gélinas. I appreciate the question.

Sudbury is one of our outstanding hospital contributors, so it's no surprise that we sent some folks up there. Thank you, and a big shout-out for Sudbury.

What happened through this pandemic—and the pandemic, obviously, was an absolutely horrible event, and I cannot put into words all that it has done. There are a few very, very small positive things that have come out of this. One is, through this process, CritiCall, local EMS and Ornge, all working together, have created a single transport system to oversee where patients are being moved throughout the province. Those were different systems previous to the pandemic, and now they all feed one system.

I'm not sure if that is exactly what our Auditor General had in mind when highlighting the concept of a command centre, but this is something that has now been born out of the pandemic and we're very committed to keeping it in place. It has made a big difference and has made for great ease, but also for some standardization around moving patients through, getting them prepared, and the ability to see who's ready to move and who's ready to go back.

I do anticipate that that system will stay in place and, I think, largely addresses any of the concerns that the Auditor General put forward in her report, but we'll look into that some more after the pandemic.

M^me^ France Gélinas: And do you share some of Anthony's worries, I would say, about once the pandemic is over, the legacy of the—you used very good words that I should remember. Oh, yes, that we ask our hospitals to be more efficient. In my line of work, we say a zero base budget increase; he says more efficient. But at the end of the day—I can talk for my hospital—it was at 128% capacity in 2019. For the little, wee dip last summer, where

we were allowed to restart, they were straightaway at 110% capacity. This all has an impact on the opportunity to transfer critically ill patients. Is there a better path forward so that we don't see 10 patients dying awaiting transfer? Those patients often come from where I represent to go down south, where you have the tertiary and quaternary system to help them.

Mr. Matthew Anderson: Thank you for the question. I think I will also pick up on a couple of the comments from Anthony. We're not trying to go back to where we were. We're, in fact, trying to take the lessons of the pandemic and go to a new place. I don't want to in any way suggest that that's going to be easy. There are going to be challenges, for sure, certainly as we get caught up on some of the procedures and the diagnostics that were not done during the pandemic. So we have another hard pressure point coming on our health care system.

I think that the optimistic side of that is that, through the pandemic, we operated as a system more so than we ever have before. Whether it was on the hospital-to-hospital side, the relationship between hospital and long-term care, there are numerous examples of where we thought and acted more like a system. That's going to be key for us, particularly as we think about how we will catch up on procedures and on diagnostics. We need to be thinking about it as a system.

There's been a number of comments today also with respect to health human resources. Without doubt, that is our greatest limiter in terms of how we can support our system and report and support our community. There are challenges there that will only be exacerbated if we do not respond as a system.

Very much to your point, MPP Gélinas, and to be as tight as I can on this: What I'm talking about in picking up on the points that Mr. Dale made is that we can no longer think about hospitals over here and home care here and long-term care here and primary care over there. What we saw was all of those elements of the system working together to respond to a common goal. We have to do that again as we look to the next phase for our health care system. If we don't, we will end up back where we were before, and no one wants to be there—not that that was bad, but it was not optimal, and we know that. We know we can do better. We've seen we can do better, and it will be through a whole-system response.

My very last comment to your question, Madame Gélinas, is that Anthony also commented about home care; home care will be key. We haven't focused on home care as much through the pandemic and through the discussions we've had, but home care will be key to supporting what we need to do from a system recovery perspective. As I say that, I'm sure my colleagues from primary care will say: But aren't they key? And they are as well. We'll need primary care working on catching up on those diagnostics, and we will need home care on the other side making sure that people are safely able to stay home or return home. If we have those two elements working really well—the in-between pieces, the acute care pieces—I think we can manage our way through the next couple of years.

M^me^ France Gélinas: Okay. Because I only have a few minutes left, Deputy, I'll go back to you. In the report, the auditor talked to us about SteriPro, which is an outside company that hospitals hire to do the sterilization of their reusable surgical tools etc. One hospital that had gone to SteriPro decided to bring this back in-house because of the poor quality of the service they were getting, but we heard of two hospitals which were rebuilt without having sterilization capacity in-house: more particularly, Humber College and Women's College Hospital.

My question to you, Deputy, is: How come a hospital would be allowed to go ahead and submit a plan that did not include the opportunity to do sterilization of OR equipment in-house?

Ms. Helen Angus: That's probably a question for my hospital team, because—I'm trying to think—I probably wasn't here when those were approved. At the time, I would assume that the decision was based on—many hospitals don't have kitchens and outsource their laundry and their other services, and that was the preferred model of the hospitals at the time. But I would ask if anybody else has a better answer than I do on this.

M^me^ France Gélinas: I think it would be ADM Dicerni, but he's not there.

Ms. Helen Angus: He's not there—

Ms. Tara Wilson: Hi. This is Tara Wilson. I'm the director of the hospitals branch. I'm happy to take that back. It might just be looking at what our expectations are from a capital planning perspective and if this is included as one of the criteria or not, if I get the question correctly.

M^me^ France Gélinas: Yes. I could see where a hospital decides that they're not going to do laundry and they contract this out, and some hospitals also contract out meal preparation. But sterilization of surgical equipment seems like a pretty basic hospital function, and I don't know too many people who are experts at doing this except for hospitals, so I'm curious as to how we ended up there.

The Chair (Mr. Taras Natyshak): Thank you very much, Madame Gélinas.

We will move to the final round. Mr. Cuzzetto.

Mr. Rudy Cuzzetto: Thank you, Chair. I just wanted to ask the deputy minister: I was wondering what is being done to address the deficiency in patient safety and medication administration?

Ms. Helen Angus: I would say medication administration is an important aspect of care delivery. Obviously, it ranges from basic pills and other things to very complex—I think Judy talked a little bit about it. Think about chemotherapy administration in hospitals, which requires a whole lot of infrastructure, special training and everything else. Certainly, Ontario Health has a clear mandate to support improvements in patient safety, and that would include medication management. I'll cue up Matt to probably provide you with a more thorough answer.

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Certainly, we do encourage hospitals, as part of their annual capital planning process, to consider the cost-effectiveness of moving towards the automation of some

of the pharmacy-related tasks. Hospitals in Ontario regularly review their existing policies and process for the administration of all medication to make sure that they are following best practices or finding opportunities to improve patient safety.

On the health information system—I think Judy also talked a little about the automation—we are making sure that as hospitals upgrade and renew their hospital information systems, they follow digital health standards. We are supporting that by working with the financing authority to provide them with loans to put those systems into place, and many of those systems have functions that support medication administration.

Perhaps, Matt, do you want to dive into this in a little more detail, or ask one of your team members to do that?

Mr. Matthew Anderson: Thank you very much, Deputy. Thank you very much for the question as well. Maybe I'll just add a couple of quick comments; I know we're running short on time a bit.

You've already heard that at Ontario Health, one of our core functions is to create quality standards. Ms. Greenberg, earlier in some of her comments, talked about a quality standard specific to medication safety. In fact, just in the last few months, Ontario Health completed a medical safety quality standard. The medication safety quality standard includes five quality statements addressing patient involvement in decisions about medications; safe and effective prescribing practices; maintaining accurate and up-to-date medication lists; conducting structured medication reviews; and recognizing, reporting and learning from medication-related patient safety incidents.

The quality standard is accompanied by a measurement guide and a slide deck that includes data on indicators and measures of success—we've made sure that that is publicly available—and also a patient guide on medication safety that is right now being finalized by our quality standards group and will be shared in the coming months. So some very specific work around this and, as Deputy Angus said, this is a really important element for hospitals. Again, sometimes medication safety is straightforward, but in many instances, we've got lots of complexity.

One of the areas as well that is particularly complex and, again, has been recognized by our Ontario Health quality teams is looking at the transitions between hospital and home quality standard. This includes a quality statement on completing medication reviews on admission before returning home and once patients are at home. I can speak just for a moment on a very personal level: When my father-in-law got discharged from hospital after cancer surgery and the two of us were sitting at the kitchen counter going through all of the medications, making sure they all lined up, I was very glad in that instance that the hospital he had been discharged from did an excellent job on medication reconciliation, briefing us before we left, and then we sat at the table and walked through all of them to make sure that we were in good shape.

So these are important elements for sure, moving forward, and something that doesn't stop at the hospital walls. It goes into the community as well.

Mr. Rudy Cuzzetto: I'll tell you this: Being a heart patient myself, having my aorta valve replaced a few years back, I know how difficult it is for the hospital to administrate all those medications to me. And myself, having a package at home right now—you know, the little dated, little plastic container that you pick your pills out every day. It must be difficult, so thank you very much for that answer.

The Chair (Mr. Taras Natyshak): Further questions?

Mr. Rudy Cuzzetto: How much more time do I have?

The Chair (Mr. Taras Natyshak): You have eight minutes and 32 seconds.

Mr. Rudy Cuzzetto: Deputy Minister, could you touch on anything else as well on here?

Ms. Helen Angus: What I want to take from this whole audit is, first of all, there's obviously considerable work to do to fully implement the balance of the recommendations, and the ministry is committed to working with our stakeholders. I think we've highlighted some areas where collaboration with a group of stakeholders, which includes the people around this meeting but goes beyond that to include the OMA and others, home care—to make sure that we're really realizing the promise of a patient-oriented and safe health care system and that that vision comes true.

I would echo what Anthony and Matt have said. I think there's a moment for reflection at the end of this pandemic. We were on a journey to deal with the capacity issues through the work of Rueben Devlin and the committee, the Premier's council, to look at ending hallway health care.

We're talking on a day where the ICU capacity is in the 70%—Anthony puts it out every morning, so he will correct me—and the overall hospital capacity is in the 80%. Obviously, that won't continue as we ramp up and catch up on the diagnostics and procedures. I would say that we did all but 4% or 5% of the cancer surgeries, but there is a significant gap in things like cataract surgeries, orthopedic surgeries and others. We are committed to doing those.

But I think the observations that, first of all, we were able to nimbly add capacity—and Mel Fraser is on the line here. If you think of how much capacity we added in 15—it depends when you think the pandemic started; I think of it as like 17 months. But how much capacity we added in terms of ICU capacity, additional medical beds, step-down units; we've added virtual care, all kinds of things into the system, and some of those are going to have to continue.

I'm fully aware that the OHA has been calling, for some time, for a capacity plan. I think that now is the time to look at what that plan might be in the context of the learnings of what we can really do when the system partners really pull together and function as a system.

I would also say that the work on Ontario health teams is entirely consistent. I think we had a bit of a running start with Ontario health teams, because they were really designed to cement the collaboration between providers around populations of patients. We've seen them use the infrastructure and the relationships that they had to deliver the vaccine program, to come to the aid of long-term-care homes that needed support from hospitals. It's been remarkable.

We were here not that long ago talking about virtual care—so the building to a different place. We obviously need more health care. There are active discussions about how much more and where. There's a capital plan. There are unprecedented investments in hospital infrastructure. But we're going to need to be imaginative. We're going to need the imagination of the sector and the input of patients to get to that different place.

But we've just had a pretty solid lesson in collaboration, and what it can achieve when we work together as a system. Matt has obviously—we've talked about CritiCall and how it's worked to transfer patients; when Ornge is up there doing Operation Remote Immunity and pulling for the Indigenous, remote population.

The story of the lab network, I don't think—it has yet to be fully told, although it is, again, remarkable in logistics and infrastructure. It's a credit to Ontario Health that out of a diffuse set of hospital and public health laboratories, we actually have a system that's moving samples around that achieves remarkable timeliness in terms of the production of COVID tests. And we have created a reserve capacity, to help public health units at Public Health Ontario, that takes the overflow. Again, I think all these systems pieces are instructive in terms of how we respond to the future capacity needs so that what the government came into this mandate with as an objective, and MPP Gélinas has raised in terms of the capacity—that we don't end up in that place again and that we look at what we've learned.

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I'll look to my colleagues to see if they have anything to add. I have nothing but admiration for what we've been able to achieve. We've got to build on that and hold those lessons tight as we get into the next phases of work.

Mr. Rudy Cuzzetto: Thank you very much. I'm going to pass this on to my colleague Michael Parsa.

The Chair (Mr. Taras Natyshak): Two minutes left, Mr. Parsa.

Mr. Michael Parsa: Two minutes, did you say, Chair?

The Chair (Mr. Taras Natyshak): Yes.

Mr. Michael Parsa: Okay. Thank you very much.

Listen, as always, I want to thank the AG and her team for the great work, because it really is incredibly valuable to us. We wouldn't be able to do our work without the great work you do, Deputy Angus, yourself, and the entire team. Thanks for being here, taking our questions.

I have a question about the types of initiatives you currently have in place to ensure that Ontarians, in particular with life-threatening and limb-threatening conditions, receive timely care from their nearest hospital, just a type of integration to improve care and improve patient experience from their nearest facility. If you can quickly answer that, please, and if you could also tell me, would a provincial command centre similar to the command centre that's at Humber River Hospital, for example, have been beneficial or helpful to our pandemic response?

Ms. Helen Angus: Matt, maybe you want to answer that. We do have CritiCall Ontario. It's housed at Hamilton Health Sciences. It's a 24-hour-a-day emergency consultation and referral service.

I've started to get the reports in that describe the amount of patient traffic in order to move patients to where there is care. Don't forget: It's only a few weeks ago that we were at 900 patients in the ICU. Today—I'll just look at my numbers—we're at 573, of which 31 are actually from Manitoba because we were able to provide a service to the rest of the country in their time of need. Manitoba does take care of a lot of Ontario patients in northwestern Ontario, so it is an important relationship. But we've moved a lot of patients around to great success.

Matt, do you want to jump in here?

Mr. Matthew Anderson: Sure. I'll just make a quick comment. Thank you very much for the question, and thank you, Deputy Angus. I don't know if that's your last official hand-off as deputy in front of this committee, but if it is, I'm proud to receive it, let me tell you.

Quickly, and I know we're just about out of time, as I mentioned—

The Chair (Mr. Taras Natyshak): You have five seconds left, Mr. Anderson. Go ahead.

Mr. Matthew Anderson: Thank you to CritiCall and the work that they've done. I'll just stop there.

The Chair (Mr. Taras Natyshak): With that, we have run out of time for questions this afternoon. I want to thank everyone on behalf of this committee. Thank you all for attending and for taking the time out to be with us to answer our questions. But even more importantly, thank you for the work you've done to maintain the critical systems for our health care system.

Mr. Dale, you're raising your hand. Do you just want to say thanks and goodbye?

Mr. Anthony Dale: I do, and if you don't mind, I just would like to say that it's very good to see Mr. Barrett at the committee hearing today. I heard the news, sir, about your COVID and your wife's hospitalization. I understand she got excellent care at Joseph Brant. I know you told that story publicly, but it's very good to see you in good health.

Mr. Toby Barrett: Am I coming through? Compared to the rest of the world, we have probably one of the best health care systems anywhere. It's huge, it's expensive, but it's probably one of the best in the world. Thank you.

The Chair (Mr. Taras Natyshak): That ends our committee session on a really great, positive note. I want to thank you all. Please stay safe and take care.

We will now pause briefly as we go into closed session so that the committee can commence report-writing.

The committee continued in closed session at 1445.

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