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Mercredi 29 mai 2013

Standing Committee on Public Accounts

Special report, Auditor General: Ornge Air Ambulance and Related Services

Comité permanent des comptes publics

Rapport spécial, vérificateur général : Services d'ambulance aérienne et services connexes d'Ornge

Chair: Norm Miller
Clerk: William Short

Président : Norm Miller
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Wednesday 29 May 2013

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES COMPTES PUBLICS

Mercredi 29 mai 2013

The committee met at 0900 in room 151.

SPECIAL REPORT, AUDITOR GENERAL: ORNGE AIR AMBULANCE AND RELATED SERVICES

The Chair (Mr. Norm Miller): Okay, I'll call the committee to order, then. Before we have our first witness, I believe we have a motion which needs to be moved. Mr. Klees.

Mr. Frank Klees: Thank you, Chair. I move that the Standing Committee on Public Accounts requests the following documents from the Ministry of Health and Long-Term Care: The financial transactions as well as the line-by-line claims history of Dr. Chris Mazza over the time period of December 2006 until present, and that the information be broken down into manageable chunks, by month or by year.

The Chair (Mr. Norm Miller): Any discussion? All in favour? Agreed.

M^me^ France Gélinas: Can I have a friendly amendment? If they want to submit it electronically so that it's easier for searching, that would work, too.

The Chair (Mr. Norm Miller): We'll vote on the amendment that it be submitted electronically. All in favour of it being submitted electronically? Agreed. Carried.

The motion is amended and carried, then.

MS. SHANON GRAUER

The Chair (Mr. Norm Miller): We have our witness for this morning, Shanon Grauer, if you would like to come forward, please. And to confirm that you received the letter for a witness coming before the committee?

Ms. Shanon Grauer: I did.

The Chair (Mr. Norm Miller): Very well. And I understand you're going to—

Interjection.

The Chair (Mr. Norm Miller): Please have a seat, and our Clerk will swear an oath with you.

The Clerk of the Committee (Mr. William Short): Good morning, Ms. Grauer. The Bible's in front of you there, if you just want to—thank you very much. Ms. Grauer, do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

Ms. Shanon Grauer: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Norm Miller): Very well. I believe you have a short opening statement. When you're ready, go ahead and do that, and then we'll have questioning by the parties.

Ms. Shanon Grauer: Thank you for inviting me to appear before your committee. As you know, my name is Shanon Grauer. I am a partner of the law firm of McCarthy Tétrault LLP and have been since 1984. I work in the business law group of the law firm and have a subspeciality in health regulatory matters. I also teach on a part-time basis as an adjunct professor at the Institute of Health Policy, Management and Evaluation at the University of Toronto, and have done so since 2001.

I am here because of my former role as a director of Ornge, then Ontario Air Ambulance, from February 2005 to October 2007. My role as a director was in my personal capacity and not on behalf of my law firm or the university. I thought the experience of being a director on an organization providing emergency medical care would provide a unique opportunity to apply my skills and also provide me with greater insight about board governance from the perspective of a director, as opposed to that of a lawyer or a teacher.

I understand that my name was given to Dr. Mazza in 2005 by Lynne Golding of Fasken's as a possible candidate to join the board of Ontario Air Ambulance, as it then was. I know Lynne professionally as we work in similar areas of the law.

I was interviewed by Dr. Mazza in January 2005 to see if I would be an appropriate candidate, and was then invited to join the board.

The other directors on the board during the period I was involved included Rainer Beltzner, Dr. Mazza, Luis Navas, Rick Potter, Dr. Bob Lester, Hamish Smith, Lorne Crawford and Enola Stoyle.

As we were a new board to a new entity, the tasks that we dealt with primarily included mission, vision and values analysis; governance documents, including letters patent and bylaws; policies; CEO compensation arrangements; establishment of committees; board education; and the performance agreement with the Ontario government.

I also briefly served on the audit committee of Ornge that was established in 2006 and attended three meetings of the audit committee. The other members of the audit

committee were Rainer Beltzner, Dr. Mazza, Maria Renzella, Enola Stoyle and Hamish Smith.

As a director, I was paid $1,000 for each board meeting I attended, and as a committee member, $250 an hour for committee work.

During my tenure on the board, Ontario Air Ambulance changed its name to Ornge, and Ornge was the only entity of which I was aware. It was a not-for-profit entity, not a charitable organization, throughout my tenure as a director.

I'd be happy to answer any questions that you may have.

The Chair (Mr. Norm Miller): Very well. We shall start with the opposition. I guess we would have 20-minute periods and then see what's left after that. Go ahead, Mr. Klees.

Mr. Frank Klees: Thank you, Ms. Grauer, for being here with us today. We have had, as you know, a number of directors from the board appearing before the committee over the last number of weeks. The reason for that is that given the history of what happened with Ornge, as a committee we're very concerned about how things could get off the rails the way they did. The board of directors had very specific responsibilities, so it's of interest to us to know where the board of directors was as this corporate entity began to grow.

You joined the board in 2005.

Ms. Shanon Grauer: Correct. February.

Mr. Frank Klees: And when did you resign?

Ms. Shanon Grauer: My last board meeting was early October 2007.

Mr. Frank Klees: I use the term "resign." Did you resign or were you asked to leave or were you asked not to come back? How did that happen, if you could just tell us.

Ms. Shanon Grauer: Mine was sort of an interesting departure, in the sense that we had two-year terms, and there were also board reviews done by outside consultants. The chair of the board asked to meet with me and I met with him on September 11, 2007. Part of the purpose for that meeting was a debrief from the board consultants. At the end of that meeting, I was advised by the chair that I would not be serving a subsequent term. In effect, technically, I think, mine was an expiry of my term, but I was not invited to serve a subsequent term.

Mr. Frank Klees: You're very diplomatic in terms of how you describe that. Were you surprised that you weren't asked to continue?

Ms. Shanon Grauer: Yes, I was. I wasn't expecting that, so, yes, I think I was surprised. I felt pretty low when I left that meeting because I had worked hard during the two and a half years. There's a learning curve with any organization to understand how it works, and I sort of felt that I was just up the learning curve, basically. So I was disappointed.

Mr. Frank Klees: You referred to a debrief from the board consultant. This was an outside consulting firm that—

Ms. Shanon Grauer: Yes.

Mr. Frank Klees: What was it about, that debrief? Do you recall any specific concerns that perhaps were raised by these consultants that would affect your reappointment?

Ms. Shanon Grauer: I don't believe I got any details out of the board debrief. What I was basically told was that Dr. Mazza did not want me to continue on the board.

Mr. Frank Klees: Did you ever think that perhaps the reason you weren't asked to come back was that you were working too hard?

Ms. Shanon Grauer: That, frankly, didn't cross my mind, but I know at times Dr. Mazza did not appreciate my asking questions—not that I thought I had the most penetrating questions in the world, but I seemed to irritate him by asking questions.

Mr. Frank Klees: Can you give us an example of some of these questions that—

Ms. Shanon Grauer: Sure. In a board meeting—I believe it was either end of December or early January 2006—Dr. Mazza made reference to an opinion that Fasken's had rendered. Being a lawyer, naturally my ears pricked up and I thought, "Gee, that's a good thing for me to take a look at as a lawyer on the board."

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The board had been constituted, by the way, to have a pretty interesting distribution of skill sets. There wasn't any duplication when I was on the board. It was a real cross-section of skill sets.

I asked if I could see the opinion. Dr. Mazza was not very happy with that request. I remember that at the board meeting, the other board members finally said, "Just give it to her." And I did get it a couple of weeks later. That was an example of a tension, if you like.

Mr. Frank Klees: Can you tell us what that opinion was about?

Ms. Shanon Grauer: Sure. It was an opinion given by Lynne Golding and it was contemplating setting up a different structure than just the one not-for-profit entity. As I recall, it was going to have a charity at the top, a not-for-profit under it and a for-profit under that, so three boxes stacked vertically. I think that the plan was to turn the not-for-profit into the charity. The reason one had to interpose a not-for-profit in between is that the legislation at the time here in Ontario included the Charitable Gifts Act, and it prohibited a charity from owning more than 10% of another organization for more than seven years. So the legal fix was to always interpose a not-for-profit, because the not-for-profit could own the for-profit.

That was, I guess, the very start or preliminary thinking of ways in which Ornge could perhaps get more revenues, because there was certainly concern that Ornge should look for other ways to obtain revenues and not be 100% dependent on the government.

Mr. Frank Klees: After reviewing that opinion, did you have any concerns or did you raise any issues at the next board meeting regarding that opinion or the proposed restructuring?

Ms. Shanon Grauer: I did not. It seemed like the opinion was fine from the standpoint of the legal hat. The

other meeting I recall where the issue of a possible restructuring of Ornge took place was on a board retreat in April 2007. At that board retreat, Dr. Mazza went through some discussion about what might be coming. I think there may have been only one other board meeting I was at before I was off the board, so I did not get an opportunity to really delve into the grand plan that was being formulated.

Mr. Frank Klees: That overview that Dr. Mazza gave at that retreat—can you just tell us how far-reaching that was? Was that the beginning of a more complex structure?

Ms. Shanon Grauer: Yes, it was.

Mr. Frank Klees: If you can just tell us, to the best of your recollection, what that was.

Ms. Shanon Grauer: I certainly will do my best, but it has been six to eight years since I was on the board and I didn't go through everything I had in preparation for the meeting. It was basically to look at creating, I think, at that time, one for-profit entity. What I recall was the idea of separating the board into the board that would serve on the charity side versus the part of the directors that would serve on the for-profit side. There would have to be recruitment of more people to help with the board structures of the various entities.

Mr. Frank Klees: Was there a discussion that there would be common directors on both boards?

Ms. Shanon Grauer: I don't believe there was. I think there was a desire to actually separate the governance of the two, because serving on a charity, as I'm sure you know, you cannot receive any board compensation. That wasn't, perhaps, the driving factor. Some directors, I presume, would have preferred to be on a for-profit entity and not be subject to that restriction.

Mr. Frank Klees: Just to get clarification on that: The charity, by this time, had already been formed. Is that correct? It had been incorporated?

Ms. Shanon Grauer: No. In fact, this was just very, very preliminary thinking. It was the first time really, in the April 2007 board meeting, that the board was given a heads-up of what was coming potentially for consideration.

In doing some due diligence since my departure and the problems that have surfaced with Ornge, I was curious to find out when Ornge became a charity as opposed to a not-for-profit, and it appears that that happened in 2008.

Mr. Frank Klees: So in that April 2007 board meeting that you're referring to, by that time Ornge had already received another opinion from Fasken Martineau dated February 21, 2007, and this was provided by Mr. Giorno. It relates to the creation of Newco and Shareco, and it speaks rather extensively about what is referred to as a proposed $1.6-million loan to Shareco from Ornge. Do you recall that transaction?

Ms. Shanon Grauer: I do not know anything about that, nor did I ever see that opinion, nor was it referenced.

Mr. Frank Klees: In that, just out of interest, obviously the question had been asked about the appropriateness of Ornge advancing a loan of $1.6 million for a start-up to the commercial corporation, as it's referred to, and in the memorandum, there are some serious concerns that have been raised by Mr. Giorno regarding the appropriateness. He speaks about fines, up to 12 months' imprisonment, or both, if in fact this transaction was found to be offside. It's just interesting that an important memo like this would not have come to the attention of the board.

In your time on the board—I know you told me that you got into trouble for asking questions—were there other circumstances that come to mind where you saw things happening or decisions were taken where you felt you didn't have the appropriate backup information so that you as a director could make a reasonable decision on this?

Ms. Shanon Grauer: There is one that sticks in my mind, and it was in 2006. This was a board meeting at which the topic of the rebranding of Ontario Air Ambulance came up, and it really didn't directly involve financial issues; it involved the branding and the image of the organization. At that board meeting, consultants who had been engaged by management to advise on what would be an appropriate new name and what would be the image and rollout strategy for rebranding spoke to the board.

This is probably debatable, because I suspect some management would say that's their prerogative, but I happen to think that something as significant as branding really was a board decision, and I felt at that meeting that the decision had already been made and we were simply being informed of it and then being asked because of the requirement to have member approval to amend letters patent to approve it. I happened to mention at one of the board reviews in 2006, to the chair, that I was not happy that that had been the approach, that I thought the board should have been more involved in the decision-making. I went so far as to suggest at the meeting that if they were determined to do that, they should basically say, "Ornge, formerly known as Ontario Air Ambulance," because I thought it was important to draw the connection, but that was not taken up so it just became Ornge.

Mr. Frank Klees: What was the reaction of the chair when you expressed your opinion about that?

Ms. Shanon Grauer: He just thanked me for my input. He didn't say much.

Mr. Frank Klees: When the discussion came about for the restructuring, of that first restructuring, where discussion came about for that first commercial corporation or for-profit entity, did the issue of transferring executive salaries into that new entity ever come up?

Ms. Shanon Grauer: In the April retreat meeting?

Mr. Frank Klees: Or at any time, really, while you were on the board.

Ms. Shanon Grauer: It certainly wasn't before April. The only time it might have come up was April, and I don't remember that specifically. I simply remember the sort of—Dr. Mazza had a board to draw on, and he was drawing sort of a graph of what might the new organiza-

tion look like, and it was more talking at the governance level with the board and what would happen to the boards, as opposed to getting into the executive side.

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Mr. Frank Klees: When you—and I'm assuming that you've seen the media and the reports on this and you've seen the spawning of the numerous for-profit companies—

Ms. Shanon Grauer: Yes.

Mr. Frank Klees: And the fact that salaries of executives had been shifted out of the not-for-profit into the for-profit and as a result, these salaries were no longer being disclosed. What was your reaction when you heard that?

Ms. Shanon Grauer: I was quite shocked and surprised because you can imagine, in my involvement there was one entity; it was a not-for-profit. Then to read about the number of entities—I thought that was quite amazing, actually. I still wonder how Ornge evolved into that, as I'm sure everybody here does, too.

Mr. Frank Klees: Other people, executives as well as directors, have commented about Dr. Mazza's personality and how engaging he was, and dynamic and charismatic. Then it turned out that we have this Dr. Jekyll and Mr. Hyde creature who, with all of the spoken good intentions, really ended up leading the destruction of a very important organization.

Did you ever, in the course of either when you met him or as you observed him as a member of the board, have a sense that Dr. Mazza has some difficult parts to his personality and may just be making some decisions that are inappropriate, or at least questionable?

Ms. Shanon Grauer: I think Dr. Mazza is a complex individual. When I first met him and was first on the board in 2005—he is very charismatic. He came with a very impressive background, as you know: an emergency medical physician from Sunnybrook; an MBA; having been the brainchild behind the idea of centralizing the air ambulance facilities in Ontario—a very persuasive, energetic man.

It was, I can tell you, a real privilege in the first year on the board of Ornge air ambulance because it had such an energy and such a mandate to centralize and get this whole project up and running. I think the highlight for me was the February retreat in 2006—or, it was the end of January 2006—when the board was together for two and a half days and really focused on, "What were we going to be? How were we going to do it?" It was just all the good stuff.

I can tell you that when Dr. Mazza's son Josh died, it profoundly affected the man. I do not underestimate that. I hope none of us ever have to go through what he went through. I remember attending, with the chair and with Enola Stoyle, the funeral, because we were trying to support Dr. Mazza, and he was very broken. It was a very emotional funeral. I'm sure that it's had a profound effect on him, and will continue to.

The tension, I think, was that he had a vision, he had a desire, and we wanted to continue to help get that continuing mandate to run air ambulance going and developing. There were instances where questions would be raised of succession planning. I think it would be imprudent of a board not to think about succession planning. What happens if something happens to your CEO, especially a CEO that's so pivotal to this organization? We kept coming back to that he had the vision and the interest to do this, so we kept supporting him in his role as CEO.

There definitely are stresses in his personality. One example I remembered in preparing for today early on was—again, I think it was in 2006. The board was presented by Luis Navas with a balanced scorecard that we would use to evaluate CEO compensation, and I personally hadn't seen a balanced scorecard before. What was done at that board meeting was we asked Dr. Mazza to leave the room while the board had a sort of in camera session talking about the proposed evaluation matrix.

I kept asking questions of Luis because Luis was our compensation expert on the board. The time flew by and it was about 45 minutes. Well, when Dr. Mazza came back in, he was extremely upset that we had taken so long because he couldn't understand what the problem was. I remember saying to him, "This isn't about you. This is about the board learning what the appropriate thing to do is to measure compensation," because he was not a happy fellow that he had been excluded from that for so long.

The Chair (Mr. Norm Miller): We are out of time, so we'll move on to the NDP. Ms. Gélinas.

M^me^ France Gélinas: Thank you. Welcome to Queen's Park, and thank you for coming.

My first question is your impression as to—you were joining a not-for-profit health care organization on a board and you were paid $1,000 per meeting back in 2005. Any trigger at all that—in your work as a lawyer and as a teacher, you've dealt with many, many health care organizations, and none of them pay their board members. How did you handle that part?

Ms. Shanon Grauer: It's a good question. I wasn't expecting any compensation when I joined the board. I was not doing this to be paid. If I wanted to earn more money, I would have stayed practising law, because my hourly rate from Ornge was substantially less than what I could have done by sitting in my office. It was something that was simply proffered to the board at large, that this was what Ornge was going to pay its board and its committee members.

I think the substantial difference in my practice dealing with health care organizations is that the hospitals are all charitable organizations. They have to be in order for their foundations to be able to give money to the hospitals, because foundations can only give to other qualified donees. As a director of a charity, you cannot receive any remuneration; it's contrary to all the fiduciary duties. So that's the legal explanation why organizations like hospitals and their directors receive no remuneration, whereas this was a not-for-profit. It was not improper legally for that, and I presumed that this was

some kind of recognition of the amount of energy and work that would be taken by directors. So it was like an honorarium, in my mind.

M^me^ France Gélinas: Okay. Do you know where it came from?

Ms. Shanon Grauer: I assume it came from Ontario Air Ambulance.

M^me^ France Gélinas: No, I meant who decided that this not-for-profit health care organization was going to pay their board of directors to attend meetings?

Ms. Shanon Grauer: I believe it was from Dr. Mazza.

M^me^ France Gélinas: Okay.

Mr. Jagmeet Singh: What was your yearly compensation?

Ms. Shanon Grauer: It's a good question. I thought this might come up, and I actually went back to my tax returns; just give me a second. I'll find it; it varied. If you average it, it was below $5,000 a year. I think the first year it was around $3,000, the second year around $5,000 and the third year around $6,000. It came up to about $14,860 in total for the time I was there.

Mr. Jagmeet Singh: Thank you.

M^me^ France Gélinas: Let's take you back to the board retreat in April 2007. You're a member of the board. You're a member of governance. You know what governance is; you teach it in university. Governance sets the strategic direction. They decide where an organization is going to go. But you are telling us that it was Dr. Mazza who was telling the governance where the organization was going to go. Could you explain the disconnect here?

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Ms. Shanon Grauer: It's an interesting dilemma here, because the organization was founded at the behest of Dr. Mazza and his work to try and centralize the air ambulance services in the province. I think he lived and breathed this mandate. I think he had the desire to continue to evolve and try and grow the organization, so he took it upon himself to develop that strategy.

I have subsequently very much wondered about governance. My own view is that perhaps we had an upside-down governance structure, because most times, you have, in the not-for-profit world, members who then elect directors who then elect officers. In our case, we seem to have the CEO recruit the board and decide who got to stay or not stay on the board. We had a closed model of membership, which means that the directors and the members were one and the same. It's not an unusual structure to have, but having the CEO in the pivotal role of inviting people on the board and then having them not stay suggests to me that the governance perhaps was inverted.

M^me^ France Gélinas: I'd agree. There were some knowledgeable, high-profile people such as yourself on the board. Nobody clued in that this thing is upside down, that the governance should be setting the strategic direction and should be directing the CEO as to where Ornge should go and not the other way around? Was this ever talked about?

Ms. Shanon Grauer: I don't think it was as blatant then as perhaps, with hindsight, it may have become. It's an interactive process. There are many powerful, excellent CEOs who interact with their boards and put forward ideas. It's not unusual, in that respect.

The kinds of topics we dealt with when I was on the board were not that unusual or difficult. They were CEO compensation arrangements, which—by the way, during my tenure, Dr. Mazza's salary was in the $300,000 range, so it was not out of whack.

The performance agreement, which Ornge had outside counsel assisting on and which was a negotiated document—Dr. Mazza did get the input of the board in it. In the early days, it was more interactive, which I think is normal.

I can remember, too, my last meeting with the chair. My final comment to him—and I don't know whether it was a sixth sense or what, but when I learned I was not going to be on the board, I said to him, "You have a strong CEO. You need a strong board." That was my final comment to the chair. I was always worried about the balance of—you need a strong board to interact with a strong CEO.

M^me^ France Gélinas: During your time on the board, were you aware of any communication with the ministry, either through the performance agreement, through the giving of the budget, through—did you know if there was any line of communication as to what was going on in this brand new multi-million-dollar transfer payment agency versus the ministry?

Ms. Shanon Grauer: Certainly around their performance agreement, there was an active role, again, by management with the ministry; they were negotiating it. Dr. Mazza was very much hands-on with that role, in negotiating the performance agreement. But other than that, I can't—and also at the very beginning, of course, when the assets were rolled out into air ambulance and Fasken's was involved in negotiating for air ambulance, that asset transaction, to legally roll the units out of the ministry and into this new company. So there was interaction there, but on a regular basis, except for sort of those two items, we didn't see much interaction with the ministry.

M^me^ France Gélinas: When the ministry transferred the budget, they transferred it to the board, not to the CEO. How was that handled?

Ms. Shanon Grauer: Well, we had outside accountants who were auditors. We had an audit committee. We had financial statements, and we did what a board, I think, normally does, which is hear reports from the CFO and look at the financials and ask questions, if we had any.

M^me^ France Gélinas: Did any question ever come from the ministry to you, as in to the board?

Ms. Shanon Grauer: No.

M^me^ France Gélinas: No? Did you ever have any questions for the ministry from the board?

Ms. Shanon Grauer: No.

M^me^ France Gélinas: So no relationship at that level whatsoever?

Ms. Shanon Grauer: None.

M^me^ France Gélinas: Okay. And when the performance agreement was presented to you, were there any issues, as in, "Well, we're not happy with this thing," or "We really had to negotiate this hard," or "I think we have something good"? What was shared with the board at that level?

Ms. Shanon Grauer: We were each given a copy of the agreement, and I think we each read it. My recollection of the primary focus for the board was on what the performance standards were, which I think were in a schedule to the agreement, and were we going to be able to meet those to ensure continuous funding, because it would be a very short life if we went offside those performance standards and not get subsequent funding annually.

M^me^ France Gélinas: So you really understood that in order to continue to have funding, you had to do what was in your performance agreement, and that if you were not to do what was in your performance agreement, the government had ultimate control to say, "You're not getting any more budge anymore."

Ms. Shanon Grauer: Correct. Right. So we were very targeted on making sure that, as best we could, those indicators were all met.

M^me^ France Gélinas: And you also understood that the ministry had ultimate power to make sure that you continue to exist or not?

Ms. Shanon Grauer: Yes. My recollection is, there are provisions in the agreement that if there were breaches of those standards, they could choose not to fund.

M^me^ France Gélinas: I'm sure you've read the article that was dedicated to you in the paper as to, "Ex-Ornge Director Describes 'Stunning' Request for Her Resignation." You've read the article, I take it?

Ms. Shanon Grauer: I have.

M^me^ France Gélinas: And how accurate is it?

Ms. Shanon Grauer: Fortunately for me, I was on page 19 of the Globe. That was the front page and that was dedicated to Enola Stoyle. Enola was on the board and also asked questions. I remember one situation where—I think it was the beginning of discussions about the foundation—J Smarts, I think it's called. She was, I thought, doing a good job because she asked, "Do the objects in air ambulance's letters patent give the organization the power to do this? Is it part of its objects, because"—well, this isn't going to be the case for much longer once the new not-for-profit statutes are proclaimed in force. Presently, we still have old fashioned objects for not-for-profit and charitable companies which limit what they can do, and Enola, I thought, had asked a good question. I was trying to also help her with that in the board meeting.

Somewhere in the process, Dr. Mazza got quite upset with that direction, and it was after that board meeting that I recall he asked Enola to stay behind, and I don't believe Enola came back to any future board meetings. I don't know exactly what happened, but I know she resigned in January 2007, or it was—her resignation was presented to the board. I have a feeling, knowing what happened to me, that perhaps for face-saving reasons this was presented as a resignation, but I believe, in the article in the Star, that—or the Globe; I'm not sure which now.

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M^me^ France Gélinas: The Globe.

Ms. Shanon Grauer: The Globe—that she was asked to leave.

M^me^ France Gélinas: She was asked to leave because she—were you there during the meeting where Dr. Mazza was talking about taking money from Ornge to start up the charitable J Smarts?

Ms. Shanon Grauer: He certainly was talking about setting up J Smarts. I don't think we got to the level of detail about where the money was going to come from, but it wouldn't surprise me that it might come from air ambulance. I guess the discussion was: Did it have an educative effect? Was this organization going to help reduce injuries among young people by educating them and therefore avoid having to do airlifts of injured young people, in the sense of the educative role of going around trying to encourage people not to take high risks in sports?

M^me^ France Gélinas: You had a role in Ornge. You were there with some of the people who stayed all the way to the end. You knew Dr. Mazza. You were there when his son passed. You saw the changes in him. You know why we're here today. It didn't turn out so good, did it?

Ms. Shanon Grauer: No.

M^me^ France Gélinas: Can you help us understand? What's your best guess as to what went wrong?

Ms. Shanon Grauer: I think it's probably—and you probably have a sense of this from all the hard work you've done—it's not any one factor; it's got to be a number of factors. It's the personality of Dr. Mazza, in part, because he's such a dynamic person who wants to achieve something; it's the terrible, unfortunate things that have happened to him personally with his son; it's a desire to try and find more than one source of funding to operate the organization with. We all know that the Ontario government has a big deficit and that it's hard for more funding to go to health care. So I don't think the board thought it was imprudent to look at the possibility of alternative funding sources, because it would take some burden off the government and give some additional support to the organization. But I think perhaps some of the advice given and relied on might have been questionable in the sense of forgetting that you're dealing with a not-for-profit organization and you're dealing with, in 2008, forwarded charity.

There are people who, in my experience, are very fine lawyers in the for-profit world, and yet, the way our for-profit charitable world works, there are other rules legally that apply to them. It's not an easy thing to take your skill set from the for-profit side and move it to the not-for-profit charitable side. Sometimes when you try that, you lose sight of what's important on the for-profit charitable

side. Perhaps there's some of that in this as well: that maybe some of the advisers came from the for-profit side and didn't appreciate the need to be extra careful and the ramifications on the not-for-profit charitable side.

The Vice-Chair (Mr. Toby Barrett): We have about a minute left.

Mr. Jagmeet Singh: Continuing with that same vein, what would you have done differently if you could have gone back in time and told your old self, "Listen, watch out for this," or, "You should ask more questions about that"? What areas would you have liked to ask more questions about or done differently?

Ms. Shanon Grauer: I really don't know how to answer that because I haven't seen any of the opinions or legal work that was done after I left. That whole structure evolved after I left, so it would be really kind of disingenuous of me to try to even hazard a guess. I suspect that if I had stayed on the board, I would have kept on asking questions and probably gotten myself into more concerns. I just know, from having worked in the not-for-profit charitable sector, it's a very special sector, and you have to be very cognizant of the special rules around it.

Also, primarily, the Canada Revenue Agency—I'm not a tax lawyer but, fortunately, in my firm we have got some wonderful tax lawyers who do know this area and have helped guide me. These creatures are there in part because of the Income Tax Act, in large measure.

Not-for-profits are not supposed to accumulate surpluses. They're supposed to use the money for their purposes. Charities are obviously to use their money for their charitable purposes. So one of the things I think I could say I would have questioned was: Is the purpose for which the money of the charity was being used in line with the Canada Revenue Agency rules? That would have been one thing I would have asked.

The Vice-Chair (Mr. Toby Barrett): Thank you. If we could go to the government members.

Ms. Dipika Damerla: Thank you so much for coming here today, Shanon. I know it has not been easy for you.

I heard your testimony earlier, and what came out was that you were told that you cannot continue on the board because Dr. Mazza didn't want you to continue. Tell me: At that point, did you ask, "Well, what do the other board members think?" Because surely something like this cannot be the decision of one person on the board. There has got to be unanimous consent if you're going to fire somebody. I'd like to get your perspective on what that dynamic was.

Ms. Shanon Grauer: It's a good question. Legally and technically, if I had wanted to put up some kind of rear-guard action, I would have asked for a members' meeting and then asked for the members' input, because members are the ones that appoint and terminate directors. But in the environment, that probably—it would have been an interesting thing to do. I did not think to do it at the time.

What I did think to do afterwards was, I reached out to the third-party consultant who had done the last 360 board review and asked if I could see my results—I didn't want to see anybody else's—to see what the other board members had said about me. They said it was confidential information to Ornge and they would have to get consent from Ornge to release it to me. When they followed up, they could not get the consent. So, to this day, I don't know if I was a good director, a bad director, or indifferent, as far as my fellow board members.

Ms. Dipika Damerla: What does that illustrate about the relationship between the board and Dr. Mazza, the fact that one man could decide who continues on the board and who doesn't? What did that illustrate—I'm trying to understand. That one incident: What does it say about the board's ability to govern?

Ms. Shanon Grauer: I go back to your colleague's comment about governance, and my answer that I think, in hindsight, it looked like an inverted governance model to me.

Ms. Dipika Damerla: I understand that it was an inverted governance model. My question, I guess, then, is: What was the board doing to correct that? Because, clearly, you were aware that the governance was upside down while you were one of the board members.

Ms. Shanon Grauer: I don't think I was aware until after. I think it's my reflection upon the experience and what has happened subsequently.

The meeting at which I was told I was no longer wanted on the board—it did come as a surprise to me, and I felt, as I mentioned, fairly low about that. I think that was one of the things that has led me to the conclusion I mentioned. I don't think that while I was a director, I thought we had an upside-down governance structure. I thought we had a very strong CEO and that the board was trying to interact accordingly.

Ms. Dipika Damerla: Can you tell me why, when you were on the board, you didn't think the governance was—well, maybe not as strong a word as "upside down," but that perhaps it wasn't as strong as it could have been?

Ms. Shanon Grauer: Well, bear in mind—

Ms. Dipika Damerla: And I'm not talking about your role, because clearly you were among the ones who were doing your duty. I'm just getting a sense of the entire board, so this is not about your performance.

Ms. Shanon Grauer: The board at large—bearing in mind that during my tenure, I attended 10 board meetings, two retreats, and I think there were three quick board phone calls. That's the subset of time we're talking about.

There were different approaches by directors. Some were asking questions and others were more listening and evaluating, but I think each one—and I come back to the January 2006 board retreat—was very committed to trying to do a good job. I remember in that retreat, we had a third party leading the retreat to help the board in its educative role, each person getting a couple of minutes to talk about what they thought their role on the board was. People were referencing their various skill sets and what they would try to do to make sure that air ambulance did the right thing.

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It wasn't readily apparent that the board was somehow failing in governance during that period. It was a dynamic between a strong management and a board that was learning the ropes, so to speak.

Ms. Dipika Damerla: With the Enola Stoyle incident, did you twig off that perhaps she didn't go voluntarily and that the resignation, as you said, was face-saving? Was that apparent to you at the time?

Ms. Shanon Grauer: I was quite shocked when Enola didn't come back. I believe we had one quick call shortly after she left, and that's when I found out that she hadn't gone voluntarily. Maybe in hindsight I should have said something at the board. I did not because I figured it was a private thing, in a sense, between her and the CEO.

Ms. Dipika Damerla: Were there other incidents like this, where Chris Mazza took decisions on his own, and then the board either didn't question him or—what I'm trying to get at is, was the board enabling this behaviour? Because when you didn't question him and say, "Listen, I had no input in Enola not coming back. I am an equal board member. If anything, I am your boss in many ways. I never had a chance to weigh in on whether Enola should continue or not," did you not at that point enable Chris Mazza's behaviour?

Ms. Shanon Grauer: In hindsight, I suspect you're right.

Ms. Dipika Damerla: Would you say—and I'm not speaking particularly to you, but in general, do you think the board didn't carry out its governance duties as it should have and enabled Chris Mazza to do this sort of thing?

Ms. Shanon Grauer: I can't make the quantum leap on that one issue. I think it's a good point you're raising. As far as his governance in general, I thought the board tried very hard to deal with governance of the entity. What I wonder about, too, in terms of just general governance—and this is something I'm starting to raise with my classes as well, because it bothers me, and I'm not sure it's exclusive to Ornge—is the idea that every three months, a group of people gets together with a board binder that they've read and ask questions of management. It feels to me more like you're catching up, because you're being briefed about what's happened as opposed to being in the front of the curve and setting the agenda.

Ms. Dipika Damerla: Fair enough.

What do you think was the relationship between Mr. Beltzner and Dr. Mazza?

Ms. Shanon Grauer: It was very close. I think that Mr. Beltzner, at the time that Dr. Mazza's son passed away, felt the need to step in and really support Dr. Mazza. I think it got closer as a result of that.

Ms. Dipika Damerla: And because of that closeness, do you think there was an independence? Was he able to carry on his role as the chair and have Dr. Mazza accountable to the board?

Ms. Shanon Grauer: I think he could. I don't know enough about what's happened from the fall of 2007 onward, because my last communication with him was in October 2007. But while I was involved, he seemed to be able to wear those two hats.

Ms. Dipika Damerla: My last question before I turn it over to my colleagues is, at the end of the day—and I know you really appreciate this because your comments have suggested that—you were there to protect the taxpayer. This was the hard-earned money of people who are flipping burgers somewhere that was being used. In hindsight, knowing everything you did during your tenure, do you think the board did a good job of protecting the taxpayer?

Ms. Shanon Grauer: It feels a little awkward to say—self-serving—that we did a good job, but as I mentioned at the outset, the tremendous energy and optimism and what seemed like a very fine plan—

Ms. Dipika Damerla: Sorry; that wasn't my question. In hindsight, did you feel the board did its—you were there to protect me and every other taxpayer in Ontario and their funds—

Ms. Shanon Grauer: I tried my best during the period I was on the board. I don't think there was anything that I ever saw that suggested there were so-called shenanigans or whatever going on during the interval of February 2005 to October 2007. The point where there were descriptions being raised of a possible for-profit operation—it was in its infancy and it was something that the board thought worth doing: to look at ways to take some of the pressure off being solely reliant on the government for funding. That didn't seem to be an incongruous thing to do.

Ms. Dipika Damerla: I guess I should just say: Knowing everything that we do now, not just that brief period that you were on the board, but you've been following this—

Ms. Shanon Grauer: Yes.

Ms. Dipika Damerla: —and you knew the players, so I just want your honest feedback.

Ms. Shanon Grauer: I'd love to be able to give you a general statement—yes or no—that they did a good job. I think it's premature for me to comment on that, because there's an ongoing investigation and there's work being done still by this committee. If it turns out that some of the allegations are, in fact, true, it will be a tragedy—very much so—and the answer to your question will be no, they didn't do a good job. On the other hand, if there are other explanations, then maybe they did an adequate job. Obviously, there have been significant issues raised which give everyone pause to be concerned about what happened.

Ms. Dipika Damerla: Thank you.

Ms. Helena Jaczek: Thank you, Ms. Grauer, for being here. I just want to follow up a little bit. You talked about the issue of the compensation of Dr. Mazza, and there was a 45-minute session with the consultants. At the end of that you were presumably fairly convinced that the $300,000 range was a reasonable remuneration. Do you remember if that included his medical director stipend? Were you aware of this issue that there was this part of his salary as well?

Ms. Shanon Grauer: Can I just make clear a slight differentiation in what I said earlier? That meeting didn't involve consultants. It was Luis Navas, who was a board member, because of his compensation expertise. We weren't, at that meeting, actually addressing the quantum of compensation. We were addressing the matrix for how we would address compensation at a subsequent meeting. The setting of the salary was to be based on the matrix we were looking at, and it was really just factors. In fact, I have a copy, if you're interested to see the matrix. So those two were separated.

When we did get to compensation, no, to my recollection, I did not ever know about the additional stipend for the medical director.

Ms. Helena Jaczek: But the actual amount that you were presented with, you felt at that point was reasonable?

Ms. Shanon Grauer: Correct.

Ms. Helena Jaczek: Were you also involved in any discussion of expenses for Dr. Mazza during the time you were on the board, or did you sign off on any expenses that you recall?

Ms. Shanon Grauer: I certainly did not. I don't recall discussions about expenses, with one possible exception. I remember discussion at some point about directors possibly going to directors' school, the Institute of Corporate Directors, and that potentially air ambulance or Ornge would pay for that.

Ms. Helena Jaczek: I see, and then you did not take advantage of that personally, but that was the only conversation?

Ms. Shanon Grauer: No. Correct.

Ms. Helena Jaczek: In relation to this issue of the sense that the Ministry of Health, the government of Ontario, needed other revenues to support Ornge, how was this presented to you as a board? Did this come from Dr. Mazza? Was there any communication from the Ministry of Health urging Ontario Air Ambulance to look for other sources of revenue?

Ms. Shanon Grauer: I believe it came from Dr. Mazza; that's my recollection. I don't recall anything coming from the ministry.

Ms. Helena Jaczek: Did he provide some budgetary figures to show that there was some shortfall in terms of service delivery and funding available from the ministry?

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Ms. Shanon Grauer: I think in a general sense, my recollection was that he thought there would be a need to do more services and the organization couldn't necessarily count on additional funding from the government and, therefore, as sort of prudent planning we would need to potentially look at other sources.

Ms. Helena Jaczek: But it wasn't specifically related to some additional service or some other component of the service? You don't remember any specificity in terms of why this revenue was required?

Ms. Shanon Grauer: No, I think it was really the general envelope concept. There were many things the organization was doing, the EMAT services and the emergency medical hospital that could be deployed, and I think has been, to help out in the field for emergencies.

Ms. Helena Jaczek: So, at that point, you never got any hint that there was any sense of personal enrichment or some sort of increasing remuneration for board members? That never occurred to you?

Ms. Shanon Grauer: I can honestly say, I did not see any of that.

Ms. Helena Jaczek: Did Dr. Mazza ever give any opinion or did you get any sense of his relationship with the Ministry of Health and Long-Term Care with the emergency health services branch? Was there ever any sense of how he was dealing with the ministry?

Ms. Shanon Grauer: My recollection is that he was very vested in having a good relationship with the ministry, and he took that relationship on himself to make sure that he knew as much as he could what the ministry wanted and that he would report back to the board occasionally that all was well, that sort of thing.

Ms. Helena Jaczek: During your time on the board, did he ever present the idea of owning aircraft, of purchasing aircraft of any sort?

Ms. Shanon Grauer: I think again at that retreat in April 2007, there may have been mention made of that but nothing substantive. Just sort of bearing in mind this was a very preliminary indication to the board of what he was thinking and what might be done, and I think there may have been some discussion there.

Ms. Helena Jaczek: Was there any questioning of him as to the rationale?

Ms. Shanon Grauer: Again, I can't really remember the details because I haven't gone back to my notes from that board meeting, but I think there was—my recollection as best I can is that there were certainly some questions from some of the finance team, the members of the board who had a finance background, about how that was going to happen. For some reason, Hamish Smith comes to mind as somebody who weighed in on that.

Ms. Helena Jaczek: Do we have time on this round or should—

The Chair (Mr. Norm Miller): You have a couple of minutes left.

Ms. Helena Jaczek: Okay. Well, actually Hamish Smith, that name was new to me and I'm wondering, he was on the board the whole time—

Ms. Shanon Grauer: No, no. He was only on for a part of the time, and then he too resigned, and the notice that the chair sent around was—and I have a copy if you would like it—basically that he resigned because he was going to be in some sort of a business venture that might put him in a conflict of interest with Ornge. Now I don't know the details of that at all, but obviously as a director I think he did the right thing. If he spotted a conflict of interest, he felt that he had to choose one or the other, and he chose to leave.

Ms. Helena Jaczek: And Mr. Crawford, again Lorne Crawford, that was not a name I was familiar with. Was that individual on the board while we were—

Ms. Shanon Grauer: Yes, he was on the board the whole time I was, I believe, and he was a lovely man. He

came from the northern part of Ontario and he was picked—I don't know—I presume by Dr. Mazza, but he was picked because of his experience in the forest industry as a businessman and his knowledge of things in northern Ontario. Again, the board seemed to have been put together with thought to have representation from different interests, and he was a delightful man.

Ms. Helena Jaczek: And when you left the board, he was still there?

Ms. Shanon Grauer: Yes.

Ms. Helena Jaczek: Okay. Thank you. That's it for now.

The Chair (Mr. Norm Miller): Very well. We'll move to the opposition. You'll each have five minutes for a second round. Mr. Klees.

Mr. Frank Klees: I'd just like to go back to your comment about the dismissal of Ms. Stoyle. If I understand correctly, she was essentially dismissed after her meeting with Dr. Mazza. Is that correct?

Ms. Shanon Grauer: I assume so because I remember walking out of the board meeting and Dr. Mazza asking her to stay. It sounded like a rather difficult discussion as I was leaving, and she didn't come back.

Mr. Frank Klees: I find it odd that a board member could be fired by the chief executive officer. Have you ever experienced that on any other board?

Ms. Shanon Grauer: No.

Mr. Frank Klees: Is that something that, with your knowledge, can in fact legally take place?

Ms. Shanon Grauer: No, it cannot. You're right.

Mr. Frank Klees: With your experience, why would you not have challenged that, as a director with fiduciary responsibilities?

Ms. Shanon Grauer: That's a good question. I think it was partly because it had happened, and Enola was moving to a LHIN board. I'm not sure it could have been rectified. I could have certainly made more of the issue, but by doing so, I'm sure I would have shortened my tenure as well on the board, and I'm not sure what's in the best interests of the corporation—which is obviously my role as a director, to act in the best interests of the organization. Is it better I should raise issues with respect to that and know it's probably not remedial, or is it better that I stay on and try to do my job?

Mr. Frank Klees: Well, that is a fundamental question, isn't it? I would have thought that as a director, an independent director, the responsibility you have is to ensure that governance is done right. This was a very early indication of something very dysfunctional in this organization. The executive director was hiring and firing directors, who ultimately have a responsibility to oversee his work.

Ms. Shanon Grauer: Correct.

Mr. Frank Klees: This is a fundamental problem. Do you ever recall a decision coming to the board that was recommended by the executive director that the board turned down?

Ms. Shanon Grauer: Sorry, do I ever recall—

Mr. Frank Klees: A recommendation.

Ms. Shanon Grauer: By the CEO?

Mr. Frank Klees: By the CEO that was turned down.

Ms. Shanon Grauer: I can't think of one off the top of my head. It would have been rare if it happened.

Mr. Frank Klees: The conclusion that I come to, after many witnesses and hearing from former directors, is that this board was essentially a rubber stamp for Chris Mazza and Rainer Beltzner. That is not the role of a board. Would you agree?

Ms. Shanon Grauer: If you're correct, yes, I would agree.

Mr. Frank Klees: What we're trying to do through this committee process is to identify what went wrong so that hopefully we can come forward with recommendations to ensure that things don't happen again the same way. The lack of oversight is why we find ourselves here today. The board of directors had that responsibility. The Ministry of Health had the responsibility, ultimately. It's very clear from the Auditor General's report that the Ministry of Health failed in its oversight responsibilities. It was a very quick response on the part of the minister to, in her words, fire the board and fire Chris Mazza. Of course, they are the sacrificial lambs now to absolve the minister. As a committee, we won't allow that to happen, but there is a fundamental failure on the part of the board of directors to do their job as we see it or certainly as I, as a member of this committee, see it in terms of that lack of oversight.

The Chair (Mr. Norm Miller): Your time is up, Mr. Klees.

Mr. Frank Klees: Almost up?

The Chair (Mr. Norm Miller): It's up, Mr. Klees. We'll move on to the NDP. Ms. Gélinas?

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M^me^ France Gélinas: Kind of in the same train of thought: So there was no communication between you and the ministry and the ministry never came to the board in its oversight capacity. Then we have a board that has no membership, that doesn't get elected by membership, it gets selected by a CEO and hired and fired at the will of the CEO when it suited his purpose. We know that the same structure is still happening in transfer payment agencies of the Ministry of Health right now. There are boards that do not have membership, there are boards where people are chosen and appointed without any democratic process. Are you worried that there could be other Ornges out there?

Ms. Shanon Grauer: Well, in what you've just described, it's a possibility, for sure, because I think the lesson I've learned is, you need a very strong board to deal with a very strong, dominant CEO, and if there isn't some separation of the ability to serve as a director from your CEO, it sets up a potential or a dynamic for what's potentially happened here. So maybe there is a need to look at corporations that receive large funding from the government, to have the directors selected in an independent fashion.

M^me^ France Gélinas: Do you see a role for the government or the ministry in this process?

Ms. Shanon Grauer: Certainly, if they chose to have it. It wouldn't be unusual to, say, have directors appointed by management board of secretariat or whatever, management cabinet board. That's a possibility.

M^me^ France Gélinas: What other governance structure do you see that would protect Ontarians, the public taxpayers, from this happening again? I'm going to the teacher's side of governance right now.

Ms. Shanon Grauer: One of the things I wonder about is that it seemed to me, in hindsight, again, that Ontario Air Ambulance was set up as a not-for-profit simply under a performance agreement to the government. It didn't have the status of some of the other organizations so closely allied to the government, like a delegated authority. Maybe something as important as our air ambulance services should be more formally constituted, like an authority like the TSSA or the ESA or something like that. Maybe that's part of the puzzle.

M^me^ France Gélinas: Following your train of thought and what my colleague was saying, we need strong oversight from the government to the board, strong oversight from a strong board to its CEO and other officers.

How were the chair, vice-chair etc. selected at Ornge?

Ms. Shanon Grauer: There certainly was a vote by the board of directors, a resolution, to approve all officer positions, including chair and vice-chair.

As far as the slate put forward, we would receive a board binder probably a week ahead of the meeting and there would be a list of candidates that we would be looking at and have the ability to say yes or no.

M^me^ France Gélinas: Was there ever an election, as in, two people running for chair?

Ms. Shanon Grauer: No.

M^me^ France Gélinas: It was always a slate.

Mr. Jagmeet Singh: Besides the independent selection of governor or directors, what other mechanisms do you think would ensure that a board maintains its role providing good oversight over—or a check and balance to a dominant CEO? Again, tapping into your teacher hat—

Ms. Shanon Grauer: I'm still a work in progress, trying to determine what would be the best model on this. As I mentioned earlier, somehow I would like to see more of a proactive role rather than a reactive role, because my experience quite often seemed to be briefing as to what had happened. We had our checklists of due diligence. We'd hear from the medical advisory people as to whether there were any incidents and how they had been handled. And that's part of good governance, right?—understanding what has happened and taking appropriate actions to minimize them happening again. But at the same time, the three-and-a-half-, four-hour meetings went by very quickly, and there wasn't a lot of time to just independently brainstorm. So either there has to be more board meetings at which time is set aside to brainstorm rather than to be reported to, or more board retreats or something to allow that activity to take place.

The other thing, too, that I feel needs to be looked at on the issue of management and governance is that some people think there's a bright line, you know, "All of this falls on the management side of the line, and all of that falls on the governance side of the line." I personally no longer think there's a bright line. I think there's a line that moves depending upon what the issues are, and so basically having directors be more aware of what management is doing, even though management will argue they're in charge of day-to-day operations and that directors have oversight. But that oversight carries a supervisory role, and I think as a good supervisory organ, the board needs to be more in tune with where management is going.

The Chair (Mr. Norm Miller): We'll move to the government. Ms. Jaczek.

Ms. Helena Jaczek: Thank you. Our government has introduced Bill 11 as a potential solution for the oversight of Ornge as it currently exists. I'm not sure if you're familiar with that bill, but it's essentially modelled on the Public Hospitals Act, so that there will be a similar type of ability to appoint members, as you've alluded to, to the board through the public appointments process. There is opportunity for the minister to order a supervisor into the organization; inspections; and we have some additional issues around whistle-blower protection as well and a complaint mechanism. Are you familiar with the Public Hospitals Act?

Ms. Shanon Grauer: I am.

Ms. Helena Jaczek: How do you feel about making the analogy here? This is obviously an essential service where the health and safety of patients is at risk. Could you comment a little bit on that?

Ms. Shanon Grauer: My understanding is air ambulance Ornge was considered a base hospital, so I like the analogy, because when we were talking in the early days about what the vision was, the vision was really a flying hospital. It wasn't just simply moving a patient from A to B but treating the patient while onboard the craft, so I think that analogy sounds quite appropriate.

Ms. Helena Jaczek: Thank you, and I believe my colleague has one.

Ms. Dipika Damerla: I'm going to preface my question by saying that based on everything we know, probably getting fired from the board is a badge of honour at Ornge, so take that as you will. That said, it's really important for me to really understand. Given the pattern, given what happened with Enola, given that you, yourself, diagnosed the issue that this is a very strong CEO, needs a strong board, given the issues that all of us have raised around the fact that the person who is—it's a bit like me hiring my own boss. I mean, what credibility does that boss have if whether the boss continues depends on me?

Given all of this, why did you not at any point, especially after you were asked to not continue, call up the Ministry of Health and Long-Term Care and say, "Listen, we are here to look after your taxpayer dollars, but I'm a little concerned, I'm a little uneasy about the balance of power between the CEO and the board, given what's also happened, and I just want to flag this"?

Ms. Shanon Grauer: I never thought of calling the ministry. I think that there were no indications other than what I might express as a difficult personality. There were no indications of misuse of funds. There were personality issues, and that was apparent between Dr. Mazza and Enola. But if I had phoned up the ministry and said, you know, "I just was asked not to stay on the board and there's a difficult CEO in charge, but with a very impressive pedigree of having pulled all this together, being an emergency medical physician, being an MBA and taking on a very big job, I'm not sure my credibility would have been very high, because it would have sounded a bit like sour grapes.

Ms. Dipika Damerla: I'll give you that, but it does go to the crux that Chris Mazza was hiring and firing and that has nothing to do with you individually. That's the crux of the problem, why the board had no governance: because they were serving at his pleasure. That's what I'm wondering, why that was never flagged to the ministry.

Ms. Shanon Grauer: Well, I can just tell you that when I was asked not to be on the board anymore, I didn't know, really—other than Dr. Mazza didn't want me there—whether there were other issues that some of the directors may have had with me. Maybe they were frustrated with me asking questions; I don't know. Maybe there were reasons beyond personality clashes, but I don't feel that I had a critical mass to go to the ministry and say "heads up." I think it's easy to think that in hindsight, with all that's happened—

Ms. Dipika Damerla: Fair enough, yes. Okay. Thank you very much.

Ms. Helena Jaczek: No further questions.

The Chair (Mr. Norm Miller): Very well. Thank you very much for coming in this morning. It's appreciated.

Ms. Shanon Grauer: Thank you.

The Chair (Mr. Norm Miller): The committee is recessed until 12:30.

The committee recessed from 1021 to 1230.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Norm Miller): I'd like to call the committee to order and, first of all, welcome back Mr. Jackson. You've already sworn an oath from your previous time, so you remain under oath. But we have an oath for our other witnesses who are before us today: Meena Deol, Heidi Eicher, Steven Haddad and Enan Hoque. Welcome, and our Clerk will have each of you do an oath or affirmation.

The Clerk of the Committee (Mr. William Short): I'll start left to right.

Mr. Hoque, did you want to swear an oath or be affirmed?

Mr. Enan Hoque: Be affirmed, please.

The Clerk of the Committee (Mr. William Short): If you'd just raise your right hand, please. Mr. Hoque, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Enan Hoque: I affirm.

The Clerk of the Committee (Mr. William Short): Thank you.

Mr. Haddad?

Mr. Steven Haddad: Affirmation, please.

The Clerk of the Committee (Mr. William Short): If you'd just raise your right hand, please. Thank you. Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Steven Haddad: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

And Ms. Deol, affirmation or oath?

Ms. Meena Deol: Affirmation.

The Clerk of the Committee (Mr. William Short): If you could just raise your right hand, please. Thank you. Ms. Deol, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Ms. Meena Deol: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

And Ms. Eicher, oath or affirmation?

Ms. Heidi Eicher: Affirmation.

The Clerk of the Committee (Mr. William Short): If you'd just raise your right hand, please. Thank you. Ms. Eicher, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Ms. Heidi Eicher: I affirm.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Norm Miller): Thank you very much. I understand you have an opening statement, so please go ahead.

Mr. Richard Jackson: Thank you. I welcome the opportunity to appear again before the Standing Committee on Public Accounts and provide members with further information on the actions the ministry has taken to improve the oversight of air ambulance and related services in Ontario.

In my opening remarks this afternoon, I would like to introduce my colleagues in the air ambulance program oversight branch, outline key elements of the provincial government's transfer payment accountability directives and describe how the branch has aligned its priorities with these directives to enhance the ministry's oversight of the air ambulance program. I would also like to delineate the oversight and regulatory accountabilities for air ambulance services in Ontario.

I'm joined this afternoon by my colleagues Meena Deol, Heidi Eicher and Steven Haddad, who are senior

program analysts with the branch, and program analyst Enan Hoque. Each member in the branch has taken on the challenge to transform the oversight of the air ambulance program. I'm proud to work with a group of individuals who have committed their skills, knowledge and expertise to develop an enhanced framework for the air ambulance program. This is important and challenging work.

As you know, I attended the committee on May 8 and at that time responded to questions relating to the reports received from Ornge. Since then, I have confirmed that it is the daily reports, not the monthly reports, that are reviewed by my staff members and I've provided that clarification to the Clerk in my letter to Mr. Short dated May 27. I will provide further details on the work we do with these reports momentarily.

I would now like to outline how the branch has developed its oversight role based on the requirements of the amended performance agreement and the accountability framework articulated in provincial transfer payment accountability directives.

As defined in the transfer payment accountability directive, oversight includes the ability to administer a program, assess risk and communicate with transfer payment recipients on a regular basis, monitor the results for the services arising from the transfer payments, and taking corrective action, where necessary. Staff in the air ambulance program oversight branch have a complementary mix of skills and experience in these components of oversight. As per these directives, in order to ensure effective accountability, expectations must be clearly defined. The amended performance agreement outlines the responsibilities and performance expectations of the service provider.

Performance must be reported and monitored. Once expectations are clearly defined, effective accountability requires that there be reporting on and monitoring of performance in relation to these expectations. There should be processes in place to report performance, review performance against expectations and take corrective action as required. The performance agreement outlines a wide range of information that Ornge is required to provide to the ministry and report to the public.

Key to the management of transfer payment programs is the overlay of a risk-based approach. Risk management practices provide the opportunity to establish the optimum level of oversight and control, enabling ministries to provide the proper level of assessment that service delivery objectives are being met. Consistent with this risk-based approach, the branch's initial oversight priorities have been focused on measuring and monitoring patient safety and patient care provided by Ornge.

I would like to advise committee members on how we use the reports we receive from Ornge. We have prioritized our analysis on Ornge's resource availability reporting, paramedics, the level of care provided by paramedics, pilot and aircraft availability, and the number of medical transports received and how they are responded to. Daily, we receive resource availability reports that outline the number of requests for medical transports, the number of requests serviced by Ornge, the number of requests that were not serviced by Ornge by reason; for example, the transport was cancelled by the sending facility, the transport request was responded to by local EMS, instances where the call could not be responded to due to weather or due to the unavailability of Ornge staff, be that paramedics or pilots or aircraft. These reports are aggregated into monthly reports.

We also receive daily resource availability reports for each of Ornge's bases that outline the number of paramedics by shift, the level of care provided—critical care, advanced care or primary care—the number of pilots by shift, the availability of aircraft by shift, and, in instances where these resources were not available, the reason why and the specific duration of the unavailability and, with respect to staffing unavailability, the steps Ornge took to backfill those positions on that day. These reports are rolled up into 10-day reports and monthly reports by Ornge, and we further aggregate this base-specific information into quarterly reports to develop longer-term data for trending analysis.

Our immediate focus is the daily reports. We don't wait for a monthly report to take action. In instances where we see patterns, for example, a specific base is not meeting required resource availability levels, one staff member is charged with contacting Ornge to obtain more information, including the steps Ornge is taking to address it.

We now have, for the first time, more than two fiscal quarters of detailed baseline information on a wide range of performance metrics outlined in the performance agreement and Ornge's quality improvement plan. We are augmenting this analysis with ongoing interjurisdictional research on air ambulance programs in Canada and in other jurisdictions.

In providing transfer payments, ministries must ensure that the recipients receiving transfer payments have governance structures and accountability processes to properly administer and manage funds and to provide the services for which the transfer payments are made. The health audit services team is presently reviewing Ornge's board governance practices to ensure appropriate processes are in place.

Ministries must also have the oversight capacity to ensure that recipients receiving transfer payments are providing the services for which the funds have been received. Through the development of Ornge's 2013-14 zero-based budget, a requirement of the performance agreement, we now have, for the first time, a detailed understanding of how government funding is used by Ornge for each of the services it provides, and we will be tracking this on an ongoing quarterly basis.

I would now like to outline for committee members the integrated oversight and regulatory regime that oversees the air ambulance program. The air ambulance program is an integrated system comprised of different components delivered by individuals with specific skills and expertise. These components include:

—the call-taking dispatch system in which priorities for medical transport are determined and appropriate resources deployed;

—patient care provided by certified paramedics performing delegated medical procedures under the direction of transport medicine physicians;

—transport provided by aircraft maintained by aviation mechanical engineers flown by certified pilots;

—ongoing training of all staff involved in the delivery of the air ambulance program;

—quality assurance programs to ensure patient care standards are achieved; and finally

—regulatory certification and compliance.

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The air ambulance program oversight branch is responsible for ensuring Ornge meets the terms and conditions of the amended performance agreement and that the recommendations from the Auditor General directed to both the ministry and Ornge are implemented.

We are supported in this role by staff in the emergency health services branch, the regulator responsible for ensuring that all ambulance services in Ontario, including Ornge, provide ambulance services according to legislation and established standards.

Significant expertise in land and air ambulance services is resident in the emergency health services branch. This branch is responsible for establishing patient care and transportation standards, certifying ambulance service providers against these standards, conducting unannounced inspections of ambulance service providers to ensure they are meeting these standards, and conducting investigations into incidents and complaints received.

Once an investigation is completed, the findings are provided to Ornge by the air ambulance program oversight branch for action. Since January 2013, the air ambulance program oversight branch, along with emergency health services branch staff, have met weekly with Ornge officials to follow up with Ornge to ensure the investigation findings have been appropriately addressed.

The air ambulance program oversight branch also accesses the expertise of several other branches in the Ministry of Health to support our oversight responsibilities, including the legal services branch for advice and interpretation on legal issues; the health audit services team for audit work and advice; the supply chain and facilities branch on issues dealing with facilities; the accounting policy and financial reporting branch for advice on approval of asset sale requests as required under the performance agreement; and from an information and information technology perspective, the branch engages the expertise of staff in the health services information and information technology cluster.

From an aviation regulatory perspective, Transport Canada is the federal regulator. Through a memorandum of agreement between the Ministry of Natural Resources and the emergency health services branch, we have access to aviation expertise that was utilized to audit Ornge's fixed- and rotary-wing aircraft operations last year.

In addition, the branch accesses consulting expertise as required. For example, we have procured the services of a consulting firm who are presently conducting a review of Ornge's critical care land ambulance program, as recommended by the Auditor General.

The service provider also has an important role in providing oversight. Medical oversight is provided by Ornge's medical advisory committee, whose membership includes Ornge's eight medical directors, the chair of Ornge's quality of care board subcommittee, Dr. Barry McLellan, as well as Dr. Andrew McCallum. The medical advisory committee advises the board and supervises on behalf of the board all aspects of medical care under the purview of Ornge. Their mandate is to ensure that medical practice meets or exceeds the standard of care based on available evidence and medical opinion.

I was interested to read the transcripts of the Acting Auditor General's remarks at his May 15 appearance before the Standing Committee on General Government on the role of oversight. Mr. Peall noted, "For oversight to be effective, there needs to be an assessment of the organization's governance practices. If boards are performing their oversight effectively, ministry oversight can be tailored accordingly."

Through my active participation on two of Ornge's board subcommittees, the operations committee and the quality of care committee as a non-voting ministry representative, I have witnessed first-hand the rigorous attention to oversight that the board members on these two committees demonstrate with respect to the quality of care and operations.

Mr. Peall also noted the importance of "periodically obtaining assurance on the reliability of the information," through audits or site visits, "to observe operations and service delivery." We will continue to utilize the health services audit team to ensure that the reports are being prepared as required under the performance agreement.

Unannounced inspections conducted by the emergency health services branch of Ornge's bases across the province further augment our on-site presence.

I would also note that the air ambulance program oversight branch staff and I have regular daily contact with senior Ornge officials to monitor ongoing initiatives. As I noted earlier, we meet weekly to review Ornge's progress in addressing findings from ministry investigations. We have established formal monthly meetings to review progress against performance agreement objectives and receive updates on Ornge initiatives.

Based on my experience in overseeing transfer payment recipients—colleges, universities, children and youth mental health agencies, children's aid societies, developmental services agencies, women's shelters and municipal social assistance delivery agents—as well as licensing child care centres and private career colleges, I can assure you that the level of oversight and regulation currently focused on Ornge is significant, as it should be. Air ambulance services are of critical importance to Ontarians and there have been serious issues at Ornge, as the Auditor General reported and that this committee has explored in considerable detail over the past year.

In closing, in terms of the work that we have done in the air ambulance program oversight branch, I think it is helpful to remember where we have come from with Ornge. Under the previous leadership at Ornge, not only was information on a wide range of Ornge's activities not provided to the ministry or the public, some of the information that was provided, for example, the number of transports, was inflated. We now have considerable data that enable us to measure Ornge's performance. Where issues are identified, we follow up with them immediately to determine the corrective action Ornge is taking to address them.

Where the ministry previously had limited knowledge of Ornge's service delivery, we now have almost real-time, detailed information on how effectively Ornge is delivering these services. Where Ornge previously did not publicly report on services it provided, we have an organization that transparently reports on the service it provides.

Has progress been made in enhancing accountability and public transparency at Ornge? Yes, there has been. Is there still work to be done? Yes, there is. This is a process of continuous improvement. One request for medical transport that is not delivered is one too many.

I am, however, confident that with new leadership at Ornge and enhanced government oversight, we are on the right path as we continue to move forward.

Thank you, and we would be pleased to answer your questions.

The Chair (Mr. Norm Miller): Thank you for the opening statement. We'll go to the NDP first. You'll have 20 minutes, Ms. Gélinas.

M^me^ France Gélinas: Thank you very much for your comments, Mr. Jackson, and thank you for coming back. Thanks to all of you for being here this afternoon.

You opened by basically putting down in words what accountability looks like when you're on the ministry side trying to hold an agency such as Ornge accountable. You talked about doing the administrative duties, assessment of risk, communications, monitoring the results and taking corrective action as needed. You talked to us about some of the tools that you have put in place in order for you to be able to do this.

I guess I'll open it up: Can you give me an example as to, by doing your work of oversight, some of the recommendations—I'd like it as real as possible—that you have done in your communication with Ornge?

Mr. Richard Jackson: I would point specifically to staffing levels at Ornge. There has been, I would say, historically at Ornge a shortage of qualified paramedics—an actual shortage of paramedics. One of the things that we monitor with Ornge on a regular basis—and they're required and will be providing us with a staffing plan in June of this year—is that we can, by base, have a full understanding of the number of paramedics they have on staff. Their optimal complement is 232 paramedics—and if I could refer to my notes, I will give you a specific breakdown of that. Of that 232, 154 are full-time and 78 are part-time. As of the end of April of this year, they had 225 paramedics on staff; 155 full-time and 70 part-time. So one more full-time than optimal and eight less in part-time.

We wanted to understand from them what it is that they are doing to address this issue. We know that they are actively recruiting for paramedics, but what we have learned is the time frame that it actually takes to bring paramedics on line. The hiring process itself takes between six to seven weeks. They have a collective agreement where the first offer of a position goes to an existing paramedic, and they call from other bases.

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They still have a contingent of primary care paramedics which—primary care paramedics cannot be matched with either critical care or advanced care to deliver the critical care services that we need. As we have approached them and worked with them to understand this, it takes over a year for a PCP to become an ACP paramedic, and an ACP takes one year of practice and then one year of training to become a critical care paramedic. So we do understand how long it takes to fill this pipeline.

We used this information in reviewing and accepting a proposal from Ornge earlier this year to add a third team of paramedics to their Thunder Bay base, so that their three aircraft would be serviced with three paramedic teams that had not been in place before.

So by having an understanding of how their processes work and how long that takes, we've been able to review a proposal, accept a proposal, but do understand that it will take time for that organization to get the paramedic care up to not just—they'll be at the right number but to train their staff to the appropriate level.

Mr. Jagmeet Singh: Just to reframe that question again, you're essentially identifying a problem and making a recommendation. If you can give me another example of where you've caught a problem from your oversight, where you've identified something that's an issue, what that problem was and then what recommendation you made—in addition to this. But if you could frame it as that: You noticed this issue—due to your oversight, you caught this problem or this issue—and then you made this recommendation.

Mr. Richard Jackson: Yes. I want to talk about a situation that has occurred in Moosonee from March through to early May of this year. There were two pilots who left the service of Ornge, and as a result, the rotary-wing aircraft in Moosonee was not available to be flown—they did not have pilots—for 44 occasions between March 15 and early May.

When we started to notice through the daily reports that that base was being down-staffed, we were in contact with Ornge to determine what was going on. That's where we learned that two pilots had left their service, and we learned from them what their plan was to address this. To serve the communities on the James Bay coast, they were using their fixed-wing aircraft from Timmins as opposed to the helicopter from Moosonee and then were transporting those individuals to hospitals in

Timmins or Sudbury. What goes on in Moosonee with the helicopter is, the helicopter's on Moose Factory—sorry, the hospital is in Moose Factory; the airport is in Moosonee, and they do river hops back and forth from that, from Moosonee to Moose Factory.

We were also paying attention to the number of instances in which a medical transport wasn't taking place during that time period, and we identified over that time period, with Ornge and the data that we have, that there were 11 transports that were delayed to the previous shift. We followed up with them to determine whether or not there had been any instances where this had impacted patient care. We confirmed with them that they were working with the hospital in Moose Factory to ensure that patients were receiving the appropriate care at the Moose Factory hospital and that in those 11 instances over that time period where service was not provided, there was no apparent impact to patient safety. And we worked with them to understand when they were bringing those two pilots online. They came online on May 16.

Mr. Jagmeet Singh: Okay. There were significant issues that happened at Ornge, and I'll tell you what I think—some of the three main issues. You've talked a lot about patient care and how you can provide oversight for that. The two other issues that were key in terms of the scandal that's before us: One was—I'll just use some colourful language—outrageous salaries, as well as public dollars being used for private ventures. In these two areas, what are you able to do to provide oversight to prevent or to flag these when they happen and then to provide recommendations to address them if they do happen? So those two areas, salaries and public dollars being used for private ventures.

Mr. Richard Jackson: With respect to the outrageous salaries that were being paid to many senior officials at Ornge, Ornge publicly reports the information of their executive salaries and compensation on their website. That's a requirement of the performance agreement. We have information, detailed information, on the salaries that are paid to each of their employees. We receive that information line by line and in aggregate format. That was part of the work that we had done in developing with Ornge, for 2013-14, a zero-based budget, so that we know every dollar of taxpayers' money that is going into Ornge, what it is budgeted against and the services that are being provided for those. That budget was put in place. We'll be monitoring that quarterly throughout the year to ensure that taxpayers' monies are being used for delivery of services at Ornge.

In terms of the public dollars being siphoned off into private operations, there is, as you well know, this complex web of companies that were set up under the previous regime. That is being wound up by Ornge in an orderly basis. We receive information on that process from them on a regular basis.

There are still companies that were incorporated as for-profit companies, particularly on the aviation side, where their aviation assets are held, but we know that those are being utilized. Although the corporate structure of those are on a for-profit basis, Ornge is not working on a for-profit model, nor do they have any activities outside of Ontario.

Mr. Jagmeet Singh: Okay.

Mr. Richard Jackson: I hope I addressed—

Mr. Jagmeet Singh: Yes.

M^me^ France Gélinas: Just a small clarification: When you said that you now have details on every salary that is paid to everybody who works at Ornge, does that include the medical—I forgot the title—medical director or basically the physician who sits there at Ornge and helps direct care during transfer? Does that include them? Are they captured in that?

Mr. Richard Jackson: The position you're talking about is the transport medicine physician. I can't tell you, Ms. Gélinas, definitively, sitting here, if we have that information for those positions. I believe that we do. I don't have that information with me to confirm that categorically for you.

M^me^ France Gélinas: Okay. But—

Mr. Richard Jackson: But we do know how much they spend on transport medical physicians as a total. That would be one of the line items that we're getting in our zero-based budget work.

M^me^ France Gélinas: So you went to a zero-based budget for them?

Mr. Richard Jackson: Yes. We can have for Ornge—we know how much they literally spend on everything they do at each specific base. I could tell you how much they spend on fuel at this base, how much they spend on medical supplies, salaries, benefits, training, legal fees—on and on and on.

M^me^ France Gélinas: I want to talk about the governance a little bit. In your opening comments, you made mention that you now sit on two committees of the board, and I forgot which ones they were. Could you remind me?

Mr. Richard Jackson: The operations committee and the quality of care committee.

M^me^ France Gélinas: And how did that decision come to be? Were you invited?

Mr. Richard Jackson: Under I believe it's article 8 of the performance agreement, when it talks about the quality of care committee that Ornge is to strike, it is specifically indicated that there would be a ministry representative on that committee, and I was appointed from the ministry perspective to be in that role. There is no specific reference in the performance agreement to the operations committee, but I was invited by Ornge to be a participant in that committee and my membership and the ministry representative is reflected in the terms of reference for that particular committee.

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M^me^ France Gélinas: Does the ministry, through your office, have any contact with the board? As in, how do you know that the board is doing a good job of governance?

Mr. Richard Jackson: In terms of the contact we have over the board, as I did note, my contact is on two

board subcommittees, of which the board members on those committees are all the members of Ornge's boards, with the exception of two: the chair does not sit on those committees and Mr. Harnick does not sit on either of those two committees.

In terms of our contact with the board, I don't have direct contact with the board chair, but I interact with those board members on those committees. As part of our due diligence, we have had the health audit services team in Ornge reviewing their board governance practices to provide them with the best advice that we can, that they are actually following appropriate processes. Actually, this coming Monday and Tuesday, I will be attending a two-day strategic planning workshop that Ornge is hosting with members of their board, senior management and other key stakeholders to provide advice to Ornge on their ongoing development of their five-year strategic plan.

That's my interface with the board. I know that senior officials above me in the organization would have contact with Mr. Delaney on a fairly regular basis, the board chair.

M^me^ France Gélinas: They would have contact with minister who?

Mr. Richard Jackson: Sorry, with Mr. Delaney, the board chair.

M^me^ France Gélinas: With Mr. Delaney. All right. Do you feel confident that with the structure you have now, where you are invited to participate in a strategic planning workshop, you are within the terms of reference of the committees of the board as ministry staff—do you feel confident that if the board were to fail in their duties of oversight, that would allow you to catch this?

Mr. Richard Jackson: I think it would certainly give me strong insights into that. I don't participate on the other three or four different subcommittees of the board, but from my own experience, I can see that there is a rigorous governance structure and there are clear terms of reference outlining the requirements and responsibilities of that board committee. The quality of information that comes to the board that is provided by senior management at Ornge appears to be quite sufficient, and the board members themselves are actively engaged in questioning, probing and providing direction, as you would expect a high-performing board to do.

M^me^ France Gélinas: Do you ever review their minutes?

Mr. Richard Jackson: We do not receive copies of the board minutes.

M^me^ France Gélinas: If you were to request the board minutes, do you figure you would get them?

Mr. Richard Jackson: They would be provided to us. We have not requested those. The performance agreement enables us to request just about anything that we would want to request beyond what is articulated in that.

The one area where we do receive extracts of board minutes is with respect to the sale of assets. The proposals that come to the ministry have to be authorized by the board, and we would see those particular minutes.

M^me^ France Gélinas: You described that the board has a rigorous structure and they have clear requirements. How do you know that?

Mr. Richard Jackson: I know it from witnessing it, participating in it, participating in the meetings, receiving the meeting packages. Over the years that I've worked in transfer payment accountability fields, one of the key things I've heard from other board members who I've spoken with is the importance of actually getting good information well before the meeting so that you actually have the time to analyze and think about it, so it's not just plunked down in front of you before you start. So that seems to be a practice. The board members of Ornge that I interact with have quite significant experience on boards of other organizations.

M^me^ France Gélinas: We had the opportunity to question, basically, every member of the board who got fired in January 2012, late December 2011. They were all extremely knowledgeable, qualified—lots of experienced people who did not provide any quality oversight of Ornge. I can see that you have a high regard for the people on the board. You feel that the structure is solid and the requirements are solid. Do you see anything else that could be done to make sure it doesn't happen again? I'm talking specifically about poor oversight from the board to the executive side of the agency.

Mr. Richard Jackson: It is something that I have thought about over time. As I said, the ministry gets a line of sight into two of the subcommittees. I think there would be some value in extending that line of sight across the other board subcommittees. It's not something that we've put forward or proposed—but if you were to ask me where I think we might be able to have a more detailed understanding and actually see it and witness it and be more ingrained in the board governance.

M^me^ France Gélinas: Usually, minutes of the boards of transfer payment agencies of the Ministry of Health—whether we look at a mental health agency, community health centres, hospitals—their minutes of the board meetings are all public documents. Their board meetings are public meetings. Does this apply to Ornge?

Mr. Richard Jackson: At this point, they do not make their board minutes public. In terms of whether those are open, public meetings, I do not know that answer.

The Chair (Mr. Norm Miller): You are out of time for your first allotment—

Mr. Richard Jackson: But I very much appreciate that advice.

M^me^ France Gélinas: No problem.

The Chair (Mr. Norm Miller): We'll move to the government. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Mr. Jackson, for coming back with your team. Since you have the whole team here, first of all, certainly on the government side, I wanted to assure you that we value our public servants here in Ontario and know that you do good work on our behalf.

Mr. Jackson, perhaps you could outline a little bit what each of your team members is responsible for, and if you'd like to tell us a little bit about their qualifications for the position, that would be very helpful as well.

Mr. Richard Jackson: If you're okay with this, I would actually like the staff themselves to provide that information, as opposed to hearing it in my voice.

Ms. Helena Jaczek: That would be great.

Mr. Richard Jackson: Maybe we could start with Heidi.

Ms. Heidi Eicher: My name is Heidi Eicher. I've been with the Ontario public service for 26 years. I have worked in a number of capacities that have involved an oversight function, and I have worked with many transfer payment recipients in an oversight and advisory capacity. I've also worked for Management Board of government as a senior adviser on a number of financial files.

Academically, I have a master's in public administration from Carleton University and an undergraduate degree in political science. I have a change leadership certificate from Humber College, and I have extensive Six Sigma skills and training.

Before I came to the oversight branch here, just to give you an example, I was working with the Ministry of Training, Colleges and Universities in the public—I'm sorry. I was working in the accountability branch in the universities unit, and I had oversight responsibility for transfer payments to medical schools and, in particular, compliance against the medical plan and ensuring that they were delivering against a provincially approved medical plan.

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Ms. Helena Jaczek: And your area of responsibility within the oversight branch now?

Ms. Heidi Eicher: My area of responsibility has focused primarily on asset sales at this point. I'm working with Ornge on the asset protocol and the sales with respect to the SK-76 aircraft. I've also been involved in reviewing and doing the analysis on staffing that Mr. Jackson was referring to previously, and taking a look at the Moosonee situation and working that through with Ornge. Those have been my key areas.

In addition, I've been responsible for various pieces of correspondence, briefing materials and such.

Ms. Helena Jaczek: Thank you. Ms. Deol?

Ms. Meena Deol: Hello. My name is Meena Deol. Prior to this position, I was a regional emergency manager with the Ministry of Community and Social Services and the Ministry of Children and Youth Services. There, I was responsible for preparing and implementing contingency planning. As well, I was involved in some larger events, I would say, and providing leadership and direction throughout those, for example, as part of the Haiti repatriation in central west region. I was also regional emergency manager; I participated in that. I've also been the lead in planning for—

The Chair (Mr. Norm Miller): Excuse me. Could I ask you to just slow down a bit?

Ms. Meena Deol: Oh, I'm sorry.

Ms. Helena Jaczek: We want to catch every word.

The Chair (Mr. Norm Miller): Some of the committee members are having difficulty following you.

Ms. Meena Deol: Sorry. I've also trained at the provincial emergency operations centre. A lot of what I did as an emergency manager was planning, project management and implementing plans.

I was also the freedom-of-information coordinator for the Toronto regional office with the Ministry of Community and Social Services, where I severed and released documents as well as provided advice on the act.

Prior to that, I have transfer payment experience as well. I was a program specialist, where I did monitoring and TP accountability for transfer payment agencies, including service contracts with municipalities and developmental service agencies. That was for the entire transfer payment budget cycle, starting from budget submission to year-end reporting, quarterly reporting and monitoring of any variances in regard to service or financial data. I also trained transfer payment agencies on the service contracts.

In that role, I was also the lead for incident reporting from transfer payment agencies as well. Many agencies have to report daily on any incidents that may occur, and I would follow up on those.

Prior to that, I was a special agreements officer. In that role, I made decisions for reviewing medical and financial information to see if families were eligible for income assistance programs, as well as had a budget. Within that budget, I provided assistance to families caring with either adults or children with severe disabilities and managed that budget, provided funding and made decisions on allocations regarding respite funding.

My role here is, primarily I've been the lead for the follow-up on investigation files. I've also been the lead with the emergency management branch with the Ministry of Health in regard to any incidents that may be occurring and staying on top of some issues; for example, there was the James Bay flooding, and working with Ornge and participating in those teleconferences and meetings. As well as Heidi, we prepare correspondence and briefing materials as well.

Ms. Dipika Damerla: I just had a quick clarification. You said you were responsible for the budget cycle for transfer payments. Was it across government?

Ms. Meena Deol: No, that was with the Ministry of Community and Social Services. I focused mainly on municipal service contracts and developmental services agency contracts.

Ms. Dipika Damerla: Okay, thanks.

Ms. Helena Jaczek: Please go ahead.

Mr. Steven Haddad: Thank you. My name is Steven Haddad. Prior to joining the air ambulance program oversight branch, I worked with the Assistive Devices Program, modernization unit. The committee may recall that the ADP was called to testify before this committee in October 2010, I believe, and there was a follow-up Auditor General's report in 2011 on the review of that work.

Some of my particular contributions as part of that were developing operational policies and procedures as part of the program review and modernization. Some of the specific files that I worked on included reviewing pricing for communications and visual aids; doing procurement of technical expertise—for example, reviewing proposals for a central equipment pool for high-technology wheelchairs, as well as selecting a vendor to create the new IT system ADAM. Unfortunately, I don't remember what the acronym stands for. In addition to that, I more recently have been involved with the critical care land ambulance program review, which was one of the Auditor General's recommendations in his 2012 report.

In terms of previous experience with adjudication of funding programs and managing relationships with transfer payment recipients, I have direct adjudication experience primarily with the economic development cluster, so the International Strategic Opportunities Program, as well as contract management with grant recipients under programs such as the Next Generation of Jobs Fund, Eastern Ontario Development Fund, Communities in Transition program and the Advanced Manufacturing Investment Strategy.

Over my time with the OPS, I have also been actively involved in what I would term implementing government decisions, so for example, drafting of treasury board and cabinet submissions and implementing recommendations of third-party reviews, such as Auditor General reports.

In terms of what my specific workload is right now, since I've joined the branch I'd say it's been pretty wide-reaching because of the nature of the file. As I previously mentioned, one of my big focuses right now is on the work that we're doing toward reviewing the critical care land ambulance program, both for value for money and service delivery. I also was responsible for drafting the sale of assets protocol which Ornge is required to follow under article 16.4 of the amended performance agreement: to seek ministry approval before selling assets with a residual value of over $100,000.

Attending meetings, as my colleagues have mentioned: We attend frequent meetings with Ornge senior management to be apprised of the initiatives that they're working on, for example, a readiness initiative, which I believe Mr. Jackson mentioned in his opening remarks, and interfacing with other divisions of the ministry on issues that may address or impact the delivery of air ambulance services, for example, a proposed life-or-limb strategy.

Ms. Helena Jaczek: Thank you. Mr. Hoque?

Mr. Enan Hoque: Hi. My name is Enan Hoque. I have a bachelor of business administration with a double major in finance and strategic management from the Schulich School of Business, York University. Prior to joining the Ontario public service, I ran and operated my own IT web consulting company where we developed websites, graphics and brochures for small businesses such as restaurants. It's a skill that I taught myself and I really enjoyed it. But I decided to move my career towards the government side and I joined the Ontario public service in 2010 through the Ontario Internship Program, which takes over—in my year, it was over 5,000 applicants, but I heard they take even more and select a smaller amount.

Since starting there, I've had the opportunity to work in business and financial planning roles for five different ministries, the first one being community and social services, where I assisted the finance manager in reviewing the quarterly reports and other finance-related material for the social services and children and youth agencies of Ontario. Moving from there, I went to the Ministry of Tourism, Culture and Sport, where I worked with the manager there, again, in another finance capacity, where the major tourism and culture—at that time it was just tourism and culture. The agencies there would submit their reports and variance analyses, and we would identify anything that needed to be identified for the manager for further discussion and review.

Moving from there, I left the Ontario internship stream. The goal of the Ontario internship stream is to translate those skills into full-time or contract work in the government. I landed my first position with the Ministry of Community Safety and Correctional Services. In that role, I had specialties in contract management, so multi-million-dollar procurement contracts I'd finish for Ontario's major correctional institutions, such as, for example, their new jails. I had to understand the contracts, had to ensure that the vendor on the other end was meeting their contract obligation, whether it be the reporting requirements, whether it be that the prices were met as appropriate, and if there were changes or amendments required, that due process was followed for full transparency and accountability.

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From that role, I moved to the Ministry of the Attorney General, where I worked on—it's a bit more on the back-end controllership, where it's the administration and finance of salaries, wages and expenses to support the lawyers of Ontario, finally landing to where I am here today in the Ministry of Health and Long-Term Care in the oversight branch.

In this role, I try to utilize the financial, data analysis and project management skills that I have. Particular to the work, as Richard noted in his opening remarks, our focus has been on the availability of resources for Ornge in addition to their staffing. One example of what I've been doing is that I've been gathering the resource availability reports, which can have multiple sheets within a workbook, but putting them together in a way where we can now baseline quarterly data and understand, quarter to quarter, what is increasing, what is declining, what could be the factors behind it, what is Ornge planning to do over their next year and, going forward, any statistical and data analysis type of work.

A meeting I had last Friday was a kickoff of a resource and statistics working group I have with Ornge. This is to complement the work that the health audit team is doing. What we're doing there is beginning to review

the reports to see how it aligns with the performance agreement and improving on it where possible. Again, based on the findings of the health audit team, it will greatly influence the working group and what we'll work on.

Ms. Helena Jaczek: Well, it certainly looks like you have a good team, Mr. Jackson, in terms of the range of qualifications and experience that you have just demonstrated.

Obviously, we're here to respond and ensure that improvements are occurring, very much guided by the Auditor General's special report of 2012. The first recommendation was very much related to the cost of ambulance services, and was Ontario comparable to other jurisdictions and so on. Could you just outline to us your progress in that regard? We've heard about a lot of pieces of this, but are you rolling this up into an analysis of the various types of transport? It does relate a little bit to the critical land ambulance piece as well, I suppose—and what progress you're making in terms of looking at those costs and ensuring we're getting value for money?

Mr. Richard Jackson: Yes, I'd be pleased to outline the work that we've been doing on this.

We have conducted a survey of other air ambulance providers across the country to have an understanding of the range of services that they provide and how much they're investing in that particular program, as well as how many transports they do, that type of work.

One of the significant observations we have from this is actually the challenge of doing detailed apple-to-apple comparisons—I never use the term "apple-to-orange" comparison—because what we have here in Ontario delivered by Ornge is really the full suite of services: They train their paramedics; they run the dispatch centre; they own their own aircraft; they use special agreement carriers; they have a critical care land ambulance program, which is not common in other jurisdictions; as well as they do organ transplant recovery flights. When we looked at other Canadian jurisdictions, those specific functions tend to be hived off between various parties. You'll have a province where the province does the dispatch; they rely on a series of service contractors to provide the actual service; the training is done—the paramedics themselves find themselves being trained.

What we're trying to do is go beyond a simple algorithm of, "There were 18,000 transports in Ontario, and that cost $152 million," because there's much more beyond that.

There's a branch in our ministry that has the responsibility to do literature reviews, and we've posed that question: Can you provide us with literature reviews that have been done on the provision of ambulance services and what those costs are? We've got a good pool of information together at this point. We now need to synthesize that and come up with some specific conclusions. But it's not as simple as it might sound.

The Chair (Mr. Norm Miller): Two minutes.

Ms. Helena Jaczek: I'll save my two minutes. Thank you.

The Chair (Mr. Norm Miller): Very well. We'll move to the opposition. Mr. Klees.

Mr. Frank Klees: Mr. Jackson, you indicated in your opening statement that you got back to the Clerk to clarify that it was the daily, not the monthly reports, that your staff reviews. When did you determine that?

Mr. Richard Jackson: I determined that shortly after my appearance here on May 8.

Mr. Frank Klees: So up until that point, you weren't even aware whether your staff was reviewing either daily or monthly reports?

Mr. Richard Jackson: I was aware that they were reviewing daily reports. I did not answer that question correctly when you posed that to me.

Mr. Frank Klees: Well, there's quite a difference between reviewing a monthly report or a daily report. Should it concern us that, as the manager of the oversight branch, you didn't know something as fundamental as that?

Mr. Richard Jackson: We roll up daily reports into longer time frames. I apologize for not providing the correct answer, Mr. Klees.

Mr. Frank Klees: Can you tell us who amongst your staff or from the staff who are here is responsible for which reports?

Mr. Richard Jackson: In terms of who is responsible for which reports, generally, we take a team approach to this, but if I were to specifically talk about reports in terms of the daily availability report and the monthly availability reports, the number of calls serviced, the number of calls, those reports are done—

Mr. Frank Klees: Let's take a report at a time. We've got some time this afternoon, which is why I wanted you to be here. I'd like to get a handle on exactly who is doing what and how they're doing it. I don't care which order you want to take the reports in, but we have some copies here. I'd like to be able to identify the report and the staff member who's responsible for specifically reviewing that report.

Mr. Richard Jackson: I will start with going down the reports in schedule A. Sorry, do committee members have a copy of that page in the performance agreement?

Mr. Frank Klees: Yes, I believe we do. If you could tell us which report you want to start with.

Mr. Richard Jackson: In terms of the report that starts, "Number of complaints," 3(b), 4(a), 4(b), 4(c), 4(d), all with respect to investigations reports, investigations, the number of open investigations, those are compiled in one report, referred to as the inspections and complaints report.

Meena Deol, as her role in—

Mr. Frank Klees: Sorry; you have to bear with me because this is the first time I'm seeing these reports, so I want to—I believe you gave us copies of these. Specifically, which report is it that that information is rolled up into?

Mr. Richard Jackson: It is a document called Investigations and Complaints.

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Mr. Frank Klees: Okay, I have it here.

Mr. Richard Jackson: There is a line graph, and tables underneath that.

Mr. Frank Klees: And who is responsible for receiving that report and analyzing it?

Mr. Richard Jackson: In terms of the work that we do with this report and on investigations, Meena Deol is the lead on investigations follow-up.

Mr. Frank Klees: Okay. The way I'd like to deal with this is just to systematically go through this. If I could address, then, the next question to Ms. Deol? Okay. Do you have a copy of that report in front of you?

Ms. Meena Deol: I do.

Mr. Frank Klees: Okay. I'm looking at the March 1, 2012, to March 31, 2013, report, schedule A. If we're looking at this report, could you describe for me, when you received this report—or let me ask you, first of all: Is this the form that you get the report in, as we see it here?

Ms. Meena Deol: That's correct.

Mr. Frank Klees: And who do you get that report from?

Ms. Meena Deol: It's posted on the SharePoint site. We have a shared site that we use with Ornge for posting of documents.

Mr. Frank Klees: So Ornge posts this information?

Ms. Meena Deol: Correct.

Mr. Frank Klees: Okay. And do you get that electronically?

Ms. Meena Deol: It's electronic.

Mr. Frank Klees: When do you get this?

Ms. Meena Deol: It should be posted at the end of the month, and that is on the site.

Mr. Frank Klees: So this is a monthly report.

Ms. Meena Deol: It's supposed to be a monthly report. This is one of the reports that I've been working on currently, and it's being revised. It's also a report that we've had our audit team look at as well, just to have an understanding of the process that Ornge is using to complete this report.

Mr. Frank Klees: Now, you did say it's "supposed" to be monthly—

Ms. Meena Deol: It is monthly, actually. I don't track the reports. That's actually one of my colleagues who tracks the reports and ensures that they come in every month.

Mr. Frank Klees: So who tracks them?

Mr. Enan Hoque: That would be me.

Mr. Frank Klees: Okay. And do they come in regularly?

Mr. Enan Hoque: I do keep track every month, every schedule, and based on my schedule, the first one came in June 2012, and they have since come in on time every month, as per the SharePoint and the performance agreement.

Mr. Frank Klees: Okay, thank you. Back to the report, then: When you receive this and you look at this report, can you tell me what it is that you're looking for by way of analyzing this information? What is the first thing that you look for here on this report?

Ms. Meena Deol: The first thing that should be on this report—as I said, this report is currently under revision—is it should clearly define the number of complaints that have been received. It also should outline the number of investigations, the number that have been completed and the number that are open.

Mr. Frank Klees: Okay. If you would walk me through this report. What is your thought process as you go through this?

Ms. Meena Deol: Through this process of looking at this report?

Mr. Frank Klees: Yes.

Ms. Meena Deol: This process—like I said, this report is being revised—

Mr. Frank Klees: I know. I don't care if it's being revised. This is what we're looking at now.

Ms. Meena Deol: Okay.

Mr. Frank Klees: We're looking at this report. What is it that you see on this report?

Ms. Meena Deol: Right now, on this report it notes that there are Ornge investigations and that there are a number that have been opened in March 2012—

Mr. Frank Klees: And how many have been opened? How many investigations have been opened in March?

Ms. Meena Deol: From this report?

Mr. Frank Klees: Of this year.

Ms. Meena Deol: In this year?

Mr. Frank Klees: Yes.

Ms. Meena Deol: The fiscal year is 2012-13, and it notes 378 investigations. However, there is a definition here, and that's the number of files Ornge has opened internally.

Mr. Frank Klees: No, no. My question is, how many investigations, according to this report, were opened in March of this year?

Ms. Meena Deol: Sorry, I'm looking at the wrong report. I'm looking at the January report.

Mr. Frank Klees: The report we're looking at states at the top, "March 1, 2012, to March 31, 2013."

Ms. Meena Deol: This one says 40.

Mr. Frank Klees: Okay. Then what is the next line under the 40?

Ms. Meena Deol: The number of investigations the ministry has opened. It notes in March that there were four.

Mr. Frank Klees: Okay. Then the next line tells us what?

Ms. Meena Deol: The total number of investigations, which is 44.

Mr. Frank Klees: Okay. And the next line?

Ms. Meena Deol: The number of investigations that have closed: nine.

Mr. Frank Klees: Okay. Next?

Ms. Meena Deol: The total number of investigations which are open.

Mr. Frank Klees: Okay.

Ms. Meena Deol: The next—sorry?

Mr. Frank Klees: Go ahead.

Ms. Meena Deol: The next line outlines the number of external complaints received.

Mr. Frank Klees: Okay.

Ms. Meena Deol: The next line outlines the number of external complaints closed.

Mr. Frank Klees: Okay. So you have that raw information that has now come in to you.

Ms. Meena Deol: That's right.

Mr. Frank Klees: What do you do with that information and how do you analyze it in terms of the impact on the service level that's being delivered and the implication to patients? What is your next step?

Ms. Meena Deol: My next step is to look at the reports to see if there are any data integrity issues with this report. The way I would do that—

Mr. Frank Klees: How would you determine that?

Ms. Meena Deol: The first thing that I did notice—actually looking at this report—April 8 is when I looked at this report. I called Ornge and I said, "I think there's an issue with this report in regard to the number of ministry investigation files noted on this report." It's different than what I had. I asked them to look at the number of investigations that they had open.

We spent the next few weeks reviewing each investigation file that was open with the ministry to ensure that each one was, from their end and our end, either opened or closed and documented correctly. I asked Ornge to make those corrections.

Also, to give you a better understanding of this report: Daily we receive incident reports from Ornge that are forwarded not only to AAPOB but also to our investigation services unit, who have access to their reporting system. Each one of these incidents is noted into their database, which our investigations unit has access to.

Further to that, when I saw that there were some issues with this report, we engaged our audit team as well to review the processes in which Ornge is documenting this information, to ensure that we're getting accurate information.

Mr. Frank Klees: Based on this report, is there any concern or was anything flagged in terms of implications to patient care?

Ms. Meena Deol: In regard to patient care?

Mr. Frank Klees: Yes.

Ms. Meena Deol: What I'm concerned with this report is the number of investigations that were open, and I also followed up with Ornge in regard to that, as to why there's a total number of files that have been opened and why they're still open.

Mr. Frank Klees: And how did they respond to you?

Ms. Meena Deol: They actually have a different—they have a system where they prioritize the type of calls, the type of investigations and closing those, and they prioritize calls—that their investigation that may have had an impact to patient care. Also to know that each one of these incidents where—oh, sorry. Each one of these cases where there may be implications to patient care, we are notified daily. We're not waiting for a monthly report to be notified of that. That report is sent to our investigations unit that has the responsibility to conduct investigations. They'll review their incident reports daily to see if, under their responsibilities, they'll be conducting an investigation into that matter.

Mr. Frank Klees: During this month, how many cases were there where there was an implication to patient care?

Ms. Meena Deol: As I said, these files have not—that would be determined through the investigations process. That would be led by the investigations unit with the emergency health services branch.

Mr. Frank Klees: So you don't have that or wouldn't have that information?

Ms. Meena Deol: No. Investigation services is responsible for conducting the investigation. What they would do is, they would review the incident reports, if they were conducting an investigation, to see if there were any contraventions to the act or standards. They would then provide our branch with a copy of their findings once they had completed the investigation. We would then forward any of the findings to Ornge and request corrective action on those findings.

Mr. Frank Klees: Do you at any time seek advice from others in the emergency health services branch who have been responsible for ambulance oversight in the past?

Ms. Meena Deol: I do.

Mr. Frank Klees: And who do you speak to?

Ms. Meena Deol: I speak to the manager of policy and implementation.

Mr. Frank Klees: And who is that?

Ms. Meena Deol: Rob Nishman.

Mr. Frank Klees: Anyone else?

Ms. Meena Deol: Investigation services, yes.

Mr. Frank Klees: And who is that?

Ms. Meena Deol: Rick Brady.

Mr. Frank Klees: And how often would you speak with them?

Ms. Meena Deol: At least weekly. When I started with the branch, the first thing that we did was—the priority was to look at open investigations to ensure that we were acting upon those. So the first thing that we did was to establish weekly meetings with Ornge and myself and with EHSB to review open investigations to ensure that there was follow-up.

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Mr. Frank Klees: Okay. Thank you very much.

Mr. Jackson, what is the next report?

Mr. Richard Jackson: The next series of reports starts with—and I'm going to talk about two reports that we do not yet have—Reaction Response Times: Scene Calls, 5(a); and 5(b), Inter-Facility Calls.

Ornge's current computer-aided dispatch system does not systematically track that information, so we do not have information, on a systematic basis, on the time frame from when the call is placed to when the call is responded to. That is an issue with the dispatch system that had been created. It was not tracking that time from

the time the call was received; it was tracking the time from when the resource was actually identified to be deployed. So we don't have that spectrum, and this was flagged by the Auditor General in his report

Ornge has procured a new computer-aided dispatch system that will enable that information to be captured and reported. That dispatch system is scheduled for implementation in the fall of 2013. One of the 2013-14 quality improvement plan metrics that Ornge has established is time from call received to time when wheels are up. That will be captured and reported in that system and reported to the ministry, and we'll be able to track that. So we do not have those two reports.

Mr. Frank Klees: That's relatively important information in terms of the business that you're in, isn't it?

Mr. Richard Jackson: I would agree with you. I think it's one of the cores of what Ornge ambulance services should be doing, the time it takes from T-zero to the time that you've delivered the service.

Mr. Frank Klees: The fact that it was identified in the Auditor General's report—would it not have made some sense, if the computer system isn't capable of tracking that, that at least an effort be made to manually track that until we've got the technology in place?

Mr. Richard Jackson: Ornge is tracking that manually. They can from their phone systems. They have tags from when those calls are being done. They're measuring the time it takes, and they've disaggregated this by two categories, for an on-scene call, where they want to be able to confirm within 10 minutes of the receipt of the call that they are deploying that resource. In their 2012-13 quality-improvement plan, they wanted to meet that; I believe it was at 100%. Their manual measurement of this in March, I believe, is in the range of 90% of on-scene calls responded to—confirmed that they will be responding—within 10 minutes.

Mr. Frank Klees: So Mr. Jackson, here's my concern, and forgive me, but it does cause me some consternation when I hear you say, "I believe this is what's happening" and "I believe these are the numbers." What you're telling me is they're doing it manually, but obviously, they're not reporting it to you. My question to you is, why are we talking in possible numbers when your responsibility is oversight, and the track record has been one of a lack of reporting and a lack of ministry oversight? Help me to understand, and give me some comfort here.

The Chair (Mr. Norm Miller): You have a minute and a half of your time.

Mr. Richard Jackson: A poor choice of words on my behalf: "Believe" was—I didn't want to quote a specific number without referencing it. But if you allow me I will refer to it, I will give you the actual number. In Q3, it was 90% of the time for an on-scene call that they indicated within 10 minutes that they had a resource available to be deployed. In Q3, for the inter-facility calls—so the target that they set in the quality improvement plan was for an inter-facility call—within 20 minutes of the receipt of that call, they would indicate if a resource was available within 95% of the time. In Q3 they achieved 96% against that particular target.

Mr. Frank Klees: Okay. Thank you.

The Chair (Mr. Norm Miller): Very good. Thank you. We'll move to the NDP, Ms. Gélinas.

M^me^ France Gélinas: Thank you. I'm also interested in looking at oversight, and I don't know if you can answer this, but if you can, please do. How would you say that oversight at your ministry has changed since everything has happened and become known?

Mr. Richard Jackson: In terms of how oversight has changed, the first point I would come to is, there was not a dedicated branch or unit responsible for oversight of the air ambulance program. There were people who did that as parts of their job but not fully dedicated to it.

In terms of what else has changed is the considerable amount of information that we now have about Ornge's performance. I don't believe, if I had been sitting here 18 months ago, that I could be relaying information to the committee with respect to this particular base, over this time period, that 98.9% of the time it was staffed with two paramedics. So we have that line of sight into Ornge that we didn't have.

I think one of the fundamental changes is a change, I wouldn't say at the ministry, but it's actually a change at Ornge where this information is provided to us. Whether we ask for it, they provide it to us; it's done in a transparent way. It's not about hiding information. It's about providing information. Are all these results positive in terms of the service that Ornge is delivering against particular parameters? It isn't.

So if I was to summarize it: a dedicated group of people looking at specific requirements of Ornge to provide that information, and the fact that we're actually receiving that information and analyzing that information and getting back to them when we see issues that we think need to be addressed.

Mr. Jagmeet Singh: In all the things that we've done, that you've outlined in terms of oversight, why couldn't any of this have been done? What prohibited this from being done before? Why couldn't the ministry have set up an oversight branch the way you've outlined and taken the various steps that you've outlined? What prohibited or precluded the government from doing that before, if anything?

Mr. Richard Jackson: I don't think anything would have prohibited the ministry from doing that.

Mr. Jagmeet Singh: I would tend to agree. Sure. Thank you.

Moving forward, there are a number of issues that we've outlined and we've addressed here at Ornge. What have you learned from your experience in terms of providing oversight for Ornge that could apply to oversight in perhaps other ministries, that could assist in preventing future Ornges from occurring?

Mr. Richard Jackson: In terms of what I think are a couple of important lessons learned from this experience—and I would suggest that you need to tailor the amount of oversight you have to the perceived risk that

that organization or that service may present itself to. But when I look at—and I'll give you an experience, my own experience of regulating private career colleges.

What did we know as a ministry at that point in time about private career colleges? We knew where they were, we knew how many people were—we had some basic financial information about them, but we didn't have that day-to-day intelligence about what was actually going on at the 600 private career colleges in Ontario and then, all of a sudden, someone would go bankrupt and students would be put ou on the street. I think one of the lessons learned is actually having this type of information available to you so that you can see things that are happening—not overly embellishing this, but literally in real time. I think that is key.

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I think what is also key is an ongoing dialogue with the service provider and having the candid conversations that need to take place. In my role as a regional director for the Ministry of Community and Social Services, I would have a group of program supervisors that would interact with the respective transfer payment agencies. That might be done periodically; they might have several different agencies that they were responsible for, but they didn't necessarily have that day-to-day understanding of what was going on and that regular contact. You need to balance that against risk.

Mr. Jagmeet Singh: Sure. Thank you very much. My colleague has more questions.

M^me^ France Gélinas: I'd like to pick up on this "ongoing dialogue" that you talk about. What has changed? Because if you read the newspaper every now and again, you will have known that Ornge, in January 2011, wrote an extensive letter outlining exactly the web of for-profit companies that they were to set up. They c.c.'d the world on this letter. They came to Queen's Park, they came to the ministry, they briefed them, and not a peep came out of anybody.

What has changed with your branch that now—if something like this were to be presented to you now, do you figure you would react?

Mr. Richard Jackson: I can tell you with 100 degrees of certainty that I would react, and that the people I work with here would react to that. Why there was not a reaction to that in January 2011 is something I do not know. I do not understand why. I have certainly followed the testimony before this committee over the last—well, since it started last March.

I can't explain what happened when I wasn't here and being involved in that, but in terms of things that I think have changed, I'll give you an example here. I want to give you a good example, if you'll give me a moment to recall one.

I'll genericize this. We get a daily report from Ornge that says, "These were the number of transports that we did. These were the number of transports that we didn't do, and these are the reasons why we didn't." If we see an incidence where it says, "We did not transport someone because there was a shortage of an air vehicle," we're immediately on the phone: "What did you mean by that? What was the shortage? Why was there a shortage? What happened with that patient? How was that patient transported?"

Ornge is telling us that information. We're reacting to that information. I don't think in the past—I will call that "the old Ornge"—we would have even thought that that was something that they would report to the minister. It was something that the ministry was not tracking or monitoring.

M^me^ France Gélinas: So I guess my question remains as to what has changed. How come, presented with the same information by the same people in the same format, you would react, but the people before you didn't? What has changed?

Mr. Richard Jackson: What has changed is that there is a specific group of people who are dedicated and responsible for paying attention to that and acting on that. That is their sole purpose, as opposed to a situation where—I would characterize it, perhaps, that Ornge was one of a series of ambulance providers. It happens to be the air ambulance provider, but there are upper-tier municipalities who are all involved in this action, and people, for whatever reason, did not react to that. I don't know why they didn't react to that. It certainly concerns me. I would imagine that it concerns many people.

M^me^ France Gélinas: So when you try to answer those questions, you say that because your sole purpose is to oversee, then you take it as your responsibility to do so. There are many, many transfer payment agencies at the Ministry of Health—thousands of them, literally—that do not have a sole-purpose branch or unit within the ministry that is there to oversee them. I'm fully confident that everything that goes on at Ornge right now is looked at, is analyzed, is questioned and is worked upon. But I'm worried that there are other little Ornges out there.

Mr. Richard Jackson: I think I would say that there's an element of risk analysis that, whatever the oversight body the branch is, or whoever it is that is responsible, needs to have confidence in the capacity of the governance of that particular organization. How that is achieved in other areas of the Ministry of Health, Ms. Gélinas, I do not know how that is done. But I can tell you, and I think it's—Ornge has been, obviously, a hugely significant issue for the province, what has transpired at Ornge. As a result of that and the high level of risk, there have been dedicated resources assigned to it.

Are there are other Ornges out there? I do not know that. That has not been the focus of my work.

M^me^ France Gélinas: None of us know that, but, by your answer, you give us confidence that strong elements of oversight are now there. You guys are a part of this. Your job is to oversee. You know how to do your job. You're dedicated to it, and it brings results. When something goes wrong in Moosonee, in Weeneebayko, you were on the phone and, basically, you got to the bottom of it and made sure that the people of that end of province had the critical transportation they needed, especially at the time where the ice was breaking up

between the island and the mainland. So things have changed for the good of the people of Ontario.

But here again, I come to what are the most important features of oversight, given that we know we don't have units like you guys for every part of the health care system, some of them spending hundreds of millions of dollars, not unlike Ornge. We don't have a dedicated unit like you guys. What are the important features of oversight that need to be there that you guys are bringing?

Mr. Richard Jackson: I would talk to, I think, a few elements that are important to oversight. First is defining what it is that we're actually expecting of the service provider, whoever that service provider is. What is it that we are expecting them to do for the investment that we are making? What are the controls that that organization has in place to monitor itself? What is the role that their respective board governance is at that particular organization?

I think you need to have an understanding of the results that they are delivering in terms of outputs and outcomes. I think you need to have an understanding of what their financial situation is and what they're using their funding for. I think there are lessons to learn from the work that we are doing, and it is a work in progress.

We've been at this for a few months. I came on board at the end of July, and there was Steven and myself and another individual. But, as I said, I think there are lessons that can be learned and can be shared with this. Ultimately, I don't think every organization that the government of Ontario funds needs this level of attention.

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M^me^ France Gélinas: I agree.

Mr. Richard Jackson: It's being able to identify which areas of where you might need that attention and dedicating those resources. We have a finite amount of resources, and we need to direct those to where we think there's the highest risk.

Mr. Jagmeet Singh: I have a question for you. In terms of oversight, how do you measure good oversight? We have different institutions and different mechanisms in place to provide that oversight. How do you actually assess if you or any other group or any other mechanism for oversight—how do you measure if that's good oversight or not? What are your performance measures to ensure that you're doing a good job of even providing that oversight?

Mr. Richard Jackson: I would think the ultimate performance measure would be in terms of the specific objectives that are assigned to that particular organization you're funding. Are they delivering upon those objectives? If you're doing a good oversight role, I think you can understand what's going on. Ultimately, I would say my role, looking over at the oversight at Ornge, is not to run the air ambulance program; it's to ensure that the people who are running the air ambulance program are running that properly. That's their operational responsibility and operational accountability. I think I have a system accountability to ensure that those systems are in place and that those are happening.

Mr. Jagmeet Singh: One measure would be at whether or not the body or the organization that's under oversight is achieving its results or its performance measures; that's one way of saying that the oversight must be good. Are there any other independent ways of measuring if the oversight is sufficient and if it's exhaustive that you can give us in terms of a way for us to measure if the mechanisms we have in place are sufficient? How do we measure and say that this is a sufficient form of oversight or that this team—or any team—is doing their job effectively to provide that oversight?

Mr. Richard Jackson: Other than saying that that's a very good question, I don't have an answer to that.

Mr. Jagmeet Singh: Sure.

Mr. Richard Jackson: If I thought about it, maybe I could come up with an answer, but I don't. It's a really valid point.

Mr. Jagmeet Singh: Thank you. I'm sure my colleague has a couple more questions.

M^me^ France Gélinas: Along the same lines, let's say you celebrate your second or third anniversary. You've now got a pretty good grip as to what makes for good oversight. Are there mechanisms within your unit or your department to share those lessons within the ministry? Do you have an opportunity to do this?

Mr. Richard Jackson: I think that the opportunities could certainly present themselves to do that and share that information. Our focus has been on actually doing the work, not going out and touting our successes, because there's still much work to be done here.

There are, certainly, forums across government. One that comes to mind is Policy Innovation and Leadership. It's a cross-ministry group where you can find yourself there to come and present and learn and share best practices across the OPS. It's one that comes to mind immediately.

M^me^ France Gélinas: On a different train of thought: Let's say you go back to your office this afternoon. You have a phone call from somebody who tells you she has just been made aware that somebody at Ornge is receiving twice his salary. He's receiving it under two different names. I'm making that up, by the way. What would you do with that information?

Mr. Richard Jackson: My immediate response to that—I know it's a hypothetical example, but it's a serious hypothetical, if that was to occur. I would be immediately in contact with Dr. McCallum, asking him what was going on: "Please explain what is going on. You need to provide me with documentation and information with respect to what is going on and how that has occurred." I would go right to the top and deal with the CEO.

The Chair (Mr. Norm Miller): We're out of time for this round, so we'll move to the government. Ms. Jaczek?

Ms. Helena Jaczek: I'll start, Chair, and I know my colleague has a couple of questions as well.

I'd like to go back to the reports you sent us, mainly because I spent a few hours going cross-eyed over them. Ms. Deol, perhaps I could go back to the investigations

and complaints report that you've been working closely with Ornge on, and the emergency health services branch as well, as I understand it.

How are you working to ensure that we have more closed files in terms of these investigations and complaints? I was fairly struck by the relatively high number that seems to have accumulated over time. Could you just talk to us a little bit about how, in your role as overseer, you're kind of pushing for the conclusion to these reports?

Ms. Meena Deol: Yes. So number one, just to clarify that report, where it indicates for the Ornge investigations—on the report that you're seeing here, currently there are definitional errors. What they've been doing is they've been documenting every incident they have and counting that as an investigation. That's why we've engaged the audit team to review, even what their definitions are and what they're reporting, number one.

With regard to the ministry investigations, every week, effective since I've taken on this portfolio, the first thing was just to look at, why are these files open, and why have they been open so long? Number one was to improve communications and to have a forum to discuss these investigations and make them a priority. So we have weekly meetings which include Ornge senior management. We have the director of professional standards and compliance, the lead for investigations at Ornge, who also started with that portfolio at around the same time I did. We also have an investigations coordinator at that meeting, I attend, and then also, with the emergency health services branch, we have the manager of policy and implementation on those lines.

The first thing we do is we review each one of the findings or the reports and outline any outstanding issues.

Ms. Helena Jaczek: Are you optimistic that over time, with this sort of intensity and urgency that you're communicating, we will start to see—do you have a goal in terms of resolution?

Ms. Meena Deol: The goal is to have no investigations open and to ensure they're done within the recommended timelines.

Some of that also has to do with trending. What we've been doing is looking at certain investigations. For example, currently there are four investigations open relating to a policy. I can name the policy. What we've done is we've forwarded that to Ornge, that they need to amend that policy. That was found in the findings and the recommendations from the investigators, that you need to review this finding and make sure staff are trained on this finding.

That policy has been revised. We received it back. It was forwarded to our investigations unit to review again and has now been sent back to Ornge. That will address those issues, to see when it comes back, to ensure that that policy takes into consideration, number one, the investigations, and that they can be closed.

We're also establishing further meetings for other issues—not issues, but other investigations for trending. For example, Ornge has reviewed their triaging policy. So we're meeting with Ornge senior management in June to review a number of files that revolved around that recommendation or considerations regarding that finding.

What we're doing is meeting—it's not just meeting, but ensuring that we're also coming to conclusions and finding other—it could be policy-related incidents as well, and ensuring that we have new policies updated as well.

Ms. Helena Jaczek: Okay, thank you.

Interjection.

Ms. Helena Jaczek: Yes, Mr. Jackson?

Mr. Richard Jackson: I would just add something to Meena's answer.

One of the things that I think we're seeing with the instances and investigations that we're doing is, the communications that would happen between the Ornge control centre, the sending hospital and the receiving hospital about explaining what is happening where—where is the resource, when is it going to arrive. Part of the strategy that Ornge has put in place is that they had a generalist model, where everybody in their dispatch centre—they were call-takers, they were flight-trackers—looked after the provincial transportation and authorization centre.

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They've now provided specific training and certification in each of those areas so that the people have a specialty that they attend to and not a generalist approach that had been introduced by the previous leadership at Ornge.

So there are systemic things, I think, that can be done with the service delivery that are actually going to reduce the number of investigations, and then we won't have as many to close.

Ms. Helena Jaczek: My follow-up relates to the quality improvement plan. We saw the first one last year; I understand Ornge has submitted a second one. Will you be including these sorts of goals just as articulated, in terms of the resolution of complaints and so on? Will there be that kind of specificity in the next iteration of the quality improvement plan? I would like to be able to look a year from now and see that this kind of improvement has occurred. How does this tie back into the expectations of the coming year?

Ms. Meena Deol: I think it's also important to note, in regard to the investigations, that a number of these investigations that are currently open occurred for incidents in 2012 or prior. As Richard was noting, I think that with the implementation of some of the changes with the OCC, the Ornge control centre, we anticipate that moving forward we would see fewer investigations, because there have been changes to the structure or some of the larger issues; for example, the changes to the model of the OCC—the fact that they're doing call-taking and auditing of their communication officers, and other steps they're taking in regard to improvements to the actual communication control centre, which are outlined in the QIP. So moving forward, we would expect to see fewer investigations.

Ms. Helena Jaczek: And they are outlined in the QIP.

Mr. Richard Jackson: I would say that it's always great to get advice from people around this table. In the specific metrics that have been approved by the board for 2013-14, there's not one that specifically speaks to the resolution of findings in a specific time frame. The fact that it's not in the QIP—I'm certainly taking the advice away today that we will be pursuing that with Ornge. If we're going to measure it, there had better be a target that we're measuring it against, and we don't have that at this point.

Ms. Helena Jaczek: I would suggest that would be useful. In other words, it is a toing and froing between Ornge and your branch in terms of developing and monitoring those metrics. Thank you for acknowledging that.

As I looked at the requests versus transports—maybe I'm being overly optimistic; this was the next series of data that we got—it seemed to me that the gap was narrowing somewhat in terms of requests vis-à-vis actual transports. Am I being overly optimistic? Could you talk to us a little bit about this series of data?

Mr. Richard Jackson: This very long series of data and—

Ms. Helena Jaczek: I found the graphs the most useful, at the end.

Mr. Richard Jackson: Okay, we're at the graphs. With the graphs that are contained in this report and the scale that they're at, I find it difficult to identify how small that gap is going.

In terms of the number of requests for transport, I think it's useful to actually look at some year-to-date summaries. I don't think there has been, I wouldn't say, a statistically significant improvement in the number of requests versus the number of transports. Ornge itself tends to actually respond to around 70%. For the other 30%, there are reasons why those are not being responded to, and some of them, to me at least, make sense. It's an on-scene call; the land team has arrived; they've called for Ornge; they realize that they can get to the tertiary hospital quicker than it will take to actually deploy the helicopter or get it there.

Ms. Helena Jaczek: What is your advice, then, because obviously now you've got a duplication, potentially, of resource. How are you handling that issue?

Mr. Richard Jackson: That is something that I think is an important part of Ornge's operational objectives for 2013-14 and for subsequent years. The terminology they would use is "to have a clearly defined mission profile." To put it as a specific example, if there is a car accident at the interchange between the 427 and the Gardiner Expressway, and there's a land team that's on there, does an Ornge helicopter need to be deployed when they're already on the route to Sunnybrook or St. Mike's?

There needs to be a clear understanding of all the stakeholders that are involved in this. I'm more than optimistic that the thought processes that are going on right now at Ornge between Dr. McCallum and his senior management team and his operational managers and the linkages that they are building with local EMSs, with hospitals and LHINs across this province, where I would say 18 months ago, two years ago, Ornge was acting in this isolated, "We are Ornge and this is what we do and we don't reach out"—because I think we need to think about this from a system perspective.

Ms. Helena Jaczek: We certainly got that impression, at least the government side, when we visited Ornge.

Dr. McCallum was talking about "Everything is on the table," which actually leads me to recommendation 2 of the Auditor General's report of 2012. Maybe Mr. Haddad would like to outline that a little bit for us. Deloitte, I understand, is studying the issue of critical land ambulance vis-à-vis air transport. Could you give us the terms of reference, perhaps, of what Deloitte is looking at? And then tell us a little bit about the pilot that's going on in Ottawa.

Mr. Steven Haddad: Certainly. I would refer you to the Auditor General's report and recommendation number 2, because to be honest, it very clearly outlines exactly what it is we're trying to accomplish with this program review, from the very first point, which is, "assessing the current total demand for critical care land ambulance transports in Ontario." Part of the first level review that we had asked Deloitte to do was sort of an operational look at how many transports are actually being conducted compared to how many, perhaps, the program had expected several years ago when it was first created.

Also, taking a look at what opportunities there might be if the service were expanded: For example, it's currently offered in three bases in Ontario, plus Toronto EMS receives funding through Ornge to deliver the service in the GTA, and to see if there might be a demand in other parts of the province for that type of service.

Part of the review that they're also doing is meeting with stakeholders from different sectors, different parts of the health care sector, to look at, potentially, capacity for other service delivery models. I think at this point it would be premature to comment on what the findings or conclusions might be of the report, because the work is still going on, but we have certainly—I think that they have received a broad range of input into their work, both in terms of operational and financial data from Ornge and other stakeholders to be able to allow them to have a very clear picture of how the program is being run and what niche market it's serving. Effectively, I refer back to the Auditor General's observations.

Ms. Helena Jaczek: And when do you expect that report to be finished?

Mr. Steven Haddad: I believe sometime next month we should be receiving a report from them.

Ms. Helena Jaczek: And a little bit about the Ottawa pilot.

Mr. Steven Haddad: Certainly. One of the things I believe Mr. Jackson mentioned earlier in his opening remarks is ensuring that the right resource is being used at the right time based on the acuity of the individual patient. The example he gave: If there was a land vehicle

that was perhaps closer to be able to respond to the patient, and that would be appropriate, perhaps the dispatch of an air, which could in fact take longer because of the time to do a weather check and going through the full process—perhaps it did make sense to make use of a land resource, and just staff it appropriately with a critical care level of paramedic.

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In the Ottawa area, a pilot that they had looked at was: Were there opportunities to defer some of these air calls, or transports that were being serviced with an aircraft—to service them with a critical care land ambulance or with one of the additional ambulance resources that they have? My understanding, though unfortunately I don't have specific details for you today, is that so far it has produced positive results in decreasing the reliance on air and ergo has resulted in some cost savings.

Ms. Helena Jaczek: Okay. Thank you very much.

The Chair (Mr. Norm Miller): Ms. Damerla.

Ms. Dipika Damerla: Thank you, Mr. Jackson, for coming again. I really want to compliment all of you on your team. In the short time I've had to evaluate you, all I can say is, you present yourself very well. You're very articulate and, most importantly, you've certainly demonstrated a good command over your briefs, so congratulations on that.

I'd like to just begin by trying to get an overall picture. You and your team have been on this job, this particular piece, for about eight or nine months now, so it's a relatively short period of time. I think of it like a garden. You first weed it and you sow the seeds. It takes a while to actually see the results, but that doesn't mean hard work hasn't gone in. I'm just trying to understand: In the short time you've had, could you just give me one or two illustrations of what you think are your team's main achievements?

Mr. Richard Jackson: I would say, when I think of the team's first achievement, it's that we've actually been able to get, for the first time, a clear understanding of the services that Ornge provides, how they provide them and the plans they have for improving those services. It was a green field that we inherited. "Here's a performance agreement. Figure out how to implement it." I would say—just being able to pull this information together and start the work of analyzing it.

I also think something that I'm proud of is the work that we have done in having a much better and detailed understanding of what Ornge actually spends its money on. We now have that from a budget perspective, and we'll be tracking that from an actual perspective, so that we can—we're paying Ornge to do organ transplants. It would be useful if we actually knew—and we do know—what that costs.

The other thing that I would say that I am proud of is the professional working relationship that we have developed with the senior people at Ornge. We are not running that organization; we are not there to be their friends; we're there to be their overseers. But we have, with our stakeholder relations skills that we all bring to this table, been able to engage their management on a regular basis on important discussions that need to take place. I think what is critical to our success moving forward is knowing that you can pick up the phone, get the information, and it doesn't matter where that's going.

Ms. Dipika Damerla: Okay. That's actually very useful, for you to have summarized it that way.

How much time do I have?

The Chair (Mr. Norm Miller): You have just a minute left.

Ms. Dipika Damerla: Oh, just a minute left.

My next question is just around the performance agreement that you mentioned. I just wanted to know: What tools does this new performance agreement give you that perhaps the old one didn't, as an overseer? Could you just elaborate on that—tools to oversee?

Mr. Richard Jackson: In terms of tools, I'll give a few examples: the fact that there is a requirement that there's a ministry representative actually sitting on a board subcommittee on an issue as important as the quality of patient care. One of the other tools is, my understanding is that, under the old performance agreement, there were only a limited number of times when the ministry could actually show up at Ornge and do the work that they needed to do. We can go and be there whenever we need to be and whenever we want to be.

I think that the other critically important tool is the amount of information that Ornge is required not just to provide to us but provide transparently to the public. Accountability is not just to the ministry; there's an accountability to the public, and I think I see that in the performance agreement, as a result of the performance agreement.

The Chair (Mr. Norm Miller): Thank you very much. We'll move on to the opposition. Mr. Klees?

Mr. Frank Klees: Thank you. I would like to pick up, Ms. Deol, where we left off in terms of this report. What I don't see anywhere in the definitions of these complaints or incidents is a reference to a significant patient adverse event. Do you know what I mean by that?

Ms. Meena Deol: Yes.

Mr. Frank Klees: Why is there no reference to that category of complaint or event?

Ms. Meena Deol: In this chart?

Mr. Frank Klees: Yes.

Ms. Meena Deol: All incidents, as defined within ambulance document standards, are included, so any incidents that apply to that standard are included in this.

Mr. Frank Klees: And so where do we go? Because I'm assuming you'll agree with me that it's the significant patient adverse event that we're really interested in, primarily. How do you, as an oversight body, get alerted to how many of those events are occurring in any given month?

Ms. Meena Deol: Every day, we see each event. Each incident is reported to us according to these standards.

Mr. Frank Klees: No, no. Hear me: There's a difference between not having gas in the tank, not having enough bandages or having a short—to what is defined as

a significant patient adverse event. Those are the critical issues. How do you, as an oversight body, get alerted to those?

Ms. Meena Deol: We have a quality of care committee that our director sits on, and some of these can be addressed through him.

Mr. Frank Klees: No, no. My question is, even the quality care committee, how do they know what to look at? Is there no trigger that comes through this reporting mechanism for that kind of event?

Ms. Meena Deol: Every event is important.

Mr. Frank Klees: I'm sorry?

Ms. Meena Deol: Every incident that's noted here would be considered a priority or important.

Mr. Frank Klees: No, no. That's not good enough. One of the findings of the Auditor General in his report was that Ornge—this is the old Ornge, under the old system—"internally reported 20 'significant patient adverse events' in 2009-10 to its board of directors, including some that involved patient deaths." These are significant events. The Auditor General, in his report, flagged this as a real concern, that these particular cases were not being properly reported.

What I'm interested in is, under your system and under your oversight, are those particular significant events identified? How are they? Surely, out of a basket of 40 incidents or complaints, somehow you must have a mechanism to identify three or four of these significant patient adverse events.

Ms. Meena Deol: Each one of these events, incidents, are—like I said, we receive these reports daily—

Mr. Frank Klees: I'm sorry. I can't accept that.

Ms. Meena Deol: I'd like to—

Mr. Richard Jackson: Please, could I assist you with the question that you're asking? Because it's a critically important question.

Mr. Frank Klees: Please.

Mr. Richard Jackson: So, in these reports—and they're referred to as "care reports"—that we receive, they outline in quite significant detail what the actual incident was. Certainly, when we would see a situation where there was a death, or certainly in situations where vital signs were absent, those would be the ones that we would identify, in consultation with the investigative arm of the emergency health services branch, and we would initiate an investigation.

We'd look at each of those reports that we get. They outline in this section—it's admittedly in very small print in the left-hand column—the type of things that need to be reported. Is there an unusual response or service delay? Is there a delay in accessing the patient? Is there an excessive amount of time on scene? When we see those, the ones that are serious, those are what drive ministry investigations, and you can—

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Mr. Frank Klees: There's nothing in here that triggers a patient death indication. This is my concern. The reason I'm asking this question, Mr. Jackson, is because I have here a Ministry of Health and Long-Term Care memo dated May 23, 2012. It's confidential for cabinet purposes. I'm going to read you what it says. The heading on it is, "Issues: Status of Investigations Related to Air Ambulance and Related Services at Ornge." It reads as follows:

"The amended PA no longer contains a requirement to report significant adverse events. Instead, Ornge is now required to report to the Ministry of Health and Long-Term Care any incident that meets the requirements for reporting under the ministry's ambulance service documentation standards." It goes on to say that it essentially is left up to Ornge to make the determination in terms of what is significant and what should be reported.

My concern and my question to you is: Are you aware of this memo? Are you aware that the reporting requirements have actually changed? If you are, are you concerned about that? I certainly would be if I was in a position of oversight because if it's being left to Ornge staff to make the determination about what is significant to report, we're right back to first base on this thing. I'd like your response on that. Are you aware of this memo? Are you aware of the concern—this is a Ministry of Health document—and, if so, what is your response to it?

Mr. Richard Jackson: The specific memo that you're referring to, Mr. Klees, I don't have in front of me, so it's difficult for me to comment on this. But we are asking Ornge to report on all incidents, not just those that are serious incidents. There are other processes within the medical oversight role that goes on through Ornge's medical advisory committee where they have a process in place where they are doing chart audits of—I believe it is 20% of the actual medical transports, where Ornge's medical directors are reviewing those charts to determine whether or not there was an issue with the level of care that was provided by their paramedics. Those reports and that summary information are provided to the quality of care committee for their review and for the board's action.

Mr. Frank Klees: Okay. Could I ask which of the staff can give me a definition of the patient care standards for air ambulance?

Mr. Richard Jackson: The patient? It's the—

Mr. Frank Klees: The patient care standards as defined in the air ambulance act. Does anybody know it offhand? It should be pretty basic, I would think.

Mr. Richard Jackson: Meena, would you like to speak to that?

Ms. Meena Deol: You want to go first?

Mr. Steven Haddad: I assume you're referring to a document that's produced by the emergency health services branch in collaboration with the medical advisory committee, which is called Ambulance Service Patient Care and Transportation Standards. The last version I have is October 2007.

Mr. Frank Klees: Okay. Can you tell me what that standard of patient care is for air ambulance?

Mr. Steven Haddad: I can describe it in general terms, yes. I'm just wondering if other members of the committee would benefit from having a copy.

Mr. Frank Klees: We don't have time. I have to leave early, actually. I was hoping, as staff being responsible for oversight of air ambulance, that you would know. I'll share it with you. I'll read it—pretty fundamental: "There must be two paramedics trained at the highest level of critical care in order to provide critical patient care on the air ambulance." That's fundamental. With that reminder, have you heard that before?

Mr. Steven Haddad: It's highlighted in my document.

Mr. Frank Klees: Good. Let me ask you this—and I think it's Mr. Hoque who's responsible for resource availability reports. Can you tell me, based on that standard of care, whether or not Ornge air ambulance is able to meet that standard of care, and if it's not, what percentage of the time is it not able to meet that standard of care?

Mr. Enan Hoque: Sure, I'd be happy to answer that for you. When we're talking about meeting the target level of care, we're talking, as you said, having two or more paramedics at the right level of care, as defined by the base. We know that in Q3 they reached that 66.4% of the time, and by the end of Q4 they reached that 70.3% of the time. We know that they've had two or more paramedics on duty in Q4 96% of the time, and that the amount of time that they had one or zero staff has also improved from Q3. Based on the staffing work that the branch is doing and Ornge is doing, we're looking to reduce that again and again.

Mr. Frank Klees: So let me simplify this, because I want to get it down to the current level of care. Last month, what percentage of the time was Ornge able to meet the standard of care, where they had at least two paramedics, one of which was trained to the critical care level?

Mr. Enan Hoque: Based on the reports you have, if we're talking about last month—well, I'll speak to the report that you have, with the last month being March, which would be 68.4% of the time.

Mr. Frank Klees: So in March, only—

Mr. Enan Hoque: It was 68.4% of the time.

Mr. Frank Klees: —68.4% of the time were we staffed to the standard of care. My understanding is that prior to Ornge taking over the full operation, there was actually a mechanism within the agreement with the service provider that if they weren't able to meet the standard of care, there were penalty clauses in those contracts. Are you aware of that? And there were financial penalties to that provider. Are you aware of that?

Mr. Enan Hoque: Yes.

Mr. Richard Jackson: Yes.

Mr. Frank Klees: Yes, Hansard doesn't pick up nods.

Mr. Richard Jackson: Yes, I know. Yes.

Mr. Enan Hoque: Yes.

Mr. Frank Klees: Can you tell me what penalties or consequences have there been to Ornge for not meeting those standards of care?

Mr. Richard Jackson: There has not been a penalty or consequence to Ornge not meeting that standard of care.

Mr. Frank Klees: From the standpoint of oversight—oversight is one thing; enforcing a non-compliance is yet something else. Would you agree with that?

Mr. Richard Jackson: I would agree with that.

Mr. Frank Klees: I would think that in order to make your work meaningful, if you find Ornge not to be in compliance with your oversight, then there should be some consequence to Ornge. Would you not agree?

Mr. Richard Jackson: In terms of a consequence, under the previous contract there was a financial penalty to that. In terms of if there was a—let's say there was a financial penalty for not meeting that level of care. We would be removing funding from Ornge. The majority of their costs are fixed. Their costs are fixed in terms of their staff, their aircraft. There's not a large variable component to their budget—fuel and medical supplies, perhaps. If there was a penalty—and there could be a penalty—the impact of that penalty would be, potentially, a further reduction in service.

Mr. Frank Klees: You make my point. The very fact that this is an internal game, that there cannot be any financial consequences, or any consequences of any significance, to Ornge for not complying means that while we may have a structure of oversight, the fact that there's no consequence—we really have no mechanism to bring these people into compliance, which is one of the reasons that I think this committee is very interested in reassessing the structure that we have. Based on information that we have in this committee, the compliance for standards of care under the previous system, where we had an external provider, was some 98% on a very consistent basis.

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Now, I'm not so much concerned about financial penalty to anyone, because what we're really concerned about here is patient care. When an organization is motivated to provide patient care at the optimum level, then that's really what this is all about and that's what we want to achieve.

I wish I had more time to pursue this, but unfortunately I have to be on my way. Thank you for being here.

Mr. Richard Jackson: You're welcome, sir.

The Chair (Mr. Norm Miller): Mr. Barrett.

Mr. Toby Barrett: Thank you, Chair. I'll continue with some questions to Mr. Jackson.

As director of an air ambulance program oversight branch, my question is: A department or a branch like this—is it seen as a time-limited department? Maybe fill me in. When was this set up, and secondly, how long do your foresee this branch existing in its present form?

Mr. Richard Jackson: It was established in July 2012. It is a permanent branch. The positions are permanent FTEs, part of the Ministry of Health and Long-Term Care's FTE complement. There is no sunshine period on when the work of this branch will cease.

Mr. Toby Barrett: Okay. We have a branch—I think it's six staff altogether, as I recall. Within either this ministry or perhaps education or agriculture, are there other branches like this, focusing on oversight and accountability? Comparables?

Mr. Richard Jackson: In terms of my own experience within the OPS, Mr. Barrett, the only comparable one that I could identify would be the private career college branch in the Ministry of Training, Colleges and Universities, in the role of the superintendent and his or her staff, with a specific focus on that one sector. There may be others. I don't—

Mr. Toby Barrett: Not that I recall any uproar with respect to career colleges. There was no special reason to have that within that line of work, was there?

Mr. Richard Jackson: There had been historically a very small—and I know this from having worked there. Private career college oversight was done by a superintendent and two investigators. They split the province east and west from Yonge Street, and they apparently were responsible for looking after that. There had been a series of instances of, I would say, serious administrative irregularities bordering on fraud, if not fraud, across private career colleges—many students being left on the street.

Mr. Toby Barrett: Oh, yes, okay. I remember that now.

Mr. Richard Jackson: That branch has grown exponentially in response to the risk that that proposed.

Mr. Toby Barrett: So maybe there were some special reasons as with the Ornge situation.

I see the mandate, obviously, is oversight, accountability, control. But I also see that as one of several functions normally of management, certainly at the CEO level or at the chief operating officer level of senior management. I personally see that as one function—along with planning and organizing and providing leadership, I see that as a function of really anybody who's being paid to be a manager.

By having this special unit—and if this is a model, perhaps, for other ministries or other government-funded bodies—does that take the onus off managers somehow, that all this is being done over here? Has it changed or can you see it changing the role of management within the Ontario public service? Maybe you disagree. I feel control is a part of management.

Mr. Richard Jackson: When you're speaking of management, Mr. Barrett, is it management actually at the organization itself that's providing the service, using provincial—

Mr. Toby Barrett: I think I'm referring to any government department or ministry that has line managers, obviously senior-level managers, even to the level of the supervisor. To my mind, if someone is being paid as a supervisor, even a coordinator, it involves planning and some organization, perhaps maybe not strategic planning. I guess my question is, even at a—I shouldn't say "lower level"—but at a supervisory level, is it not accountability and oversight and control—even keeping an eye on how many paper clips were bought—part of their job?

Mr. Richard Jackson: I would agree with you 100% that transfer payment accountability is a responsibility of any public servant that has that role. The transfer payment accountability directive that we base our work on, and is certainly used across the OPS, articulates specifically the responsibilities of every person in the organization when it comes to accountability. I think what has happened here with Ornge is that the organization got so far off-track that there needed to be dedicated resources paying attention to what was going on because of the critical services that it provides and how badly they lost their way.

The Chair (Mr. Norm Miller): You are out of time, Mr. Barrett. There's a bit of time left, if you'd like to use it. We'll move to the NDP. You have a few minutes. Who would like to go over there? Mr. Singh.

Mr. Jagmeet Singh: Sure. I probably won't use my full time; I'll just ask a couple of quick questions. I just want to touch on an issue that came up today. Just to give you a frame of reference, we spoke with one of the directors who was dismissed. There's an article about her being dismissed, as well as one of her colleagues. The issue that came up was that both of these members of the board had asked a number of questions and were seen as unwanted because their questions were maybe too probing. Dr. Mazza, at the time, did not feel that they were appropriate to be on the board and so encouraged them to—he ostensibly fired them, but in an another way.

It got the committee thinking about the importance of proper governance to ensure that organizations have oversight internally as well as externally from the ministry. In order to have a wholesome picture of oversight, if we have boards that have members who are dedicated to overseeing the organization internally as well as the ministry or an external oversight, that would be the most robust form.

What guidelines would you recommend—clear guidelines? One of the suggestions is having a non-voting member from the ministry sit in at board meetings. I know that you're already doing that, but what other guidelines would you recommend to ensure good governance in a board of directors, perhaps outlining what mechanism or what method to select these board members and any other criteria you can think of that would establish a good board as a starting point for internal oversight?

Mr. Richard Jackson: I think a critical part of any board's role is, I would say, the ability to do their own self-evaluation in terms of reflecting upon the work that you're doing as a board and the government structures that you have in place, and looking at ways to continually improve them.

I think another tool and mechanism that is useful to have in place is a framework in which to evaluate the capacity of boards. There's a tremendous amount of responsibility placed on boards. I know, from the work that I've done previously at the Ministry of Community and Social Services and the Ministry of Children and Youth Services, one of the pieces of advice that was provided by the Auditor General at that point—because our response would be that that's the board's responsibility. Well, how do you know that the board is carrying out their responsibility? So those two ministries developed a

board self-assessment tool that was used. The program staff who were responsible for oversight would review that, identify if there were weaknesses in board governance structure, and then, if those were there, approach the board and say, "What processes are you putting in place to address those particular issues?"

The Chair (Mr. Norm Miller): Okay. We'll move on to the government. Ms. Damerla?

Ms. Dipika Damerla: Thank you. Mr. Jackson, I just wanted to continue with the line of questioning we were going with around the performance agreement. I just wanted to know: At this point, do you feel that this particular performance agreement gives you all the tools you need to protect the taxpayer?

Mr. Richard Jackson: In terms of the performance agreement, I think it, in and of itself, provides a wide range of tools. When I look at the role of oversight or regulation—and I will specifically note the legislation that's presently before the general government committee, Bill 11. To have the full toolkit of oversight and regulatory responsibilities, the ability for the Lieutenant Governor in Council to appoint a supervisor when an organization is off-track and when that organization is of such critical importance—it's not like you can just pull the plug and say, "We won't have an air ambulance program tomorrow." We do need, I think, the ability; it would not be used in any wanton fashion, but when that unique set of circumstances applies where you actually have that ability. So that would be one of the things that I would—how I'd respond to you.

Ms. Dipika Damerla: And that would come through Bill 11, and that's what you're suggesting, right?

Mr. Richard Jackson: Right. The current performance agreement doesn't allow us to appoint a supervisor.

Ms. Dipika Damerla: But if we could get Bill 11 through and enact it, then that would give you those rights to supervise, if required.

Mr. Richard Jackson: That would give the ministry and the government the authority to do that, yes.

Ms. Dipika Damerla: So what you're really saying is that it's a package deal; it's good that we have the performance agreement, but we really need to beef it up with the help of Bill 11.

Mr. Richard Jackson: I think I would suggest that that backstop be available.

Ms. Dipika Damerla: Excellent. That was going to be my next question, but you have answered it—the value of Bill 11—and I really appreciate that. I don't have any more questions, but if my colleagues have any—

Ms. Helena Jaczek: If we have just one minute: As you're probably aware, Bill 11 is modelled on the Public Hospitals Act. Do you see a parallel between the protection of patient safety in a hospital and air ambulance as you've come to know it?

Mr. Richard Jackson: I think there are very strong similarities between the public hospital system and what is actually going on in an air ambulance. We are transporting people from one hospital—sorry, not we; Ornge. Ornge is transporting someone from one hospital to another hospital, providing a high level of care. It seems like it's literally a mobile hospital moving from place to place.

Ms. Helena Jaczek: Thank you very much.

The Chair (Mr. Norm Miller): Thank you. Mr. Barrett, you had one further question?

Mr. Toby Barrett: Maybe one quick one, just maybe going back to the manager/supervisor analogy. Through your department, you have mechanisms for compliance. At the supervisory or management level—beyond, say, job performance reviews—do we have an appropriate compliance structure in place to ensure that that oversight, if it is a function of management, is being accomplished? I just ask that in general.

Mr. Richard Jackson: Yes. I'd answer it in general with—I think that process is in place. I was doing this recently, in the past few weeks. There's a process within the OPS called the "certificate of assurance" process—

Mr. Toby Barrett: Certificate of insurance?

Mr. Richard Jackson: The certificate of assurance process, which outlines in quite a level of detail the various levels of checks, balances and controls that you need to have in place, and you need to be able to attest that you actually have those mechanisms in place. So I think that tool and that mechanism does exist.

Mr. Toby Barrett: Very good.

The Chair (Mr. Norm Miller): Thank you, Mr. Jackson, and all of your team, for coming in and helping with the work of the committee today. It's appreciated.

Mr. Richard Jackson: Thank you very much. I appreciate the advice that we got from many committee members today in assisting us in doing our work going forward.

The Chair (Mr. Norm Miller): Thank you.

Committee members, next week we will be using our time doing report writing. Also, if committee members could let our Clerk know about the CCPAC meeting, that would be appreciated as well. Otherwise, we are adjourned.

The committee adjourned at 1455.

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