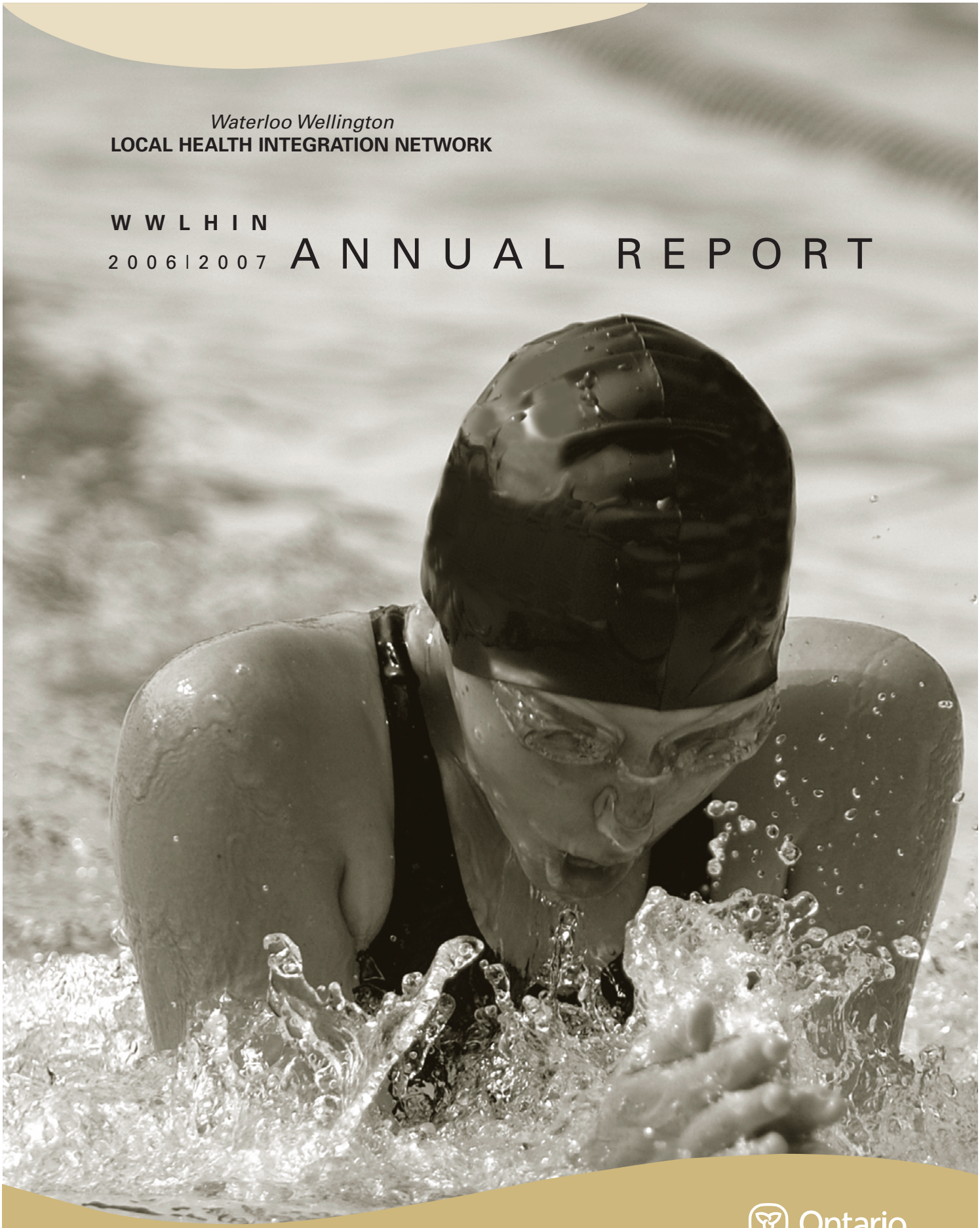
Waterloo Wellington
LOCAL HEALTH INTEGRATION NETWORK

WWLHIN 2006|2007 ANNUAL REPORT



Ontario

Waterloo Wellington
LOCAL HEALTH INTEGRATION NETWORK (WWLHIN)

INTRODUCTION

The Local Health Services Integration Act, passed in March 2006, is intended to provide an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the health system at the local level by local health integration networks (LHINs).

LHINs are responsible for planning, integrating and funding health care providers (hospitals, long-term care homes, community support services, community health centres, Community Care Access Centres and community mental health and addictions agencies) in their specific geographic areas.

Waterloo Wellington LHIN

The WWLHIN is one of 14 LHINs across the province, each with specific geographic boundaries. The WWLHIN area is home to almost 690,000 people and includes five geographic planning areas:

Urban Guelph – includes the City of Guelph, Township of Guelph/Eramosa, Township of Puslinch
Urban Waterloo and Rural Waterloo South – includes the City of Waterloo, City of Kitchener, City of Cambridge, Ayr, Roseville, Branchton
Rural Waterloo – includes Townships of Woolwich, Wellesley, Wilmot, North Dumfries
Rural South Grey and North Wellington – includes the Town of Minto, Township of Mt. Forest-Arthur-West Luther-Arthur
Rural Wellington – includes the Townships of Mapleton, Centre Wellington, Town of Erin

The Waterloo Wellington LHIN area is a rural and urban mix. The area is experiencing rapid growth with families moving in. There are a high percentage of people who are aging. Residents benefit from a broad range of health services available in the community, as well as access to more services just a short drive away. Waterloo Wellington is a prosperous area and, relative to the rest of the province, has a higher proportion of the population who say their health is excellent or very good.

2006|2007 ANNUAL REPORT

Waterloo Wellington

LOCAL HEALTH INTEGRATION NETWORK (WWLHIN)

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"The past year has been outstanding thanks to the interest, participation and support we have received from individuals and health service providers in our work toward improving our community's health care system."

Sandra Hanmer, WWLHIN CEO

Ontario

ABOUT OUR WWLHIN

MANDATE

Health care services in Ontario are fragmented and many health care providers work, plan and deliver care in isolation. Patients and their loved ones must make their way through a complex health system as they move from one health service provider to another.

Local Health Integration Networks have been created to change that through legislation that will change the way our health care system is managed.

The WWLHIN does not directly provide services. The government has given the WWLHIN the mandate for planning, coordinating, integrating and funding health services at the local level and to create a system that is sustainable.

The WWLHIN has been specifically mandated to engage people and providers in our community about their needs and priorities – an unprecedented opportunity for community input into health care planning. The goal is to ensure our system reflects our community; what we have, what we need, what works for us, what does not. Together we will develop a health system that responds to our community's needs and priorities, does not cost more than it has to, and that is realistic and do-able.

VISION

A health care system that will keep Ontarians healthy, will get them good care when they are sick and will be there for their children and grandchildren.

MISSION

Inspiring people to improve quality of life now and in the future through collaborative relations and health system integration.

VALUES

Community – demonstrated by respect, engagement and focus on people

Integrity – demonstrated by sound decision-making processes and honesty

Innovation – demonstrated by creativity, future focus and change

Accountability – demonstrated by follow-through, evidence-based outcomes and transparency

"I find the commitment of people in this area to the values that the WWLHIN has established is energizing and gives me confidence that we will see continuing improvement in people-centered health care in this area." Bill Blackie, Director, WWLHIN Board

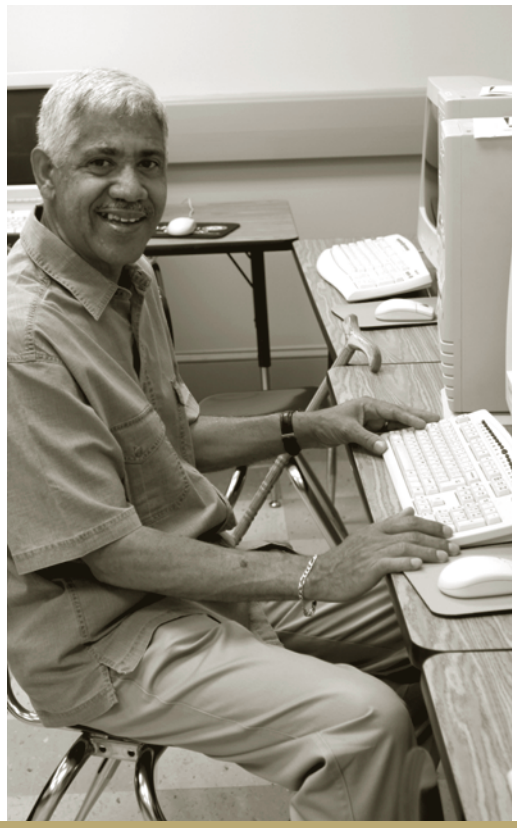
MEMORANDUM OF UNDERSTANDING

The relationship between the WWLHIN and the Ministry of Health and Long-Term Care is described by a Memorandum of Understanding (MOU), the purpose of which is to clarify the relationship between the Minister and the WWLHIN. The Minister and the WWLHIN act according to the responsibilities set out for each in the MOU. In addition, the WWLHIN is subject to, and complies with, the legislation, policies, guidelines and directives identified in Schedule A to the MOU.

ACCOUNTABILITY AGREEMENT

In addition to the Memorandum of Understanding, the WWLHIN is subject to an Accountability Agreement. This document includes performance goals and objectives, performance standards, targets and measures, and a plan for spending the money the WWLHIN receives.

During the period April 2006 – March 2007, the WWLHIN and the ministry signed the Memorandum of Understanding and Accountability Agreement in preparation for April 1, 2007 when the WWLHIN assumed full responsibility for planning, coordinating, integrating and funding health services.



KNOWLEDGE TRANSFER

Also in preparation for April 1, 2007, the Ministry of Health and Long-Term Care regional offices ceased to function on March 31, 2007.

Regional office staff worked closely with the WWLHIN for more than a year transferring critical knowledge and ensuring that the WWLHIN is equipped to assume its new role. We thank everyone at the regional office for their efforts.

The regional office staff developed, designed and populated a template to provide information on every health care provider agency in our area including service agreements, funding letters and necessary correspondence. These documents provide both current information and two years of history for reference and decision-making.

BOARD CHAIR AND CEO REPORT

Kathy Durst, *Chair*

Sandra Hanmer, *CEO*

It has been a ground-breaking year for the WWLHIN as we began to make local health care history.

We started the year with a small staff and board. Over the year our numbers increased to a full contingent of nine board members and 21 staff. Collectively these individuals have committed their skills, education, and energy to turning what is a good local health care system into a great one. We recognize and thank them for their impressive efforts on behalf of our community.

The consultative or 'community engagement' activities that we began in our first year (2005-06) continued in 2006-07 as we worked toward identifying the priorities our residents have for their health system. Our community's voice was very focused; very clear. We want a health system that is accessible, affordable, effective, promotes healthy lifestyles, meets our needs now and is an investment for our future. We want to 'live and live well in Waterloo Wellington!'

The information we collected and analyzed led to the creation of the Integrated Health Service Plan (IHSP). The IHSP outlines the directions we must take to achieve the health system we want.

Community engagement and the development of the IHSP were two of the WWLHIN's accomplishments in the past year. Other performance goals included fulfilling governance objectives, addressing local health system performance - especially looking at wait times, and establishing funding and allocation processes. We are pleased to report that all our 2006-2007 performance goals were accomplished. Details are included throughout this annual report.

A highlight of the year was the Collaborative Governance Workshop. This initiative brought the board chairs from health service provider agencies together for an open and new discussion. Participants were challenged to shift from 'institutional think' to 'system think'. We are looking forward to our second workshop in May, 2007 as these discussions progress.

We continue to invite participation in the WWLHIN through community engagement activities as well as the creation of specific-focus committees. In the past year, we welcomed individuals to our various Community of Interest planning groups, our Community Council, and our Wait Times Steering Committee and five wait times working groups.

We are looking forward to assuming full responsibility for planning, coordinating, integrating and funding local health services. We will be responsible for a $787,438,400 budget covering services provided by hospitals, long-term care homes, Community Care Access Centres, community support service agencies, mental health and addiction agencies and community health centres. We appreciate and thank the staff at the regional office for the smooth transfer of information to enable a seamless transition.

Thanks to our community's involvement, the past year has set the direction for our activities in the future. We look forward to the health service accomplishments that we will share.

Kathy Durst, *Chair*

Sandra Hanmer, *CEO*

BOARD OF DIRECTORS

Kathy Durst, appointed Chair effective June 2005 for a 3-year term.

Bill Blackie, appointed Director effective January 2006 for a thirteen-month term. Bill has been re-appointed for an additional 3-year term.

Mary D'Alton, appointed Director effective May 2006 for a 1-year term. Mary has been re-appointed for an additional 3-year term. Mary is Chair of the Governance Committee.

Paul Truex, appointed Director and designated Vice-chair effective June 2005 for a 3-year term.

Bruce Schieck, appointed Director effective January 2006 for a 2-year term.

Glenna Heggie, appointed Director effective May 2006 for a 2-year term.

Paul Holyoke, appointed Director and designated Secretary effective June 2005 for a 3-year term.

Ken Whyte, appointed Director effective May 2006 for a one-year term. Ken has been re-appointed for an additional 3-year term.

Don Ross, appointed Director effective June 2006 for a 2-year term. Don is Chair of the Finance and Audit Committee.

GOVERNANCE

The WWLHIN, a not-for-profit organization, is governed by a board of nine directors selected by the Lieutenant Governor in Council and appointed through Order in Council. The board is bound by agreements with the Ministry of Health and Long-Term Care, is responsible for the management and control of the affairs of the WWLHIN and is the key point of interaction with the ministry.

The board is skills based, drawing on individuals with a variety of experiences and expertise. The WWLHIN has adopted a model of governance that embraces generative thinking and collaboration. In the generative thinking model the board brings diverse individual and community perspectives and provides an environment where new ideas and solutions are generated. Board members are required to come prepared, participate and work diligently as a group, deal transparently with complex and sometimes controversial issues and to be constantly engaging the community in an ongoing conversation.

The second principle of our governance model is a collaborative approach to governing bodies of health service organizations. This approach is based on a mutual understanding of health care issues, open communication, and an acceptance of the distinct stewardship mandates of both the WWLHIN and the health service provider boards. It ensures full engagement by all in the development of an integrated health service plan and provides support for new governance relationships and partnerships.

WWLHIN board meetings are open to the public and take place at locations throughout the Waterloo Wellington area. Our website www.wwlhin.on.ca provides a schedule of meeting dates and locations as well as the agenda and minutes of board meetings.

During the 2006-2007 fiscal year, the Board of Directors established two standing committees: Governance and Finance and Audit.

The Governance Committee, chaired by Mary D'Alton, has the responsibility for establishing, monitoring and evaluating board development and processes, and the recruitment of new board and board committee members.

The Governance Committee created a Community Nominations sub-committee that is responsible for carrying out a process to choose and recommend up to six board member nominees to the board. Also during this time, the Governance Committee developed a governance manual, the policies and procedures of which are being reviewed by the board.

The Governance Committee also reviewed and selected a board assessment tool that was developed in conjunction with the Joseph L. Rotman School of Management, University of Toronto and has been accepted by all 14 LHINs. The committee will take responsibility for implementing the tool, evaluating the results and developing action plans to address any issues identified.

The Finance and Audit Committee, chaired by Don Ross, held its inaugural meeting in September 2006. The committee has the responsibility to oversee the financial health of the WWLHIN corporation by ensuring that appropriate controls and accountabilities exist with respect to finance and areas of material risk. The 2006-07 audit results and the 2007-08 operating budget were reviewed with this committee prior to submission to the Board of Directors.

A highlight of the past year was the Collaborative Governance Workshop, hosted by WWLHIN board chair, Kathy Durst, and attended by all WWLHIN board members. The workshop brought together the chairs of boards of health service provider organizations in a first dialogue about system-wide collaboration. Building on the shared information and positive results from this workshop, a second workshop is planned for May 2007.

The Board of Directors recognizes the importance of thorough orientation and ongoing professional development for members. A formal orientation program has been developed and implemented that includes an orientation manual, participation in the provincial orientation program for board directors, and a series of meetings with the chair and CEO to review WWLHIN specific issues. Consideration is being given to the creation of mentors for new board members.

GOVERNANCE cont'd

Board members are encouraged to participate in internal and external education opportunities. Conference and course information are made available to board members and after attendance at these learning opportunities, information is shared with the rest of the board.

In October 2006 the WWLHIN Board of Directors approved conflict of interest policies. The purpose of the Conflict of Interest Policy is to maintain and enhance public confidence and trust in the WWLHIN. It promotes a standard of conduct that will establish the integrity, objectivity, and impartiality of the affairs and decision-making processes of the Local Health Integration Networks. It enables the Minister, the LHIN and its directors to recognize and to avoid, mitigate or manage conflict of interest situations and to ensure that all real, perceived or potential situations are resolved in the public interest.

All board members have met with a Conflict of Interest Commissioner and the WWLHIN has been provided with the following statement:

"All board members of the Waterloo Wellington Local Health Integration Network met with a Conflict of Interest Commissioner in 2006/07 and completed their declarations. The Conflict of Interest Commissioners provided advice in accordance with the LHIN Conflict of Interest Policy."

"We have a board that has a genuine desire to understand our community's needs. They want to be challenged to live out our mission and to deal with hard issues. I deeply appreciate their contributions."

Kathy Durst, Chair, WWLHIN Board

OUR WWLHIN STAFF

For most of the 2006-07 fiscal year we functioned with just five full-time staff and two temporary staff. By the end of the year our staff contingent grew to 21. We are very proud of the highly qualified, dedicated staff that works for the WWLHIN and our community.

The WWLHIN Executive Office team includes:

Sandra Hanmer, Chief Executive Officer
Sue Southwell, Executive Assistant
Kate Borthwick, Administrative Assistant
Owen C. D'Souza, Controller
Staci Bartlett, Business Support Manager
Annette Holman, Receptionist

Our Planning, Integration and Community Engagement team includes:

Donnamarie Dunk, Senior Director
Shelagh Balfoort, Administrative Assistant
Maria van Dyk, Senior Integration Consultant
Blair Philippi, Integration Consultant
Kim Hodgson, Senior Community Engagement Consultant
Gillian Woolner, Community Engagement Consultant
Stephanie Cerutti, Planning Consultant
Sonal Garach, Program Assistant

For Performance, Contracts and Allocations our team includes:

Bruce Lauckner, Senior Director
Kristy Kerr, Administrative Assistant
Stewart Sutley, Senior Funding and Allocations Consultant
Joanne Hader, Senior Performance and Contracts Management Consultant
Rebecca Webb, Performance and Contracts Management Consultant
Tim Lewis, Funding and Allocations Consultant
Alanna Gillis, Program Assistant

MEETING OUR PERFORMANCE GOALS

Performance Goals

The WWLHIN signs an Accountability Agreement with the Ministry of Health and Long-Term Care (MOHLTC) that sets out the mutual understanding between the MOHLTC and the WWLHIN and performance obligations for the period.

The WWLHIN's performance obligations in the 2006-07 fiscal year fall into five categories: Community Engagement, Integrated Health Service Plan, Corporate Governance, Local Health System Performance, and Funding and Allocation.

As of March 31, 2007, the WWLHIN had met all its performance obligations as outlined in the Accountability Agreement, 2006-2007.

Community Engagement

Essential to the WWLHIN was the development of a community engagement strategy and plan that would guide our ongoing activities. In the past year we carried out extensive community engagement activities (described in more detail on page 11.) Our community engagement strategy anchors our goal of ensuring that everyone who wants to have a voice about our local health system has the opportunity to be heard.

To ensure that we were on the right track, the WWLHIN collaborated with the other 13 LHINs in an externally-led evaluation of the effectiveness of our community engagement activities. A report was submitted to the Ministry in January and met the requirements for reporting on the effectiveness of our strategy.

Integrated Health Service Plan

One of our performance goals in 2006-07 was the development of an Integrated Health Service Plan (IHSP) based on an

environmental scan of our local area, identifying and analyzing local issues and priorities, and describing our readiness to take action in the priority areas.

We developed and released the Integrated Health Service Plan (IHSP) to the public and the Ministry of Health and Long-Term Care in December, 2006. More information about the plan can be found on page 12 of this annual report.

Corporate Governance

Included in the Accountability Agreement are performance requirements for corporate governance.

The WWLHIN Board of Directors, chaired by Kathy Durst, achieved all the goals set out in the Accountability Agreement including: establishing and developing a governance model; collaborating with other LHINs to create and adopt a board effectiveness and assessment tool; implementing an orientation and professional development program; and implementing Phase I and II of the MOHLTC-approved Conflict of Interest Policy for LHIN board members. For more information about the board's activities, please see page 5.

Local Health System Performance

The WWLHIN works closely with health service providers in our community and has reported progress about focus areas to the MOHLTC on a quarterly basis as required. These reports include actions agreed to be taken by the WWLHIN and by health service providers to improve system performance.

The areas of focus include: wait times — specifically for cancer surgery, cardiac care, cataract surgery, hip and knee replacement, and MRI/CT; long-term care; quality of care; alternate level of care; readmission rates for acute myocardial infarction; surgical throughput; and critical care capacity development. More information about our local health system performance can be found on page 15.

Funding and Allocation

We exhibited prudent fiscal management by balancing our 2006-07 operating budget (please see our Financial Statements on page 17). We also participated with the MOHLTC in the development of an Annual Service Plan for 2007-08, new allocation and funding models, and the Results-based Plan (RbP) for 2007-08 for operating budgets. We provided the MOHLTC with all financial and annual reports as required.

"I've been impressed with the collaborative efforts already underway among health care providers in our area."

Paul Truex, Vice-chair, WWLHIN Board

COMMITMENT TO COMMUNITY INVOLVEMENT

Community Engagement

The WWLHIN is committed to hearing what the community has to say about health care.

In the past year, we invested a great deal of time listening to residents and health service providers share their concerns and ideas for improving the health system. This 'community engagement' is part of the WWLHIN's systematic approach to ensurng that everyone's voice is heard, and continues to be heard, throughout all our activities.

WWLHIN's community engagement activities began with the development of a community engagement framework that identified three strategic approaches: a communication strategy that includes both inbound and outbound information exchange; a knowledge and decision-making strategy involving the development of Community of Interest groups; and a maintenance strategy that involves both a feedback and a best practice component.

We sought the community's perspective on four key areas – accessibility, ease of use, quality of care and involvement in health care decision making. Respondents were also asked to identify practical changes that they believed would improve the health system.

We met with hundreds of individuals and organizations at town hall sessions, held focus groups, made site visits, gathered information through surveys, met with special interest groups, and invited the community to open board meetings and our first anniversary open house. In addition, we carried out an extensive analysis of relevant data including changing demographics, advances in science, economic shifts, the state of our health care industry, political strategies and technological innovations.

Analysis of the information gathered from the various data collection activities and our community consultations revealed a number of common themes about how health services are perceived

and experienced by residents of the WWLHIN area. Issues with respect to accessibility were identified by all population groups, as were issues related to creating a better understanding and coordination of the system.

The findings were discussed at a symposium "Champions of Change" held in September and attended by 250 participants. As well, six validation forums were held in October throughout our geographic area. The findings that would form the basis of the Integrated Health Service Plan were confirmed.

The Integrated Health Service Plan (IHSP)

Based on the information collected from our community about health care needs, as well as extensive data analysis, we developed the Integrated Health Service Plan (IHSP) 2007-2010, a three-year strategic plan for health care services and delivery for the Waterloo Wellington LHIN area.

The IHSP reflects needs identified through community consultation, determines specific areas and actions, is guided by the provincial vision and directions, and has a focus on health system collaboration, coordination and integration.

To ensure the plan remains relevant and continues to reflect the needs of our community, the IHSP will be reviewed and revised annually as we continue to gather input from individuals and organizations.

The Integrated Health Service Plan identified four priorities for our local health system reflecting our community's observations, priorities and ideas for our health system.

The priorities are a health system that:

Improves access to services and reduces wait times, including

- Access to appropriate services
- Timeliness of service delivery
- Availability of appropriate services

Promotes healthy lifestyles and prevents illness, including

- Promoting healthy living choices
- Facilitating coordinated preventative care and services
- Increasing capacity of programs that enhance an individual's health

Is effective and affordable, including

- Best practices for operational process and clinical practice
- User friendliness of the system
- Coordination and integration of services and programs

Meets our needs now and in the future, including

- Enhancing system performance management and funding models
- Increasing health human resources
- Building an information and technology foundation
- Building partnerships and alliances

The IHSP was released in December 2006. To review the IHSP please visit our web site at www.wwlhin.on.ca or contact the office for a brochure.

To ensure the widest possible communication of the plan, a strategy was implemented that includes: the distribution of the complete document to health service providers; a shorter version of the IHSP, in brochure form, for the public and other related professionals; publication on our

web site; electronic distribution to a wide network of interested parties; articles in our newsletters; presentations to area groups; distribution at board meetings and in general information packages. The communication activities to support the IHSP are on-going.

The development and release of the IHSP was anchored in our community engagement strategy that defined five levels of engagement: inform and educate, involve, empower, advise and collaborate. Most of the activities related to developing the IHSP were associated with the first two levels of the framework.

Recognizing the need to continue to engage our communities we developed a framework for implementing the IHSP that would include the last three levels of engagement – empower, advise and collaborate. The implementation strategies include the development of a Community Council and Community of Interest (COI) roundtables.

Community Council

The Community Council, chaired by Paul Holyoke, is comprised of 15 individuals with wide community contacts and in-depth knowledge of the communities in the WWLHIN area. The council will provide the WWLHIN with high-level input and feedback about issues and needs within the health system.

Communities of Interest (COI)

Community of Interest planning groups represent many perspectives and back-grounds and will focus on the IHSP priorities and address improving how services in the system are coordinated and integrated and the effectiveness of care available. Through the COI groups health issues in the WWLHIN area will be identified and addressed now and in the future.

COI groups are charged with being very focused and specific in their work; an example is the tasks being addressed by the Aboriginal Health Council.

Between 16,000 and 20,000 Aboriginal people live in the WWLHIN area. Many Aboriginal people receive health care from mainstream health providers but an unidentified number may be accessing Aboriginal health services outside of this area.

The Aboriginal Health Council has been formed to address the specific issues faced by Aboriginal people living in WWLHIN. This council will examine how best to meet the health needs of this specific population, taking into account the complex interaction of cultural, social and economic factors.

Another example of our focused approach was the development of the Health Human Resources Council. During our information seeking sessions both the public and health care provider agencies identified health human resources needs.

The WWLHIN hosted a Health Human Resources Think Tank to bring together local health service providers, industry and education representatives and experts in health human resources with the goal of developing a vision and strategy to address our area's health human resources needs. Recommendations for members for the Heath Human Relations Council were made and the council has held its initial meeting.

Other Community of Interest planning groups have been launched and will bring the same high level of project-oriented focus to these areas:

- Chronic Disease Prevention and Management • E-health
- Emergency Services • Wait Times
- Critical Care • Services for Seniors
- Healthy Lifestyles/Disease Prevention and Health Promotion
- Primary Care • System Navigation
- Mental Health and Addictions
- Rural Health • French Language

Memberships to these Community of Interest roundtables continue to be accepted. A copy of the Terms of Reference and Expression of Interest for each Community of Interest is available on our web site at www.wwlhin.on.ca.

Additional COIs will be established in the near future. These include:

- Supportive Housing
- Rehabilitative Care • Respite Care
- Palliative and End of Life Care
- Children and Youth
- Vulnerable Populations
- Seniors • Multicultural

The IHSP demonstrates our commitment to developing local solutions for local issues through the involvement of our local community.

"I love talking to people about our mission and seeing them become excited about the amazing potential we have in creating a local health system that works for our unique community's needs."

Ken Whyte, Director, WWLHIN Board

LOCAL HEALTH SYSTEM PERFORMANCE

Areas of Performance

Together with health service providers and individuals with specific expertise, we addressed seven areas of local health system performance: wait times, time to long-term care placement, perception of quality of care, percentage of Alternate Level of Care (ALC) days, readmission rate for acute myocardial infarction, improvements in surgical throughput, and critical care capacity development.

Wait Times

We created a Wait Times Steering Committee followed by Wait Times Working Groups to address five priority areas: cancer surgery, cardiac care, cataract surgery, joint replacement (hip and knee) and MRI/CT. The steering committee and working groups are represented by individuals from a broad range of perspectives across the health sector.

The steering committee and working groups met over the past year and began work on their specific areas of focus, looking at capacity, quality and efficiencies.

Through the collaborative work of the steering committee, working groups and many front-line health professionals, wait times in Waterloo Wellington decreased significantly in most areas. Also, Waterloo Wellington continues to be better than the overall provincial targets in most areas.

Surgical wait times are defined as the time between when a surgery is ordered and when it is performed. MRI and CT wait times are defined as the time between when a diagnostic scan is ordered and when it is completed.

Procedure	Overall Provincial Target In Days (90th Percentile)	April/May 2006 WWLHIN Wait Time In Days	Feb/March 2007 WWLHIN Wait Time In Days	% Change During Year
Cancer Surgery	84	62	66	6.45
Angiography	-	37	26	-29.73
Angioplasty	-	20	6	-70.00
Bypass Surgery	182	46	29	-36.96
Cataract	182	250	131	-47.60
Hip Replacement	182	393	251	-36.13
Knee Replacement	182	493	283	-42.60
MRI	28	71	212	198.59
CT	28	28	40	42.86

Long Term Care Placement

The WWLHIN at 23 days for placement in a long-term care home from an acute setting
is performing better than the provincial average of 34 days for placement. However, the wait time from a community setting is 243 days, above the provincial average of 71 days.

The WWLHIN is taking steps to address the time to placement from the community. Firstly, 288 new long-term care beds were funded in 2006-07. Secondly, the WWLHIN has created a Community of Interest planning table to address issues related to seniors' access to services including the length of wait to long-term care placement.

Perception of Quality of Care

A Primary Care Access Survey indicates that in the third quarter of 2006-07, 58% of the population in WWLHIN rated the quality of health care provided in Ontario to be the same or improved over the last five years.

Alternative Level of Care Days (ALC)

Throughout 2006-07, the Central West Regional Office of the MOHLTC worked closely with our hospitals and the Community Care Access Centre (CCAC) on issues related to Alternative Level of Care Days (for patients who no longer need acute hospital care but instead need long-term or community-based care). Two of the factors affecting ALC in our area are the limited number of appropriate beds in long-term care facilities and the stretched capacity of community support services.

ALC will continue to be addressed in the future through work with the hospitals, CCAC, community support services and the Community of Interest that is looking at seniors' issues.

Acute Myocardial Infarction (AMI)

Throughout 2006-07, the acute myocardial infarction rate of 3.30 in the WWLHIN remained one of the lowest in the province amongst LHINs and under the provincial average of 4.48. Although rates remain low, the Cardiac Care Working Group
continues to investigate potential improvements to sustain or further reduce this rate.

Improvements in Surgical Throughput

Through Phase 1 of the Surgical Efficiency Targets Program, WWLHIN hospitals implemented the Operating Room Benchmark Collaborative. Key performance indicators will be collected in 2007 and hospitals will work with surgical consultants to identify areas for improvement.

Critical Care Capacity Development

Critical care leads from WWLHIN hospitals have been working on increasing critical care capacity. In 2006-07, the WWLHIN made progress in improving the delivery of critical care including: the implementation of two additional ICU beds to handle increased demand; funding for new mechanical ventilation technology for patients who are not able to be cared for safely on conventional breathing machines; and piloting a critical care information system that provides real

Approved by

Kathy Durst Chair

Paul Holyoke, Secretary

Deloitte.

Auditors' Report

To the Members of the Board of Directors of the Waterloo Wellington Local Health Integration Network

We have audited the statement of financial position of Waterloo Wellington Local Health Integration Network (the "LHIN") as at March 31, 2007 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of Waterloo Wellington Local Health Integration Network as at March 31, 2007 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants

Toronto, Ontario
May 4, 2007

STATEMENT OF FINANCIAL POSITION

MARCH 31, 2007

		2007	2006
		(Notes 3, 14)	
FINANCIAL ASSETS			
Cash		**$ 596,543**	$ 26,178
		596,543	26,178
LIABILITIES			
Accounts payable and accrued liabilities (Note 4)		**502,198**	—
Due to the Ministry of Health and Long-Term Care ("MOHLTC")		**21,460**	26,178
Due to the LHIN Shared Services Office (Note 5)		**72,885**	—
Deferred capital contributions (Note 6)		**418,535**	480,855
	507,033	**1,015,078**	
NET DEBT	(480,855)	**(418,535)**	
NON-FINANCIAL ASSETS			
Capital assets (Note 7)		**418,535**	480,855
ACCUMULATED SURPLUS		**$ —**	$ —

APPROVED BY THE BOARD

Kathy Durst, Chair

Paul Holyoke, Board Secretary

STATEMENT OF FINANCIAL ACTIVITIES

Year Ended MARCH 31, 2007

	2007		2006
	Budget (unaudited) (Note 8)	**Actual**	Actual (Notes 3, 14)
REVENUE			
MOHLTC funding	**$ 3,026,713**	**$ 2,949,722**	$ 233,597
E-Health funding (Note 11)	**181,000**	**181,000**	—
Amortization of deferred capital contributions (Note 6)	**—**	**132,725**	120,214
	3,207,713	**3,263,447**	353,811
EXPENSES			
General and administrative (Note 9)	**3,026,713**	**3,075,867**	327,633
E-Health (Note 11)	**181,000**	**166,120**	—
	3,207,713	**3,241,987**	327,633
ANNUAL SURPLUS BEFORE FUNDING REPAYABLE TO THE MOHLTC	**—**	**21,460**	26,178
FUNDING REPAYABLE TO THE MOHLTC	**—**	**(21,460)**	(26,178)
ANNUAL SURPLUS	**—**	**—**	—
OPENING ACCUMULATED SURPLUS	**—**	**—**	—
CLOSING ACCUMULATED SURPLUS	$ —	$ —	$ —

STATEMENT OF CHANGES IN NET DEBT

Year Ended MARCH 31, 2007

	2007	2006
		(Notes 3, 14)
ANNUAL SURPLUS	**$ —**	$ —
ACQUISITION OF TANGIBLE CAPITAL ASSETS	**(70,405)**	(601,069)
AMORTIZATION OF TANGIBLE CAPITAL ASSETS	**132,725**	120,214
DECREASE (INCREASE) IN NET DEBT	**62,320**	(480,855)
OPENING NET DEBT	**(480,855)**	—
CLOSING NET DEBT	**$ (418,535)**	$ (480,855)

STATEMENT OF CASH FLOWS

Year Ended MARCH 31, 2007

	2007	2006 (Notes 3, 14)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
OPERATING		
Annual surplus	**$ —**	$ —
Add items not affecting cash:		
Amortization of capital assets	**132,725**	120,214
Amortization of deferred capital contributions (Note 6)	**(132,725)**	(120,214)
	—	—
USES		
Decrease in due to MOHLTC	**(4,718)**	—
	(4,718)	—
SOURCES		
Increase in accounts payable and accrued liabilities	**502,198**	—
Increase in due to MOHLTC	**—**	26,178
Increase in due to LHIN Shared Services Office	**72,885**	—
	575,083	26,178
	570,365	26,178
INVESTING TRANSACTIONS		
Acquisition of capital assets	**(70,405)**	(601,069)
FINANCING TRANSACTIONS		
Increase in deferred capital contributions (Note 6)	**70,405**	601,069
NET INCREASE IN CASH	**570,365**	26,178
CASH, BEGINNING OF YEAR	**26,178**	—
CASH, END OF YEAR	**$ 596,543**	$ 26,178

1. DESCRIPTION OF BUSINESS

Formation and status

The Waterloo Wellington Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Waterloo Wellington Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC").

The LHIN has also entered into an annual Accountability Agreement for the fiscal year 2007 with the Ministry of Health and Long Term Care which describes the responsibilities of the LHIN and the performance standards that are required to be maintained and achieved in order to obtain funding from the Province.

As of April 1, 2007, funding payments to providers will flow through the LHIN's financial statements. These transfer payments will be reflected as revenue and expenses in the LHIN's financial statements for the year ended March 31, 2008 and thereafter.

LHIN operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN includes all of the County of Wellington, the Region of Waterloo, and the City of Guelph. This LHIN also contains part of Grey County, which is split with the South West and the North Simcoe Muskoka LHINs.

2. SIGNIFICANT ACCOUNTING POLICIES

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items such as the amortization of tangible capital assets and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Deferred contributions

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

2. SIGNIFICANT ACCOUNTING POLICIES con't

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. This amortization revenue is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment, furniture and fixtures	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. ADOPTION OF PUBLIC SECTOR ACCOUNTING RECOMMENDATIONS

At the direction of the MOHLTC, commencing in 2007, the LHIN has adopted generally accepted accounting principles, applying government accounting standards issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The comparative figures included in these financial statements have been restated to conform with the accounting standards adopted for the current year.

As a result of this change, during the year the LHIN obtained the fair market value for the donated tangible capital assets received in the prior fiscal period and chose to reflect this more meaningful valuation in the financial statements. This change has been applied retroactively and the prior period has been restated resulting in an increase in deferred capital contributions, net debt and capital assets of $480,855 on the statement of financial position. On the statement of financial activities amortization of deferred capital contributions increased by $120,214 as did general and administrative expenses. On the statement of changes in net debt acquisition of tangible capital assets increased by $601,069, amortization of tangible capital assets increased by $120,214 and closing net debt increased by $480,855.

4. PRIOR PERIOD ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities totaling $195,456 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 9 related to the prior period.

5. RELATED PARTY TRANSACTIONS

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all the LHINs. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

6. DEFERRED CAPITAL CONTRIBUTIONS

	2007	2006
Balance, beginning of year	**$ 480,855**	$ —
Capital contributions received during the year	**70,405**	601,069
Amortization for the year	**(132,725)**	(120,214)
Balance, end of year	**$ 418,535**	$ 480,855

7. CAPITAL ASSETS

			2007	2006
	Cost	**Accumulated Amortization**	**Net Book Value**	Net Book Value
Office equipment, furniture and fixtures	**$ 89,476**	**$ 31,789**	**$ 57,687**	$ 55,577
Computer equipment	**14,079**	**4,646**	**9,433**	—
Web development	**17,000**	**—**	**17,000**	—
Leasehold improvements	**550,920**	**216,505**	**334,415**	425,278
	$ 671,475	**$ 252,940**	**$ 418,535**	$ 480,855

8. BUDGET FIGURES

The total operating budget of $3,026,713 has been approved by the MOHLTC. The figures are unaudited and have been reported for the purposes of these statements to comply with PSAB reporting principles. E-Health funding was received as described in Note 11.

9. GENERAL AND ADMINISTRATIVE EXPENSES

For the period ended March 31, 2006, certain operating expenses, other than those disclosed on the Statement of Financial Activities, were approved and paid for on behalf of the LHIN by the MOHLTC. These amounts were not included with the LHIN's financial activities and are disclosed below for information purposes. These expenses are as follows:

Salaries and benefits	$ 94,358
Accommodation/occupancy	1,231,217
Common services	42,126
Information technology	95,733
Other expenditures	211,124
	$ 1,674,558

For the first three months of fiscal 2007, all financial information was processed by the MOHLTC on behalf of the LHIN. Unlike 2006, these amounts are considered expenses of the LHIN directly and are included as part of the financial activities of the LHIN and included in the Statement of Financial Activities.

Subsequent to the prior year's fiscal close, additional amounts totaling $31,869 of prior period expenses were noted as not having been accrued and are included in the current year expenses, due to differences in cut-off reporting by the MOHLTC. For the year ended March 31, 2007, these amounts were included in the Statement of Financial Activities of the LHIN.

9. GENERAL AND ADMINISTRATIVE EXPENSES con't

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2007	2006
Salaries and benefits	**$ 1,359,281**	$ 203,181
Occupancy	**235,554**	—
Amortization	**132,725**	120,214
Shared services	**290,190**	—
Public relations	**110,506**	—
Consulting services	**377,540**	—
Supplies	**156,294**	2,547
Board member expenses	**166,299**	—
Mail, courier and telecommunications	**54,529**	1,070
Other	**192,949**	621
	$ 3,075,867	$ 327,633

10. PENSION AGREEMENTS

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 21 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2007 was $91,807 (2006 - $20,420) for current service costs and is included as an expense in the Statement of Financial Activities.

11. E-HEALTH

During fiscal 2007, the Waterloo Wellington LHIN received funding in the amount of $181,000 from the MOHLTC. These funds were used toward initiatives in support of its strategic E-Health Plan as defined in its Integrated Health Services Plan.

12. GUARANTEES

The LHIN is subject to the provision of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the Financial Administration Act.

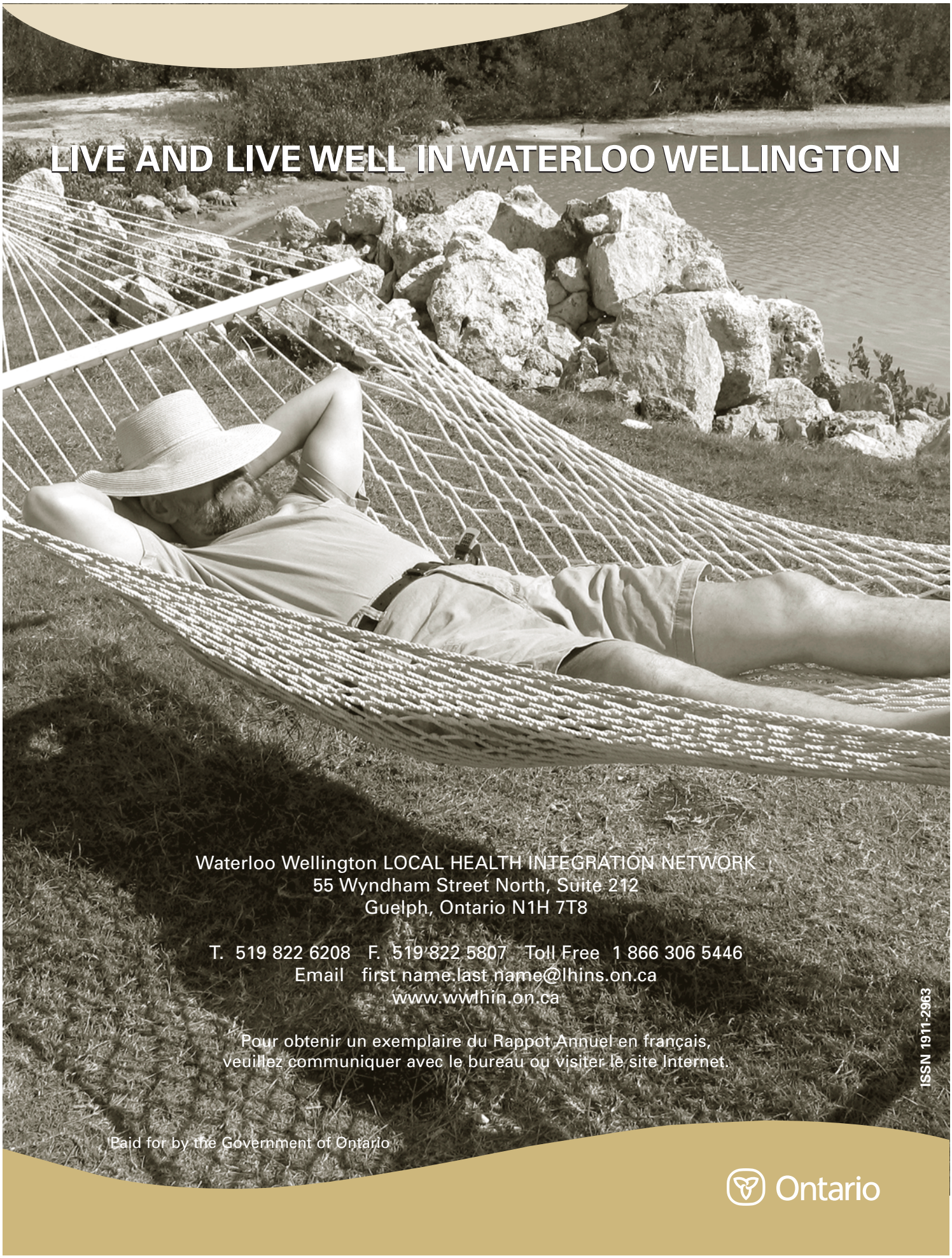
13. COMMITMENTS

The LHIN has commitments under various operating leases, including those for building and equipment. Minimum lease payments due in each of the next five years and thereafter are as follows:

2008	$ 209,656
2009	212,061
2010	212,061
2011	203,841
2012 and thereafter	203,007
	$ 1,040,626

14. COMPARATIVE FIGURES

The prior period figures are from the date of incorporation, June 2, 2005 to March 31, 2006. The comparative figures have been reclassified to conform to the current year's presentation. During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting. Presentation changes are a result of the change in presentation format to comply with PSAB.



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