STRATEGIC ANALYSIS OF CANCER CARE ONTARIO'S

Mission, Vision and Values

Completed by:
Charmaine Chui
Alex Drossos
Evan Ferlejowski
Navleen Ghuman
Anthony Van't Spyker

Executive Summary

Cancer Care Ontario (CCO) is responsible for reducing the effects of cancer and ensuring that Ontarians receive high-quality cancer treatment and services. To achieve its goals, CCO is creating a better-coordinated system by improving communication among those who provide cancer services to patients and developing new programs and guidelines in areas such as cancer prevention, supportive care, screening, and education. CCO is responsible for long-term planning of the cancer care system and ensures that patients across the province receive the same high quality of care, regardless of location.

Recently the need for change within CCO was identified. In December 2001, the final report of the Cancer Services Implementation Committee indicated that there were long wait times, and, although the quality of care was above standard, diagnostic and therapeutic services were discontinuous and fragmented, causing patients difficulty. As a result Cancer Care Ontario's new CEO, Dr. Hudson, set priorities to carry out many of the recommendations of this report. The four areas of concentration for his objectives include Cancer Services Integration, Quality Delivery, Surgical Oncology, and Information Management. These contrast the previous CCO strategic goals of System Management, Service Delivery, Improved Outcomes, Prevention and Screening, and Education. Dr. Hudson has directed the "new" CCO to be partnership-oriented by supporting regional facilities in servicing patients and families and advocating for and acting as the adviser on provincial cancer information, research and care practices.

To elucidate the level of knowledge and acceptance within the organization of the current vision statement, an employee survey and interviews of senior management were conducted. Generally, there appears to be a lack of awareness about the vision, but despite the lack of knowledge, employees seemed satisfied with and strongly committed to the vision statement. From interviews with senior management there was strong agreement that the current vision is quite inadequate when considering CCO's new focus, as the statement is "inaccessible, not memorable and bureaucratic." A new vision statement is currently in development to match the new objectives of CCO.

Therefore, as CCO transitions to focus on its strength (information management) and position itself to benefit from opportunities, an effective and well-communicated vision, mission, and values will be an invaluable tool to align its investors, customers, employees and society with the new directions.

Table of Contents

1. Introduction 4
2. The Business of Cancer Care Ontario 4
3. Company Background 4
4. CCO's Previous Strategy 6
   a. Product Market Focus 7
5. Change in Leadership 7
6. CCO's Current Strategy 8
   a. New Product Market Focus 10
7. Mission, Vision and Values 11
8. CCO's Mission, Vision and Values 12
   a. History 12
   b. Development 12
   c. Content 13
   d. Communication 13
9. Achieving the Vision and Mission 14
   a. Attract and Retain Investors 14
   b. Attract and Retain Customers 16
   c. Attract and Retain Employees 18
   d. Attract and Retain the Good Will of Society 20
10. Survey Analysis 23
11. Analysis of Interview Findings 26
   a. Cancer Care Ontario Provincial Office – Summary of Interviews 26
   b. Hamilton Regional Cancer Centre – Summary of Interviews 29
12. SWOT Analysis 30
13. PEST Analysis 33
14. $E^O \cong R^S$ 34
15. Recommendations 37
   a. Mission and Vision 37
   b. Product Market Focus 39
   c. Building Relationships with Pharmaceutical Companies 40
   d. Outsourcing IT Functions 40
   e. Regional Organization of CCO 41
16. Conclusion 41
   Appendix A: Survey instrument 42
   Appendix B: Survey data analysis 44
   Appendix C: Interviews at Cancer Care Ontario 51
   Appendix D: Interviews at the Hamilton Regional Cancer Centre 52
References 53

1. Introduction

Cancer Care Ontario (CCO) is the governing body for the provincial cancer system. In the past, CCO has been responsible for the system management, service delivery, improving treatment outcomes, prevention and screening programs, and education. To improve the quality these services, CCO has recently changed its focus to create a new, better-coordinated system. In this new model, CCO's role will become more focused on the management of information. The purpose of the following report is to assess the effectiveness of CCO's strategy. To conduct a thorough analysis, both the previous and current strategies will be assessed; these strategies will also be referred to the "old" and "new" strategies within the report. An organization's strategy is comprised of its vision, mission, values, objectives and its product market focus. These statements will be used as the framework for the analysis. After critiquing CCO's strategy, recommendations for improvement will be presented.

2. The Business of Cancer Care Ontario

CCO is responsible for reducing the effects of cancer and ensure that people in Ontario receive high-quality cancer treatment. To help achieve its goals, CCO is creating a better-coordinated system by improving communication among those who provide services to cancer patients and developing new programs in areas such as cancer prevention, supportive care, screening, education and the development of treatment guidelines.

CCO is responsible for long-term planning of the cancer care system and ensures that patients across the province receive the same high quality of care, regardless of where they live. Most of its work is achieved through the nine CCO regional cancer centres (RCCs) located across the province that plan and coordinate regional cancer services.

3. Company Background

Since the Ontario Cancer Treatment and Research Foundation (OCTRF) was restructured and became CCO in 1997, the government agency has never truly been able to realize its full mandate, especially in the arena of principle advisor of cancer services in Ontario to the Ministry of Health and Long-Term Care (MOHLTC). More recently, under the direction of the Minister of Health, Tony Clement, Dr. Alan Hudson

was asked to chair an independent committee whose purpose was to examine the issues and provide advice about Ontario cancer services. The report was released in December 2001.[1]

Dr. Hudson worked with other members of the committee to learn about cancer services and their deficiencies. The result was a 106-page report with 23 recommendations to improve upon cancer services delivery in Ontario and most importantly, to strengthen CCO's role as principal advisor to the MOHLTC on all matters related to the cancer control system and cancer control services. On January 31st, 2002, CCO announced that Dr. Alan Hudson would become its next President and CEO, beginning April 1st, 2002. Now in his position for a little more than a year, Dr. Hudson is committed to realizing the full potential of the report findings and, as the Chair of the committee, obviously has a personal interest in seeing that the implementation is successful. On Thursday April 24th, 2003, Dr. Hudson will give the first ever Ontario Cancer "State of the Union" address in conjunction with one of CCO's regular board meetings. This event will highlight the progress to date since Dr. Hudson's leadership began, and what further changes are expected in the days, months and years ahead.

Dr. Hudson's priorities since he started as CEO were to carry out many of the recommendations of the CSIC report. The four areas of concentration for his objectives include:

- Cancer Services Integration
- Quality Delivery
- Surgical Oncology
- Information Management

It is the fourth of these objectives, Information Management (IM), which is foreseen to provide the "glue" to keep the rest together. Between June and November 2002, Cancer Care Ontario (CCO) developed a five year Cancer Information Management strategic plan aimed at improving the quality of cancer services across Ontario. Recognizing the importance of IM, this strategy is the only strategic plan CCO intends to follow. The Cancer IM Strategy focuses on the following five strategic directions:

- Improving access to cancer care
- Enhancing cancer system performance
- Enabling optimal clinical decisions

- Building research capacity
- Facilitating integrated delivery of cancer care

4. CCO's Previous Strategy

The previous CCO strategy was directed by five goals:

- System Management – to ensure the effective planning, organization, management and delivery of cancer control services;
- Service Delivery – to improve access to individuals to the cancer system, to expedite movement of patients through the system and to ensure quality of services available to patients;
- Improved Outcomes – to improve the outcomes of individuals with cancer through research, evidence-based care and supportive care;
- Prevention and Screening – to reduce the incidence and mortality of cancer in Ontario through cancer prevention and screening;
- Education – to improve access to and use of information and knowledge about cancer by the public, patients and caregivers.[2]

The creation of Cancer Care Ontario Regional Councils (CCORs) developed a platform from which these goals could be achieved. Each CCOR established leadership and a mechanism to create and share knowledge across the cancer system. CCORs also acted as points of coordination for regional services. This infrastructure allowed for the creation of improved service delivery by providing treatment networks round and regional multidiscipline teams. Evidence-based guidelines were distributed, coordination of community-based prevention and screening were initiated, there was an increase in affiliations with the Ontario Breast Screening Program (OBSP) and the educational programs were established.

Once this base was established, CCO realized that in order to continue to achieve its vision the strategy would have to focus on:

- Improving outcomes and satisfaction for patients, public and professionals
- Collaboration and community involvement
- Information systems to enable improved outcomes, satisfaction and collaboration
- HR planning, recruiting and retention[3]

a. Product Market Focus

CCO manages nine regional cancer centres in Hamilton, Kingston, Kitchener (currently an interim centre), London, Ottawa, Sudbury, Thunder Bay, Toronto and Windsor (see Appendix F), as well as the Ontario Breast Screening Program (OBSP), the Ontario Cancer Registry (OCR), and the Ontario Cancer Genetics Network (OCGN). Between 2002 and 2005, plans call for new regional cancer centres in Mississauga, Oshawa, and St. Catharine's, and a satellite centre in Sault Ste. Marie. CCO relies on input from its regional partners to develop provincial standards and to determine the type and quality of services that should be available across Ontario. Ultimately, CCO's market is very clearly defined. It includes all Ontario residences, but especially those who are currently affected by cancer, or likely to be affected in the future. It also includes the family members of these individuals. All Ontario residents are part of the market because of CCO's role in cancer prevention, education and research. CCO's product is fairly broad. It includes programs such as the OBSP, OCR, and OCGN as noted above, but also all modalities of care, research, education, and prevention. CCO's scope of practice includes direct patient care and overall system management.

5. Change in Leadership

On April 1, 2002, Dr. Alan Hudson was appointed President and Chief Executive Officer of Cancer Care Ontario[4]. Dr. Hudson brings a wealth of experience and knowledge to CCO. Trained as a neurosurgeon, his research in peripheral nerve injuries has established him as world authority on the subject[5]. As Chairman of Neurosurgery at the University of Toronto, Dr. Hudson was awarded for teaching excellence. Dr. Hudson has also gained an abundance of experience in leadership within the Ontario health care system. From 1989 to 1991, he served as McCutcheon Chair and Surgeon in Chief at Toronto Hospital. From 1991 to 2000, Dr. Hudson was President and Chief Executive Officer of Toronto's University Health network.

Dr. Hudson quickly recognized the need for change at CCO. There were long wait times, and, although the quality of care was good to excellent, diagnostic and therapeutic services were discontinuous and fragmented causing a difficult journey for patients[6]. A strategic plan was set with cooperation from numerous stakeholders to create a more integrated system providing better patient care.

Dr. Hudson's leadership approach in the transition includes having the right people on board and constant communication. He realized that those in "comfortable

chairs will not move to new seats."[7] Therefore, he assessed which stakeholders would help and which would hinder the restructuring, determining CCO's readiness for change. Considering the vast network of departments and organizations involved, Dr. Hudson felt communication was vitally important. Without it, the organization is analogous to "the lead dog of the sleigh team (seeing) the view ahead, while many other team members spend much time looking at the rear end of the dog ahead."[8] Dr. Hudson feels that there is frequently too little time, effort, funds and staff dedicated to creating timely, reliable and credible communication.

In an interview with Dr. Hudson, we asked his thoughts about an organization's vision, mission, and values. He responded that the "*vision is <u>absolutely</u> critical for any organization. It is critical to get it right, everyone should be able to recite it, and it should last a decade or so*" (see Appendix C for Alan Hudson Interview). He sees the vision acting like a lighthouse across the sea; "wind" will change strategy, but the organization must always aim for the lighthouse in the end. He feels the mission should provide the "what" and the values should indicate "how". A new vision, mission and values will be formed soon to reflect the structure of the "new" CCO.

6. CCO's Current Strategy

CCO is changing to create a quality-focused organization that is knowledgeable, relevant, evidence-based, and a trusted resource for cancer data. The "new" CCO will be partnership-oriented in supporting regional facilities in servicing patients and families and will advocate for and act as the adviser on provincial cancer information and care practices.[9] Specifically, CCO has outlined four corporate priorities, these are:

1. Accelerated integration of cancer centres with hospitals through the development of Integrated Cancer Programs (ICPs) and ultimately Regional Cancer Programs (RCPs);
2. Establishment of a Cancer Quality Council of Ontario (CQCO), made up of experts that will set standards, monitor cancer services and guide improvements to the cancer system;
3. Improve the delivery and quality of surgical oncology; and
4. Creation of a comprehensive information management strategy in Ontario to provide accessible information so that CCO can govern and manage more efficiently.[10]

A collaborative effort between CCO and its partners developed an information management strategy that was created to realize these new priorities. At the same time, this partnership helped focus on integrating cancer systems to ensure that patients and their families receive seamless care. The strategy identifies the following principles:

1. Appropriate application of evidence based guidelines in all care settings to support consistent practice;
2. Management decision-making at provincial, regional and local levels supported by the availability of relevant and consistent information and appropriate analytical tools;
3. Integrated Health Records to support point-of-care access to relevant patient-related information while ensuring privacy and confidentiality;
4. Monitoring of system performance at the provincial, regional and local levels to support expected outcomes and adherence to an accountability framework;
5. Comprehensive datasets, with common data standards, to support practice reviews, peer comparisons, research and outcome evaluation; and
6. Information technology infrastructure to support IM initiatives.[11]

Through the Cancer IM Strategy, CCO aims to achieve the following five strategic directions:

1. *Improving Access to Cancer Care*

   A mechanism is needed to manage and monitor waiting times. As well, it is important to track patients as they use the different cancer services, and not to treat them as individual cases. By managing a patient's interactions across the continuum of cancer care, patients will benefit from equitable access and increased quality of care.

2. *Enhancing Cancer System Performance*

   Improving system performance management will require significant detailed inter-institutional information. Funding has been obtained to implement Data Tracking, Referral and Analysis of Capacity for Cancer (D-TRACC) to support earlier recognition of pending constraints in the system, support development of mitigation

strategies, identify best practices and increase efficiency in cancer service delivery. Furthermore, the Cancer Quality Council of Ontario has been established to monitor, assess and improve provincial performance of the cancer system.

3. *Enabling Optimal Clinical Decisions*

   Programs should be designed to provide the most appropriate clinical decisions and help prevent clinical errors. This can be done through computerized provider order entry (CPOE), evidence-based clinical practice guidelines, and enhancing quality and safety of systemic and radiation therapy and managing the health records as part of larger hospital/regional electronic health records.

4. *Building Research Capacity*

   The Ontario Cancer Research Network (OCRN) was created in 2000 to establish a cancer research infrastructure with emphasis on translating new knowledge into clinical practice.

5. *Facilitating Integrated Delivery of Cancer Care*

   Cancer care is fragmented across health care organization in Ontario resulting in poor coordination in patient care. Integration at the care, management, information and technology levels will result in providing patients with seamless coordinated care.[12]

a. New Product Market Focus

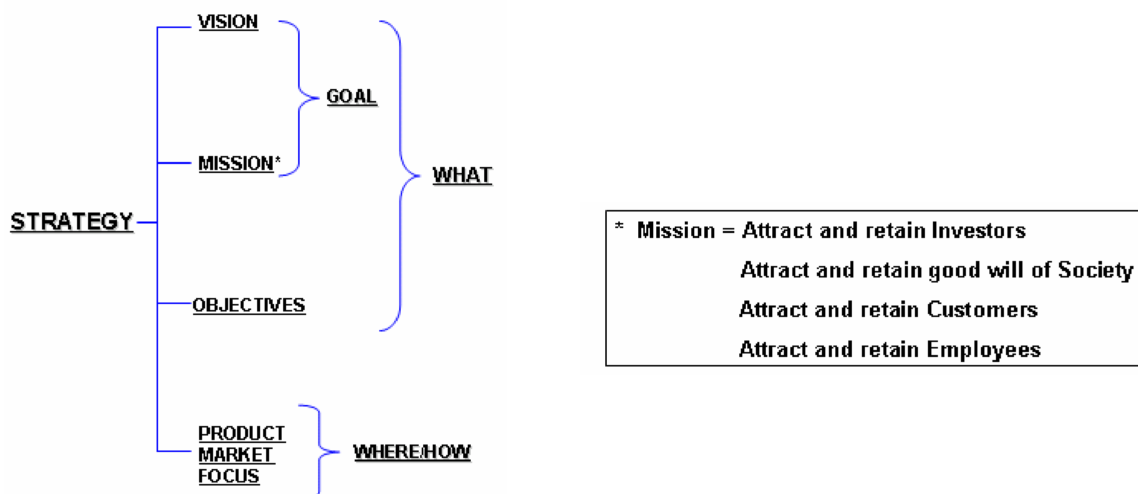
CCO is moving away from being a service provider (leaving this to its new partners the hospitals with whom the regional cancer centres will integrate) to being a manager of information and quality. The product market focus for CCO has also changed because of this transition. Thus, CCO's market now includes both patients and the regional cancer centres (or more appropriately now the ICPs, integrated cancer programs). The product that CCO is offering is high quality data, tracking mechanisms and guidelines that will be provided to its customers to help them create seamless care systems for patients. Effectively, in changing its strategy, CCO has narrowed its product market focus from what it previously was.

7. Mission, Vision and Values

In essence, an organization's strategy is comprised on its vision, mission, values, objectives and its product market focus. While these terms are used frequently, many are unaware of their intended characteristics. A ***vision*** statement should describe aspirations for the future and should be designed to inspire and appeal to the emotions and aspirations of the organization's members.[13] More simplistically, the vision describes what an organization should be. Conversely, the ***mission*** deals with the organization's present reason for being. The statement intends to capture an organization's unique and enduring purpose and practices.[14] It has been argued, especially for hospital and non-profit organizations, that one of the purposes of the mission statement should be a focus on resource allocation, because higher-order objectives, such as a common purpose, will be more difficult to establish.[15] The mission should also include its core ***values***, which describe the beliefs of how the organization views itself, and its ***objectives*** or goals.

Together the vision, mission, values, and objectives describe the "what" portion of an organizations strategy. The "how and where" portion is explain by its product market focus (PMF). The choice of PMF should be determined by identifying environmental opportunities to which the organization has the resource strengths to satisfy. This relationship is represented by the equation $E^{o}=R^{s}$, coined by Dr. Christopher Bart.[16] It will be discussed in greater detail in Section 14 of this report.

Together the "what" and the "how and where" comprise an organizations strategy, as illustrated in the following diagram:



As CCO transitions to their new focus on information management, an effective and well communicated vision, mission, and values can be an invaluable tool. CCO is comprised of a complex network of departments and partner organizations with numerous stakeholders. Used properly, statements could be used to explain where the organization is going in the transition and why it is going there. With this, confusion could be reduced and better control over the actions and behaviours of employees and other stakeholder could be exhibited to bring about a more focused allocation of organizational resources towards achieving CCO's goals.[17]

Presently, CCO has not created a formal vision and mission statement to reflect their new direction. However, Dr. Hudson disclosed that one would be developed soon. The following analysis will focus on the vision and mission of the "old" CCO. The analysis will use the statements as a framework to discover their effectiveness. Hopefully, through this process, recommendation for the development and implementation of the impending vision and mission statements can be made.

8. CCO's Mission, Vision and Values

a. History

The CCO mission, vision and values (MVV) were developed as part of the 1997 strategic planning process. The impetus for creating them at that time was related to the change from the former OCTRF to the new CCO. Once developed, the MVV, as well as the strategic goals, as they were called, were communicated to a variety of stakeholders through a variety of media.

b. Development

Through anecdotal evidence, it appears that the development of the MVV in 1997 was largely a top-down process, with senior management drafting the statements, finalizing them, and then simply communicating them to others. Even the CEOs at the regional cancer centres were not involved in the creation, which likely explains at least in part why, even today, they don't feel a sense of ownership to the statements.[18,19]

Research has demonstrated an autocratic development process reduces the statement's effectiveness. Increased involvement of stakeholders, including the frontline staff, in the process will lead to a wider sense of ownership of the statements, and, consequently, an increased employee commitment and satisfaction.[20]

c. Content

The following are CCO's vision, mission, and values statements:

The ***vision*** of Cancer Care Ontario is to lessen the growing burden of cancer in Ontario by ensuring that all Ontario residents have timely, equitable access to an integrated system of excellent, coordinated and efficient programs in prevention, early detection, care, education and research.[21]

In fulfillment of its ***mission,*** Cancer Care Ontario will be accountable to the Government of Ontario for provision of strategic direction and leadership in all sectors of cancer control, for development of standards and guidelines for all sectors, for ensuring that cancer patients in all regions have equitable access to contemporary, coordinated and effective services, for developing partnerships with community institutions, agencies and care providers and for the management of key components of the cancer system.[22]

The ***value*** structure of CCO will emphasize its primary responsibility to cancer patients and their families and its obligation to deliver services in a fashion which recognizes the unique needs of Ontario's various communities and regions.[23]

While these are the 'official' statements, not all are used. In fact, it was only after an exhaustive search that the mission statement could be found. However, CCO's vision statement is used frequently and will, therefore, be the focus of our analysis. As stated earlier the vision statement should be an inspirational statement of the organization's aspirations. CCO's vision statement does not possess these characteristics. If fact, it possess more similarities to a mission statement, stating the organization's current reason for being.

d. Communication

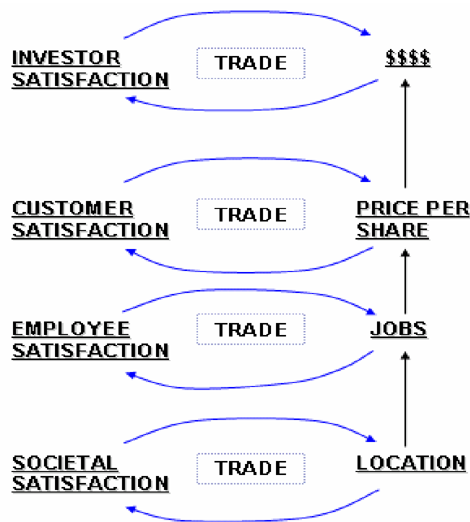
CCO vision statement is communicated through some literature and its website. Interestingly, comparing the vision statement published in different CCO sources discovered the vision message is not always consistent. Although the main meaning is unaltered, the vision is sometime shortened and reworded slightly. This prevents stakeholder from knowing and remembering the vision statement.

In order for vision/mission statement to be effective, it must be properly communicated. This involves sending the message, having it received, ensuring that it is understood and remembered.[24] While CCO does print their vision in public

documents, there is currently no program in place to ensure it is received, understood or remembered.

9. Achieving the Vision and Mission

In essence, an organizations existence and success hinges on its ability to exchange goods, services, or something else of value with multiple stakeholders. The mission statement should outline how this is achieved by the organization. The stakeholders that an organization must satisfy are its investors, its customers, its employees, and the society in which it operates. The following cascading diagram illustrates this relationship:



While this diagram is catered to profit focused organizations, a similar relationship exists in the non-profit sector. In the healthcare industry, the investors characterize the government that provides funding, customers include patients or other organizations the organization serves, employees are its staff, and society represents the general public. In the following section, CCO's ability to attract and retain investors, customers, employees and the goodwill of society will be analyzed.

a. Attract and Retain Investors

Cancer Care Ontario has a unique relationship with its investors. Because it is not a profit-generating organization, its investors must be viewed as those companies or individuals that provide the funding and political support, without which it could not function. A curious anomaly of this arrangement is that an investor can also be

considered a customer. For instance, the Ministry of Health and Long-term Care (MOHLTC) not only provides the funding for operations, it also receives information from CCO. However, because the MOHLTC provides the financial support without which CCO would be unable to operate, it is considered an investor, not a customer, for the purposes of this discussion. And, because the MOHLTC provides funding from taxpayers' money, the general public is also considered an investor that is wholly represented by the MOHLTC.

Unlike profit-generating organizations where investor retention is based on the share price, revenues, and other profit-related items, a non-profit organization retains its investors by proving it is performing mandated tasks expected by the investors. In CCO's case, a Memorandum of Understanding (MOU) has been established between CCO and the MOHLTC. The MOU outlines the operational accountability and the financial, auditing and reporting responsibilities between CCO and the MOHLTC. Failure to competently carryout or attempt these tasks affect investor confidence potentially resulting in less funding, or at a minimum lowered consumer confidence. The table below summarizes the components of the MOU and thus CCO's responsibilities to the MOHLTC.[25]

1. to reduce the burden of cancer on the people of Ontario;
2. to be the principal advisor to the Minister on all matters relating to the Cancer Control System and Cancer Control Services;
3. to be accountable for assessing, monitoring and reporting to the Minister on the organization and status of the Cancer Control System and Cancer Control Services, including all matters relating to access, effectiveness and quality;
4. in co-operation with publicly funded providers and agencies and other key stakeholders to lead in the development of an overall strategic plan for the Cancer Control System and the delivery of Cancer Control Services in Ontario;
5. in co-operation with publicly funded providers and agencies and other key stakeholders to develop plans for presentation to the Ministry on resource distribution and coordination of all Cancer Control Services in the province as a whole and in each region of the province;
6. to develop through the CCORs, in consultation with the DHCs, regional plans for the delivery of Cancer Control Services in each region of the province and to recommend the plans to the Minister;

7. to plan, fund, provide and manage services in the Regional Cancer Centres, in partnership with hospitals and in other facilities as necessary;
8. to develop, disseminate, monitor, report on and encourage adherence to standards and guidelines for all Cancer Control Services;
9. to promote and contribute to the development and funding of cancer research, alone and in combination with other research funders;
10. in partnership with the Ministry, institutions of learning and other relevant parties, to plan, promote and contribute to the education and training of health professionals providing Cancer Control Services;
11. to promote and support programs designed to prevent cancer and programs in cancer related patient and public education;
12. to gather and disseminate information about cancer;
13. as necessary to further its objects and mandate, and in accordance with the provisions of this MOU and other agreements, the Freedom of Information and Protection of Privacy Act (FIPPA), the Act and other legislation, to directly or indirectly collect personal health information; and
14. to do any other things that it or the Minister considers necessary or advisable to attain its objects or fulfill its mandate.

Many of the mandates are fulfilled through the annual report and with projects or working groups performed in conjunction with the MOHLTC. CCO is fulfilling the rest of these mandates through various awareness programs such as Aboriginal awareness drives, support of women's breast cancer screening programs, and with the effort to centralize all relevant cancer patient information. Furthermore, via the regional cancer centres, CCO is tracking the indicators required by the MOHLTC, passing that information through the proper channels. CCO has capital expansion initiatives underway to aid in fulfilling the entire mandate and achieve the objectives set out by the MOHLTC.

b. Attract and Retain Customers

CCO's mission statement stresses the importance of improving the quality of cancer patients by addressing both the equity to care and equality of care for all the residents of Ontario. The mission statement also introduced the various non-treatment related programs in place to help decrease the mortality and morbidity of cancer.[26]

Some of these include programs in prevention, early detection, early treatment, education and research.

In the so-called “old” strategy, CCO is responsible for channel funding and support to regional cancer centres (RCCs) and provide supporting services to patients through the RCCs. While the cancer centres receives services and support from CCO, it is an employer-employee relationship that link the two entities together. How CCO attracts and retains employees will be discussed later on in the report. CCO established the following goals to align with its first strategic plan in 1997, which also helps to attract and retain customers.

Firstly, to ensure that quality care is delivered to all cancer patients, CCO developed a governance structure that promotes provincial standards and regional partnerships.[27] This structure promoted the development of knowledge to ensure optimal use of resources. Commitment from the regional partners was measured by the willingness of regional service providers to participate through signing affiliation agreements. Secondly, to improve the a*ccess to care* of individuals to cancer care, CCO facilitated the movement of patients through the system by regional coordination of services and maintenance of systems to diagnosis, treatment and supportive care. Through this system, deficiencies in the services can also be identified.[28] With the integration of surgical oncology in the strategy, patients were able to have access to expertise in radiation, systemic and surgical oncology at the regional centres.

Thirdly, one of the goals of all health services providers is to achieve improved outcomes for patients. CCO planned to achieve this goal by producing and implementing guidelines for cancer control, the use of multidisciplinary clinics and evidence based practices.[29] In order to further reduce the incidences and mortality of cancer, prevention and screening programs were established not only for cancer patients, but also for the general public. CCO's increased affiliation with the Ontario Breast Screening Program (OBSP) was one of many successful CCO initiatives. Last but not least, coordination of cancer education services with various agencies was also established so that cancer patients, family members and the general public have access to accurate cancer information. Both prevention, screening and education programs will be discussed in detail in the "attract and retain good will of society" section of the report.

In the new Cancer Information Management Strategy, CCO will play a role in information management and services for all the regional cancer programs[30]. In this new plan, CCO is a much stronger service provider to the cancer control system than in

the old strategy. Therefore, two groups, the patients and the cancer system will be considered as customers to CCO in the new strategy.

Some of the goals in the new strategy that help to attract and retain customers include: to improve access to cancer care by reducing waiting time and length of treatment through a comprehensive referral and wait list management system; and to ensure a continuum of cancer care. This has an echo effect to the access of care for patients goal in the old strategy since CCO is still committed to improving the access of care to all cancer patients in Ontario. Secondly, in order to enhance the performance of the cancer system, CCO will continue to provide decision makers with timely, accurate and relevant system level information. Newly funded programs by the Ministry of Health and Long-Term Care (MOHLTC) include Data Tracking, Referral and Analysis of Capacity for Cancer (D-TRACC) to enable efficiency, and identify best practices etc. These programs will help to maximize efficiency and effective allocation of resources to both the cancer system and patients.

Moreover, to enable an optimal clinical decisions process, CCO will be implementing clinical decision support tools such as Computerized Provider Order Entry (CPOE)[31] and promote the development of evidence based clinical practice so that guidelines to be readily available at the "point of care". Maintaining quality of care in the "new" CCO is once again emphasized in the new strategy. CCO will also be expanding the research capacity of the organization through the use of the Ontario Cancer Research Network (OCRN).[32] Research enables new treatments to be discovered and implemented which will directly benefit the quality of life of all cancer patients.

Another focus of the new strategy is to provide seamless care to cancer patients. The delivery of care will be integrated to ensure a continuum of care and that cancer services are not fragmented. This is called the Integrated Cancer Program (ICP) at the local level, and the Regional Cancer Program (RCP) at the regional level. Successful ICPs and RCPs will link the traditional radiation and systemic programs of the cancer centres seamlessly to the surgery, systemic therapy and diagnostic services of the host hospitals. Facilitating the transfer of patient information and knowledge are what CCO wants to achieve with the ICPs and RCPs in the new strategy.

c. Attract and Retain Employees

CCO is aware of the importance of attracting and retaining employees. Working in a publicly funded health care system that has seen some drastic changes in the last

decade, CCO, like other health care organizations, has realized that their employees are its greatest asset. Much is done to try to attract and retain employees and the success can be found in CCO overall having a turnover rate of 12.7% in 2002[33], which is considerably lower than the industry norm.

Since the environment of CCO is one where there is continuous change in terms of research and technologies, CCO recognizes the importance of offering training and development opportunities to its employees. This first starts with making sure that employees have received essential training. There are many forms of training such as on-the-job training, to internal or external training programs.[34] Development activities involve allowing staff to participate in seminars, conferences and allowing employees to continue their education through educational reimbursement programs, study leave programs, or prepaid leave programs. One area that CCO could improve is to implement a formal orientation program; presently, there is not one.

CCO is sensitive to the needs of its diverse employee population. The organization offers three paid “Float days” that can be used as days in addition to regular paid holidays. Thus, employees can uses these days for various religious holidays that they would have a difficult time observing by only using the Canadian statutory holidays. This is just one of the many advantages that CCO offers as part of its comprehensive compensation, benefit and group benefit plans. Overtime pay, paid vacations, leaves of absences, supplementary unemployment benefits, health and extended health benefits, dental and pension plans are a few of the other benefits that eligible employees are offered. Realizing that employees are affected not just by work related situations, but also by what is happening in their personal lives, CCO offers free confidential professional counseling and referral services through a consulting firm that specializes in employee assistance programs. The counselors are experienced in working with work-related and personal problems.

CCO realizes that because of the nature of its industry, it is important that employees are kept up to date with what is occurring within the organization. CCO has arranged various communication techniques to keep staff informed such as the CCO newsletter, the President’s bulletins, HR InfoShare, physical and electronic bulletin boards, and staff meetings. All of these allow employees to be fully informed.

CCO finds it important to recognize and honour the service and commitment of its employees. Management understand that the employees are responsible for helping build CCO and those employees continue to contribute actively to the organization.

Regular full and part time employees who have worked for significant periods of consecutive years are presented with symbols of appreciation. The CEOs of the regional cancer centres present these awards. CCO also has similar recognition ceremonies. However, it has been mentioned a few times that not enough is done to recognize all the individuals who work at the centres.

With the new structure of CCO, the regional cancer centre employees will no longer be employees of CCO, but of the hospitals with which the centres are integrating. Only individuals working at CCO provincial office will be CCO employees and they will retain all benefits that have mentioned. All other employees (i.e. those currently working at the regional cancer centres) will acquire the benefits package of the host hospital.

d. Attract and Retain the Good Will of Society

Some might argue a health care organization's entire existence is for the benefit of the overall population. However, for the purposes of this discussion, to examine CCO's ability to attract and retain the goodwill of society only those functions that benefit the general public, not just cancer patients, will be considered.

CCO's vision statement specifically addresses the organization's role in cancer prevention and screening programs; two areas that benefit all residents of Ontario. Interestingly, CCO's mission statement does not. It only broadly mentions CCO's role in providing "…strategic direction and leadership in all sectors of cancer control."[35] Despite this omission, CCO does have a significant role in satisfying the needs of society.

An examination of CCO's functions and programs that aid society was conducted under both the "old" CCO and "new" CCO structure. The following are the activities preformed by CCO under the "old" structure that benefit the general public.

CCO's Cancer Surveillance Unit collects and manages epidemiological data on cancer incidence in the Ontario population through a program called the Ontario Cancer Registry (OCR).[36] This database contains extensive information on cancer patients diagnosed and treated in the province since the late 1960s.[37] CCO uses the information in a few different ways. The data are reported to the Ontario Ministry of Health and Long-Term Care. From this information, the Ministry can plan the appropriate allocation of funds to cancer programs and treatment facilities. The epidemiological data is also used to study the effectiveness of the province's screening programs. As well, CCO uses the information to research the causes of cancer and improve procedures for prevention, diagnosis, treatment, and care.[38]

CCO's Research Unit in the Division of Preventive Oncology conducts much of this research.[39] The long-term goal of the Division is to reduce the incidence and mortality of cancer in the Ontario population. By tracking and analyzing the trends and rates of the disease, researchers attempt to find associations between cancer and risk factors. The risk factors that are investigated include environmental, occupational, lifestyle, and familial/genetic. The links discovered between cancer incidences and causes provide imperative findings in cancer prevention.

To be of benefit to society, the public must be educated on the risk factors discovered so that cancer-causing behavior can be modified. CCO disperses this information in many different ways. CCO's Ontario Tobacco Strategy attempts to reduce smoking in the province by the increasing media coverage on tobacco control issues.[40] It interacts with the media through press releases, information packages, and events in an attempt to increase coverage. A similar program called the Nutrition Intervention Strategy targets poor diet and eating habits.[41] The Public Affairs department also produces many brochures on topics of importance and a magazine entitled Cancer Care three times annually.[42] These publications are distributed through the CCO web site as well as in hard copy to relevant stakeholders and interest groups. CCO also shares research finding at other points of contact with the public such as the regional cancer centres, the Canadian Cancer Society, and other government agencies.

CCO provides extensive screening programs for the public. Early detection is crucial as treatment in the early stages of cancer is usually more effective. The screening programs are designed to include patient recruitment, follow up, recall, and timely assessment. CCO monitors the programs to ensure that they have the proper level of staffing and funding. As well, it educates the medical staff at the screening facilities on the standard techniques for cancer detection.

The Ontario Breast Screening Program is CCO's largest such program. Established in 1990, the program screens women over the age of 50 every two years. Presently, there are 90 breast screening sites in the province providing services to approximately 150,000 women annually.[43] CCO also manages similar screening programs for cervical cancer and one has been proposed for colorectal cancer.

Under the new integrated cancer control system, there will be slight changes to how CCO attracts and retains the goodwill of society. CCO research and education in the prevention of cancer will continue with some improvements and new programs introduced. The screening programs will still be offered with greater involvement from

CCO in the management of information and administration through a new patient-tracking program.

One of the major initiatives under the new CCO strategy is to increase the level of cancer research in the province. This will be achieved through the enhancement of the Ontario Cancer Registry and through the implementation of new programs.

Improvements to the Ontario Cancer Registry are planned. The “old” CCO used to collect data passively from medical professionals at the screening or treatment facilities. Upgrades to information systems will allow the automatic collection of data through a database matching mechanism.[44] This will enable more accurate and timely collection of data. In addition, CCO is currently investigating the inclusion of periodic population-based surveys in the database on areas such as the exposure to risk factors.

CCO will also work in co-operation with the Ontario Cancer Research Network (OCRN) to introduce new cancer research projects. Funded by the Ontario Ministry of Enterprise, Opportunity and Innovation, CCO and OCRN will invest a total of $100 million in the following four new initiatives over four years:[45]

- The Cancer Clinical Trials Infrastructure Program will increase the number of patients enrolled in trials to improve the quality and consistency of the cancer trials process.
- The Clinical Trials Information Network will inform both patients and physicians of all cancer clinical trials conducted in the province.
- The Tumor Bank Network will coordinate cancer tissue procurement, storage and distribution to researchers. This will develop an extensive genetic, biological and clinical database on all known tumor types.
- The Cancer Research Project Fund will support a broad spectrum of research projects in Ontario.

The aforementioned screening programs will continue operations under the new CCO structure. In addition, CCO will implement a new tracking mechanism to monitor the quality of screening, facilitate appropriate follow up, provide routing reminders to patients about the next required screening test and evaluate outcomes.[46] The objective of this enhancement will be to ensure that screening programs are properly managed and developed and increase the level of participation of the Ontario population.

10. Survey Analysis

To discover the level of use and acceptance of the CCO vision statement within the organization, a survey of all employees was conducted. The objective of the research was to uncover how well the vision has been communicated to employees, what their level of satisfaction is, and the extent to which the statement influences employee's actions. Analysis of the results will also examine differences between departments, years of service and staff types. From this information, best practices and areas for improvement will be identified.

Methodology

A one-page survey was designed and approved by CCO management for distribution (See Appendix A for a Survey Example). Since the organization is in a state of transition, the vision was stated at the start of the survey to ensure the employees were responding to the intended vision statement. The survey was sent to all CCO employees by email as an attachment on February 21, 2003. The employees were instructed to print the survey, complete and return it to collection boxes, which were located in two common areas within the office areas. Employees were asked to return the surveys by March 7, 2003. This two-week period was believed to be ample time for participation. Three days prior to the deadline, a reminder email was sent to all employees, again with the survey attached. Extra copies were also made available next to the collection boxes.

The survey probed for the vision's the level of awareness, impact, and satisfaction of the employees. Respondents were asked to indicate their department, staff level, and years of service at CCO. The survey data was analyzed using the software program SPSS. The data was first analyzed for overall results to the questions. Then, a secondary stage of analysis attempted to discover differences among departments, staff levels, and years of service. To discover these differences a one-way analysis of variance (ANOVA) was conducted. This method determines whether differences among the population means exist[47]. A Tukey analysis was conducted following the ANOVA is a difference was found. This statistical tool allows the comparison of every possible pair of means using a single level of significance. A 10% level of significance was selected.

Demographics

Of approximately 230 employees contacted, 62 completed the survey; a response rate of 27%. The low response rate is likely due to the low priority employees put on the survey relative to other tasks. It was hoped that a larger sample could be obtained to ensure analysis could produce statistically valid results. Unfortunately, this is not always possible.

COO is comprised of many specialized departments. Consequently, respondents were scattered among 13 different departments. Only 55 of the 62 respondents indicated to which department they belonged. The frequency of the respondents with respect to departments can be found in Appendix B, Table 1. Five options for staff type were offered on the questionnaire: management, clinical, research, support staff, other professional. The frequency of the respondent with respect to staff type can be found in Appendix B, Table 2. The average length employees have been with CCO was reported to be 6.4 years (see Appendix B, Table 3). For simplicity, respondents with similar years experience at CCO were grouped together. Employees were classified as 'new to CCO' with 1-2 years of service, 'intermediate' with 2-5 years, 'experienced' with 6 to 10 years, or 'long-time' with 11 or more years. The frequency of respondents with respect to years of service is found in Appendix B, Table 4.

Limitation to the Study

Due to the nature of the research conducted there are certain assumptions and limitations to the findings and statistical analysis.

- Limited Sample Size. Due to a low response rate (27%), there were only 62 respondents. When further divided into the different categories, sample sizes are created that are too small to support statistically valid conclusions.
- The ANOVA analysis assumes that each sample is derived from an independently and normally distributed population at random. This assumption has not been tested.
- The Tukey analysis assumes sample means are equal. However, this was not the case. The number of respondents in each department, at each staff level, and in each experience bracket varied.

Overall Findings

Generally, there appears to be a lack of awareness about the vision. Of the 62 respondents, 12 (or 19%) responded that they were only vaguely aware of the statement, and 8 (or 13%) said that they unaware of its existence (See Appendix B, Table 5). Had the questionnaire not included the statement to aid recall, it is likely that there would have been a lower level of awareness. Ensuring all employees have knowledge of the vision statement is vital. Without this knowledge, there is a lack of focus and it is impossible to harness the organization's collective energy and direct it towards the goals stated in the vision.[48]

Despite the lack of knowledge, employees seemed to be satisfied with the vision statement. The average response was 5.31 on the 7 point scale (where 7 is satisfied to the greatest extent) (see Appendix B, Table 3). Research has shown that the higher the satisfaction is with the mission/vision, the greater the impact of the statement on employee growth and behaviour.[49] However, some staff felt strongly that they were not satisfied.

In general, employees reported that the vision statement had a great effect on their decision making and behaviour; the average scores reported were 4.89 and 4.91, respectively (See Appendix B, Table 3). As well, employees felt strongly committed to the vision with an average score of 5.31. However, these findings are highly suspicious considering the low level of awareness (if they don't know about the statement, how can they be impacted by it?).

Differences Among Staff Type

The ANOVA statistical tool was applied to the mean responses to discover if there were any differences by staff type (Appendix B, Table 6). A difference was found in awareness level. Investigating further, the Tukey analysis discovered that the awareness level among management was significantly lower than research staff (see Appendix B, Table 7). This was a surprising result, because management is usually the staff type that is most informed about the organization. However, the lack of awareness with management was consistent with the findings that management reported the lowest mean score for satisfaction with the vision statement, and its impact on behaviour and decision-making (see Appendix B, Table 8). It should be noted that these differences were not significant at the 10% level, likely due to the small sample size.

Differences Among Experience Brackets

An ANOVA comparison of responses from those with varying years of experience at CCO found no significant differences (see Appendix B, Table 9). This is again most likely due to the small sample size. Visually comparing means shows that the 'long-time' (11+ years) employees appeared to be the most informed about the vision statement, while those that were 'new to CCO' (1-2 years) were the least informed (see Appendix B, Table 10). Experienced employees also seemed to be the most satisfied and committed to the vision statement. Although there were minor differences between the brackets as to the impact the statement had on behaviour, decision-making, and source of inspiration, those 'new to CCO' were least influenced. This was a predictable response as, currently, there is no formal orientation program at CCO to make new employees aware of the vision and its importance.[50]

Differences Among Departments

The 62 respondents were distributed over 13 different departments. An ANOVA analysis was attempted, but since many of the departments only had one respondent, the sample sizes were too small to conduct the analysis in SPSS. The means were compared visually (see Appendix B, Table 11). The Preventive Oncology department appears to be the least satisfied, and least impacted by the vision. However, as mentioned, the small sample size prevented drawing statistically significant conclusions. An interview with a CCO employee, who wished to remain anonymous, alleged that many in the Division of Preventive Oncology feel that they are not nearly as much a part of CCO as other departments. This could explain the low scores reported.

11. Analysis of Interview Findings

Interviews were conducted with six senior managers at the Cancer Care Ontario (CCO) provincial office and with four senior managers at the Hamilton Regional Cancer Centre (HRCC). All interview transcripts are included in Appendix C and D.

a. Cancer Care Ontario Provincial Office – Summary of Interviews

The six members of CCO's senior management team interviewed include: Alan Hudson, President and CEO; Bill Evans, Executive Vice President; Ian Brunskill, CIO and Vice President Planning; Angie Heydon, Director, President's Office; Christine

Naugler, Communications Officer; Terry Sullivan, Vice President Preventive Oncology; and Donna Kline, Vice President Public Affairs. The response of these members are summarized and discussed in the following section.

Content of the Vision Statement

Dr. Alan Hudson, CEO, expressed the strongest feeling towards the current vision statement. He described it as "horse shit". He believes that there is a complete disconnect between the vision and reality. Other senior management members agreed that its content was fundamentally different from the day-to-day operations of CCO. It was also felt that the vision statement did not address the responsibility of CCO to those stakeholders that aren't patients.

There was a general feeling that the statement did not "speak" to people, as it was "inaccessible, not memorable and bureaucratic". Some felt that employees are not able to clearly understanding the vision; an issue that arises when the statement is created by committees. Most senior managers felt that the use of the word "burden" is too negative for the statement.

Development of the Vision

The original vision statement was developed when CCO was first created from the original Ontario Cancer Treatment and Research Foundation. However, most of the senior managers did not know the details of its creation.

The process that was used to create the current vision statement was viewed by some member as a "secretive", involving only senior management, while others saw the process as an inclusive, involving all stakeholders. All parties agreed that it was a top-down approach that started from the senior managers and trickled down to the lower levels of management and to the regional cancer centres. A few member of the senior management team believe that the process that was used in the development of the vision statement was neither creative nor flexible. Instead, it was viewed to be a simple but formally prescribed process with feedback from employees.

Communication of the Vision

With regards to the methods used to communication the vision statement, most members agree that board members were directly informed while other stakeholders

must learn of the statement through posters, publications and the CCO website. Many doubted the effectiveness of these methods of communication.

The senior team members do not believe that the vision statement is known by all the relevant stakeholders. Since there has been no show of disagreement or rejection of the vision, for those that know of it, it is interpreted that people accept it.

Implementing the Vision

Although managers said the statement exists to guide the daily operation of the organization, they felt it has not been successful in doing so. Most members of the senior team agree that the organizational systems that currently exist do not align well with the vision. However, all agreed that the vision statement is always used during strategic planning sessions.

One member of the senior team mentioned that while the statement itself is not effective, the "idea" behind the vision statement is important. The spirit of the vision regarding the patient care focus is embraced by most employees. As a result, most felt that employees at CCO are committed and proud to work for the organization. However, how committed these employees are to CCO's new direction is still uncertain. Due to numerous changes in the organization's leadership in the last few years, some felt it is difficult to get a sense of the values and beliefs outside the managers' circle.

Some members believe that it is unrealistic to expect that all employees share this same sense of vision.

Testing the Vision's Effectiveness

The vision progress is measured indirectly through wait time studies, regional population and treatment patterns. Many other items mentioned in the vision are not measured nor reported regularly. Most felt that it is a difficult task to measure if the organization has "lessened the burden of cancer." CCO does not survey its employees to determine their knowledge level of the vision. Managers felt that employees of CCO could probably point out the key ideas of the vision statement and identify key words but wouldn't be able to recite the vision statement precisely. Even the managers themselves were unable to recite the vision statement by heart.

b. Hamilton Regional Cancer Centre – Summary of Interviews

To discover the effectiveness and use of the vision statement with CCO employees located outside head office, interviews were conducted at the Hamilton Regional Cancer Centre (HRCC). This was of particular interest since the regional centres will be divested from CCO and formally integrate with their "host hospital" under CCO's new strategic plan. Four members of the HRCC senior management team were interviewed: George Browman, Vice President Regional Cancer Services; Anne Snider, Director of Planning and Administration; Sandy McFarlane, Director of Nursing and Patient Services; and Carol Rand, Director of Community Oncology and Regional Operations. The transcripts are included in Appendix D.

Content of the Mission

Despite being an arm of CCO, the regional cancer centres have their own mission statements. This speaks to the inability of CCO's vision to be meaningful to the entire organization. The HRCC mission is as follows:[51]

> The Cancer Care Ontario Hamilton Regional Cancer Centre is committed to excellence in coordinating a comprehensive cancer program in Central West Ontario. Our goal is to reduce cancer incidence, morbidity and mortality.
>
> The health care professionals and support staff at the Centre are dedicated to providing our patients with high quality service in radiation therapy, systemic therapy, and patient and family supportive care.
>
> We provide leadership in education to patients, the community, our health care professionals and students on all aspects of cancer control: prevention, early detection, and treatment.
>
> We are devoted to active research into the causes, prevention and effective and efficient management of cancer. To maintain our high standards, we continually evaluate and improve the services and programs offered at the Centre.
>
> Our team of health care professionals works in partnership with patients and other health care facilities and organizations in order to respond to the changing needs of the region.

Importance of the Mission

The VP of HRCC emphasized the importance of distinguishing between a mission-driven organization and an organization that becomes a "slave" to the mission

statement. All of the senior management team believes that an organization needs to have a mission statement to stay focused and to have as a tool to align decisions.

Communication and Use of the Mission

The HRCC uses similar methods of communication to CCO. However, the HRCC goes to further measures to integrate the mission with its business activities. For example, HRCC recruitment ads include the mission of the organization. During the compulsory orientation session, all new employees are introduced to CCO's vision in generic terms with a liberal translation of both CCO’s and HRCC's mission statements. As a result, HRCC managers felt that the values and beliefs as stated in the mission are widely shared throughout the organization. All individuals within same disease site team share the same sense of mission regarding patient care. It was felt the smaller size of the centres (relative to the entire CCO organization) allows HRCC to maintain this sense of mission.

The statement was not used as a tool for performance evaluation. One senior team member thought it was more difficult to directly link mission to rewards in a public organization than in a profit-oriented business.

Regional Cancer Centres and “Integration" Strategy

Senior management at HRCC does believe that the planned integration will result in seamless care and improve outcomes for cancer patients. The centre also supports having greater regional authority of control in a decentralized organization. On the other hand, the team members worry about the speed of integration, and the single employer model. Uncertainty and concerns were raised on whether integrating is the only model that would improve patient care. The threat of inequity might also increase from integration. Conflicting views were observed on the issue of whether a new mission, vision and values should be created to reflect the new strategy.

12. SWOT Analysis

Strengths

CCO is a public agency involved in providing services to cancer patients, their families and clinicians. Since the demand for cancer care and services is continuous, there will be continuous need for the agency and its services.

CCO is an agency that realizes the importance of superior cancer care research data. CCO develops evidence-based guidelines to create evidence-based care information for patients, families, and health care providers, at the same time maintaining the quality, currency, and accessibility of resources.[52] Thus, through the use of evidence-based guidelines, CCO bridges the gap between research and clinical care. Related to evidence-based practices, CCO and the regional cancer centres are affiliated with universities. Thus CCO has access to and links with cutting edge cancer research and researchers.

CCO's emphasis on research has lead to increased prominence of its programs. Research indicates that screening for breast cancer is beneficial as it aids in early detection of malignant tumors resulting in better treatment outcomes. With this knowledge, CCO was able to implement the Ontario Breast Screen Program, one of the most eminent cancer prevention programs in Ontario in the last decade.

One of CCO's greatest strength is its employees. Employees are described as passionate about their job and proud of the service they provide. For example, higher wages can be found in comparable private agencies, yet turnover rates at CCO are less than 13%.[53] Therefore, it must be something besides monetary benefit that retains these people. Furthermore, due to the nature of this business, high employee retention can be viewed as another asset. These long-term employees form a firm knowledge base of cancer related information and serve as excellent advisors or mentors to any new hire.

The New Drug Funding Program (NDFP) funds highly expensive anti-cancer drugs for qualifying patients. This is one of CCO's flagship programs that protect patients from the expensive drugs costs. Last year the NDFP reimbursed hospitals to the tune of over $50 million.[54]

Weaknesses

CCO was an organization controlling many different regional centres and was composed of many disjointed or poorly connected departments. Within CCO the silo effect can be observed as different departments work towards achieving departmental objectives, but have difficulty moving along as a unified organization.

Currently CCO funds nine region cancer centres. Though CCO is working towards providing the same services in all regions, each region has different needs.

Difficulties arise in provision of equitable funding based on standardized indicators when each region requires different indicators to measure their unique needs.

CCO is an organization that is focused on the whole spectrum of cancer care. From managing regional cancer centres (a divested task under the new CCO), providing funding, to developing evidence-based guidelines, CCO has a large range of initiatives. Unfortunately this organization has difficulty excelling in all initiatives and thus lacks focus.

Opportunities

There is great potential to centralize patient information from all over the province, regardless of the stage of cancer. CCO could provide all of this information from a central system to interested parties. Thus clinicians and patients could obtain this information in a timely fashion, allowing them to make more knowledgeable decisions regarding their care.

Regional cancer centres can merge their resources and care practices with hospitals. This is a way of providing better care services to the patients. Also, the regional cancer centres will have an opportunity to share resources with the host hospitals.

There is potential to involve community physicians in order to provide care to patients once discharged from the cancer centres. This initiative would facilitate community oncology expansion and allow for seamless care to patients.

Being a provincial agency, CCO can become a recruitment centre for oncology clinicians. This would expand recruitment from a national to a global prospective.

Threats

Privatization of cancer care would make CCO obsolete. CCO would no longer be required to offer its services to the general public.

A major issue for this organization is that it is publicly funded resulting in potential fluctuations in funding levels for operational activities. In addition, since it is a publicly funded organization there is always a possibility that the Ministry of Health and Long-Term Care could decide that the organization is no longer required or that restructuring is needed.

Another threat is that patients could choose to receive cancer care elsewhere (out of province or out of country). This would decrease the need for CCO because care for these patients would not be tracked.

13. PEST Analysis

Due to the nature of the health care industry, a PEST analysis of the factors affecting Cancer Care Ontario's strategy is appropriate.

Political Influences

- The most obvious political influences are from the Canadian federal and provincial governments. Funding, agendas, and political campaign promises affect Cancer Care Ontario to different extents.
- The Ministry of Health and Long-term Care, Ontario's provincial department responsible for health care, is instrumental to the functioning of CCO. It lists its requirements for information, which must be collected by CCO. Also, it has developed a Memorandum of Understanding with CCO to lay-out their relationship and expectations of each party.
- Finally, hospitals affect the political environment around CCO. Under the new strategy, the regional cancer centres are associated with these hospitals, though Cancer Care Ontario deals with the patient information. The governance of the hospitals and their relationship with both the regional cancer centres as well as CCO are political influences on CCO.

Economic Influences

- Funding of Cancer Care Ontario is the largest of the economic influences. Funding sources come from the Provincial government, private donors (though funds primarily go to the regional cancer centres), Pharmaceutical companies, and various fundraising dollars from interest groups such as the Canadian Cancer Society. Shifts in the economy affect the dollars given, donated, and promised to CCO. This can affect the programs CCO can sponsor and a number of programs it already coordinates.

Societal Influences

- The incidence of cancer in the general population and the incidence within target populations affect the attention CCO gives to certain types of cancers and to certain population determinants.
- Media coverage can decide what form of cancer is in the limelight at any given time. CCO must be responsive to this to be able to provide the required support to frontline cancer centres susceptible to the media blitzes. Media-developed cultural sensitivity to various cancer issues is also an influence. For instance, currently there is great media coverage on breast cancer and cancer within the Aboriginal populations. CCO must respond to these.
- Environmental carcinogen-producing activities affect CCO. Whether it is from second hand smoke to something currently unknown, these must be dealt with or have action plans developed.

Technological Influences

- Medical technology and equipment are needed to perform new treatments and surgeries and require more information to support their use.
- Advancement in treatments, e.g. better diagnostics, will increase diagnosis of treatable cancers.
- Research technologies will enable scientists to better determine cause and affect relationships between various carcinogens, cancers, and possible treatments. Once again this creates more information that needs to be tracked, sorted, and passed through the proper channels.
- Information technology and improved communication systems allow for a different delivery of treatments through telemedicine and eHealth initiatives.
- Genetics can provide a screening function to have better early detection systems.

14. $E^O \cong R^S$

A good strategy is one where the organization's resource strengths are concentrated on fulfilling an external environmental opportunity.[55] This relationship is represented by the formula $E^o=R^s$. To assess whether CCO's strategy is considered focused and effective, their resource strengths were compared to the external cancer care environment to determine whether the formula is satisfied. This analysis is

conducted for the ‘new’ CCO strategy. The results are divided into aspects of the strategy that satisfy $E^o=R^s$, and those that do not.

Satisfy $E^o=R^s$

The following section discusses portions of CCO’s strategy where the resource strengths are used to meet an external environmental opportunity.

- Holistic Management of Ontario Cancer Care
  It is important that a healthcare system be managed at a holistic level. The advantage of this is that one party can lobby for provincial funding, creating a more powerful and persuasive group. As well, a centralized organization can properly plan to ensure resources are made available to meet long-term trends and ensure that the quality of all services provided is maintained. CCO has been successful and has the personnel to continue in this role.
- Providing Evidence-Based Guidelines
  CCO is involved in a strong research network that is focused on improving preventive, screening, and treatment procedures. As well, its patient tracking capabilities allow it to analyze the outcomes of different activities to identify best practices. These resource strengths provide Ontario’s cancer care system with an important tool. From the information collected, CCO develops practice standards called Evidence-Based Guidelines that have been proven to be the most effective. The advantage to these guidelines is an increased quality of care that is consistent throughout the system.
- New Drug Funding Program
  The NDFP makes expensive pharmaceutical treatments available to patients who otherwise couldn’t afford them. There is clearly an opportunity for this program to ensure all Ontario residents can access the same level of treatment, regardless of cost of the drugs in question. As a centralized organization, CCO can effectively lobby for drug funding from the provincial government. As well, CCO is able to use the data it collects to forecast future demand, allowing the government to budget more accordingly.
- Educating the Public
  Through its data management role, CCO is able to identify and often quantify environmental risk factors. Communicating this information to the public is a natural fit. Presently, CCO has programs to educate the public on the cancer risk

associated with smoking and poor diet. As well, data can be used to prove the effectiveness of screening programs and therefore to encourage increased participation. By providing this information, the public benefits through a reduction in cancer incidence.

Do Not Satisfy $E^o = R^s$

The following section discusses portions of CCO's strategy where the either an external environmental threat is present or a resource weakness.

- Management of Screening Programs

  The Ontario screening programs are a vital element of provided cancer services. Early detection has been directly linked to more favourable treatment outcomes. However, CCO's management of these screening programs is problematic. While CCO does have the resource strength to provide the Evidence-Based Guidelines for screening techniques, they lack the ability to properly manage each screening centre. The screening centres are dispersed geographically throughout the province. The geographic isolation fragments the screening system. In fact, many of the screening centres feel that they are (or at least would prefer to be) autonomous from CCO.

- Management of All IT Functions

  Currently, CCO manages all its IT requirements in-house. The vast size of the organization and its data management intensive role makes providing and maintaining IT needs very resource intensive. Although an opportunity for this service clearly exists, IT is not one of CCO's core competencies.

- Regional Organization of CCO

  CCO oversees a network of treatment and screening centres that are regionally based. However, this organization contrasts Ontario's overall healthcare system. Unlike other provinces, Ontario lacks health regions. For CCO, this provides an environmental threat. Without an already existing regional organization and infrastructure available to use, CCO must essentially create its own. This necessitates a greater expenditure of resources.

15. Recommendations

From the strategic analysis conducted, areas for improvement were identified. The following recommendations are designed to address these shortcomings. These recommendations focus on CCO's mission and vision statements, product market focus, and organizational structure.

a. Mission and Vision

Currently, CCO employees are confused about their roles and responsibilities. Employees are unsure how the mission/vision statement is affecting their jobs. From the interviews conducted, it was seen that the mission/vision statement is not incorporated into employee job descriptions or performance appraisals nor is it used in recruitment, termination and rewarding of employees. The current mission/vision statement does not have any "personal" effect on individual employees. To increase the impact of the mission/vision statement, CCO must improve the statement itself through development, communication, and implementation.

Content

A new mission and/or vision for CCO is necessary to reflect its new strategy. A good mission statement captures an organizations' unique and enduring reason for being, and energizes stakeholders to pursue common goals.[56] It must be simple enough to remember. Research has shown that mission/vision statements between 30 to 60 words have the greatest impact on performance.[57] As well, they should be crafted in such a way that they "speak to people" and are inspirational.

The new mission/vision statement should place more emphasis on employees. The old one mentioned only patients and the various functions of CCO but did not address its employees. As well, for employees to accept the mission and vision, personal values should act as the cornerstone of the statements.[58] Especially in the healthcare sector, employees want to be proud of where they work and feel that they are making a difference to society. This should be reflected in the mission and vision.

Development

Apart from having the right content, the process used in developing a mission and vision statement in vital to its acceptance and effectiveness. It has been shown

that increased involvement of stakeholders in the process will lead to a wider sense of ownership of the statement, and, consequently, an increased employee commitment and satisfaction.[59] Therefore, CCO should involve staff from as many different departments and from many different levels of the corporate ladder. Typically, those at the bottom are ignored in the process; yet, these 'front-line' employees are usually intimately involved in implementing the mission.

The development process should be flexible rather than rigid. Deadlines should be avoided. Only once the statements are believed to have wide spread acceptance (i.e. secret ballot), should the process be considered complete.

Communication

Currently, many employees do not know the CCO vision statement. Many of those surveyed were unaware or only vaguely aware. As well, the present vision lacks consistency; different versions of the vision were used in CCO's public documents. In addition, the mission statement, although it exists, is not communicated. Only after an exhaustive search through company documentation was this statement discovered. These are all signals that the communication of CCO's MVV needs to be improved. Even a great mission and vision statement is of little use if it is not communicated successfully. To achieve proper communication of the statements, four principles must exist: the message must be sent, it must be received, it must be understood, and it must be remembered.[60]

There are many different methods of sending a message, such as emails, newsletters, posters and plaques. However, the most effective communication method is the one that is often neglected; word of mouth. Research has shown than when used, word of mouth is the most powerful means to ensure that the mission/vision statement is sent, received, understood and remembered.[61] The advantage of this method is employees can ask questions and clarify how the statements relate to their role in the organization. In addition to other forms, CCO should rely heavily on word of mouth communication.

Two groups of stakeholders with which there is often a lack of communication are customers and investors. Making these groups aware of the organization's mission and vision has been shown to have substantial benefits.[62] CCO should make sure that the mission is expressed to patients, the government, partner organizations, and the public.

Implementation

If an organization doesn't "live" its mission statement, it will be of little importance to employees. From the employees' entry into the organization to their exit, the mission should be the focus of all activities. It is recommended that CCO integrates the mission/vision into business practices.

Some organizations use the mission statement in selection and orientation of employees. This practice ensures that the right people are hired and they clearly understand the organizational values and their role in achieving the mission early. The results of the employee survey discovered that a number of employees who have been with CCO for less than two years were unaware or only vaguely aware of the vision statement. As well, the decisions and behaviour of those new to CCO were impacted little by its contents. The probable cause of this is CCO's lack of a proper orientation program.

The MVV should be used during interviews to see if the applicant is a good fit to the organization. As well, CCO should introduce a formal orientation program, clearly explaining the mission/vision statement and ensuring the employee understands how the statement affects their role in the organization. If it is discovered in the orientation process that the employee does not accept the organization's values, they should be fired. "They are a virus to others!"[63]

One of the greater tools management has to communicate organizational priorities is to align the mission/vision statement with the organization's reward system.[64] CCO should ensure that performance evaluations have a strong connection to the mission statement. Once employee remuneration is tied to mission/vision achievement, the decisions and behaviour of employees will change accordingly.

b. Product Market Focus

The analysis has shown that CCO's restructuring is a positive move. CCO has a core competency of managing information and guideline development. Therefore, it is logical that it focuses on this area. In the past, the management of care delivery has been problematic. The geographical isolation of the regional cancer care centres limited CCO's ability to oversee or address concerns regarding patient care at these sites, at the local level. As a result, many of the regional cancer centres viewed themselves as autonomous units.

With this in mind, it is recommended that CCO also move away from operating the regional screening programs. This would remove the organization from the "patient care" segment altogether. The geographic dispersion of the screening centres present similar problems that the regional centres did. Quality of service of the screening programs could be assured by providing evidence-based guidelines of best practices and through periodic audits. This move would allow CCO to establish greater focus on its information management role.

c. Building Relationships with Pharmaceutical Companies

The New Drug Funding Program has been a well recognized success of CCO. As a result of this program, expensive pharmaceuticals are supplied to patients who otherwise couldn't afford them. This centralized purchasing role provides CCO enormous influence with the pharmaceutical industry. It is recommended that the CCO establish a stronger partnership with the pharmaceutical industry in order to improve the level of cancer treatment, especially in Systemic Therapy and Chemotherapy.

As discussed, CCO collects information on every cancer case in Ontario. The depth of this database is unrivaled in Canada. However, despite its existence, many pharmaceutical companies conduct their own research. If CCO were to provide its tracking information to pharmaceutical companies, it would be advantageous to both parties. The drug companies would have much richer data to support decisions on areas to focus research and shortcomings of current drug therapies. CCO would benefit by being able to provide cancer patients with a higher quality of drug treatments. It is noted that if pursued, the confidentiality of each patient must be assured.

In addition to the sharing of data, CCO has the power to reduce the cost of drug therapies. Quantity purchases of drugs to supply the entire province should allow CCO to obtain drugs at a discount. As well, by working closely with the drug companies, CCO may be able to lobby for lower prices. It is recognized, however, that the drug efficacy should be of the utmost importance.

d. Outsourcing IT Functions

CCO manages and interacts with a vast network of departments and organizations. As well, its operations, such as patient tracking, require sophisticated data management capabilities. As a result, CCO has enormous IT requirements. Presently, the organization supplies its own IT services in-house. However, IT

capabilities are not a CCO core competency. CCO should consider outsourcing many of its IT functions. Using external companies that specialize in IT services should increase quality and reduce costs. Considering the importance CCO IT requirements, control of critical elements should be retained. For example, project management should remain an internal activity.

e. Regional Organization of CCO

Ontario's healthcare system is unique in that it does not have health regions. In contrast, CCO does operate a regionally based system. Therefore, without a provincial regional infrastructure to use, in essence, CCO must create one. This results in a situation that requires CCO to be careful in its operations and planning. The extra responsibility CCO must fulfill can force the expenditure of additional resources. To avoid excess costs and ensure the system is well integrated, CCO management must remain detail oriented and diligently aware of the provincial infrastructure.

16. Conclusion

The strategic analysis has determined that CCO's new strategy is a positive move. The organization has become more focused, capitalizing on its resource strengths to satisfy external opportunities. Interviews with CCO employees discovered a sense of optimism about transition. There is an overall feeling that CCO's new strategy will create a cancer care system that is less fragmented, providing better patient care. However, some recommendations have been proposed. New vision and mission statements should be constructed, communicated and implemented to reduce confusion, especially through the strategy change. This will allow for focused energy of all stakeholders towards the organization's common goals. As well, the opportunity exists for CCO to divest some of its operational efforts in the screening programs, outsource IT services, and create a more productive relationship with the pharmaceutical industry.

Appendix A: Survey instrument

CCO VISION STATEMENT SURVEY

This survey is intended to assess the impact of CCO's Vision statement on employees. The survey is required for a course at McMaster University and will be used by students in a case write-up. The results will be forwarded to CCO senior management. **There are no "right" or "wrong" answers.**

<u>The anonymity of individual responses is assured</u>

Your help in completing this survey is greatly appreciated!

CCO's Vision Statement is:

To lessen the growing burden of cancer in Ontario by ensuring that all Ontario residents have timely, equitable access to an integrated system of excellent, coordinated and efficient programs in prevention, early detection, care, education and research.

1. Were you aware that this is CCO vision statement?

   ☐ **YES** ☐ It only seems **VAGUELY** familiar ☐ **NO**, this is the first time I'm seeing it

   <If you answered NO, please proceed to Question 8>

2. To what extent are you committed to the vision statement?

1	2	3	4	5	6	7
Not at all						To the greatest extent

3. To what extent does the vision statement impact your behaviour?

1	2	3	4	5	6	7
Not at all						To the greatest extent

4. To what extent does the vision statement impact the behaviour of others in your department?

1	2	3	4	5	6	7
Not at all						To the greatest extent

5. To what extent does the vision statement impact your decision-making?

1	2	3	4	5	6	7
Not at all						To the greatest extent

6. To what extent does the vision statement act as a source of inspiration, energy, and purpose in doing your job?

1	2	3	4	5	6	7
Not at all						To the greatest extent

7. How satisfied are you with CCO's vision statement?

1	2	3	4	5	6	7
Not at all Satisfied						Extremely Satisfied

8. Years with CCO: ______________________

9. Department: ______________________

10. Staff Type:
    - ☐ Management
    - ☐ Clinical
    - ☐ Research
    - ☐ Support Staff
    - ☐ Other Professional

Appendix B: Survey data analysis

Table 1: Frequency of Department Responses

	Departments	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	IT	11	12.0	20.0	20.0
	Admin	3	3.3	5.5	25.5
	Preventive Oncology	21	22.8	38.2	63.6
	HR	1	1.1	1.8	65.5
	OCGN	1	1.1	1.8	67.3
	OBSP	2	2.2	3.6	70.9
	Finance	3	3.3	5.5	76.4
	Radiation Coordinators Office	4	4.3	7.3	83.6
	Research	4	4.3	7.3	90.9
	Systemic Therapy	2	2.2	3.6	94.5
	ACCU	1	1.1	1.8	96.4
	CQCO	1	1.1	1.8	98.2
	Surgical Oncology	1	1.1	1.8	100.0
	Total	55	59.8	100.0	
Missing	System	37	40.2		
Total		92	100.0		

Table 2: Frequency of Staff Type Responses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Support	23	25.0	37.1	37.1
	Management	13	14.1	21.0	58.1
	Research	14	16.2	21.0	79.0
	Other	12	13.0	19.4	100.0
	Total	62	67.4	100.0	
Missing	System	30	32.6		
Total		92	100.0		

Table 3: Mean Responses of All Respondents

	N	Mean
Aware of Vision	62	.45
Committed to Vision	54	5.93
Impact Your Behaviour	54	4.89
Impact Others Behaviour	52	4.75
Impact Your Decisions	54	4.91
Act as Source Inspiration	55	4.93
Satisfied with Vision	55	5.31
Year with Org.	61	6.44
Valid N (listwise)	52	

Table 4: Frequency of Years Bracket Responses

	Classification		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	New to CCO	1-2 Years	19	20.7	31.1	31.1
	Intermediate	3-5 Years	18	19.6	29.5	60.7
	Experienced	6-10 Years	12	13.0	19.7	80.3
	Long-Time	11+ Years	12	13.0	19.7	100.0
		Total	61	66.3	100.0	
Missing		System	31	33.7		
Total			92	100.0		

Table 5: Frequency of Awareness Responses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	42	45.7	67.7	67.7
	Vaguely	12	13.0	19.4	87.1
	No	8	8.7	12.9	100.0
	Total	62	67.4	100.0	
Missing	System	30	32.6		
Total		92	100.0		

Table 6: Analysis of Variance with Respect to Staff Type

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Aware of Vision	Between Groups	3.814	3	1.271	2.678	.055
	Within Groups	27.541	58	.475		
	Total	31.355	61			
Committed to Vision	Between Groups	9.341	3	3.114	1.361	.265
	Within Groups	114.363	50	2.287		
	Total	123.704	53			
Impact Your Behaviour	Between Groups	16.114	3	5.371	1.482	.231
	Within Groups	181.220	50	3.624		
	Total	197.333	53			
Impact Others Behaviour	Between Groups	15.391	3	5.130	1.517	.222
	Within Groups	162.359	48	3.382		
	Total	177.750	51			
Impact Your Decisions	Between Groups	19.283	3	6.428	1.735	.172
	Within Groups	185.254	50	3.705		
	Total	204.537	53			
Act as Source Inspiration	Between Groups	9.964	3	3.321	.893	.451
	Within Groups	189.745	51	3.720		
	Total	199.709	54			
Satisfied with Vision	Between Groups	12.683	3	4.228	1.409	.251
	Within Groups	153.063	51	3.001		
	Total	165.745	54			

Table 7: Tukey Analysis Comparing Mean Responses by Staff Type

Multiple Comparisons

Tukey HSD

Dependent Variable	(I) Staff Type	(J) Staff Type	Mean Difference (I-J)	Std. Error	Sig.	90% Confidence Interval	
						Lower Bound	Upper Bound
Aware of Vision	Support	Management	-.50	.239	.170	-1.06	.06
		Research	.20	.234	.816	-.34	.75
		Other	-.24	.245	.773	-.81	.34
	Management	Support	.50	.239	.170	-.06	1.06
		Research	.70*	.265	.049	.08	1.33
		Other	.26	.276	.777	-.38	.91
	Research	Support	-.20	.234	.816	-.75	.34
		Management	-.70*	.265	.049	-1.33	-.08
		Other	-.44	.271	.373	-1.08	.19
	Other	Support	.24	.245	.773	-.34	.81
		Management	-.26	.276	.777	-.91	.38
		Research	.44	.271	.373	-.19	1.08
Committed to Vision	Support	Management	.25	.586	.974	-1.13	1.63
		Research	-.81	.539	.442	-2.08	.46
		Other	-.62	.568	.693	-1.96	.71
	Management	Support	-.25	.586	.974	-1.63	1.13
		Research	-1.06	.636	.351	-2.56	.43
		Other	-.87	.661	.554	-2.43	.68
	Research	Support	.81	.539	.442	-.46	2.08
		Management	1.06	.636	.351	-.43	2.56
		Other	.19	.620	.990	-1.27	1.65
	Other	Support	.62	.568	.693	-.71	1.96
		Management	.87	.661	.554	-.68	2.43
		Research	-.19	.620	.990	-1.65	1.27
Impact Your Behaviour	Support	Management	1.40	.737	.242	-.33	3.13
		Research	.25	.678	.983	-1.35	1.84
		Other	.95	.715	.553	-.74	2.63
	Management	Support	-1.40	.737	.242	-3.13	.33
		Research	-1.15	.801	.480	-3.04	.73
		Other	-.45	.832	.947	-2.41	1.50
	Research	Support	-.25	.678	.983	-1.84	1.35
		Management	1.15	.801	.480	-.73	3.04
		Other	.70	.780	.807	-1.14	2.53
	Other	Support	-.95	.715	.553	-2.63	.74
		Management	.45	.832	.947	-1.50	2.41
		Research	-.70	.780	.807	-2.53	1.14
Impact Others Behaviour	Support	Management	1.60	.769	.174	-.21	3.41
		Research	.18	.655	.993	-1.37	1.72
		Other	.28	.690	.977	-1.34	1.91
	Management	Support	-1.60	.769	.174	-3.41	.21
		Research	-1.42	.826	.324	-3.37	.52
		Other	-1.32	.855	.421	-3.33	.69
	Research	Support	-.18	.655	.993	-1.72	1.37
		Management	1.42	.826	.324	-.52	3.37
		Other	.10	.753	.999	-1.67	1.88
	Other	Support	-.28	.690	.977	-1.91	1.34
		Management	1.32	.855	.421	-.69	3.33
		Research	-.10	.753	.999	-1.88	1.67
Impact Your Decisions	Support	Management	1.45	.745	.223	-.30	3.20
		Research	-.03	.686	1.000	-1.65	1.58
		Other	.90	.723	.605	-.80	2.60
	Management	Support	-1.45	.745	.223	-3.20	.30
		Research	-1.48	.810	.270	-3.39	.42
		Other	-.55	.841	.912	-2.53	1.42
	Research	Support	.03	.686	1.000	-1.58	1.65
		Management	1.48	.810	.270	-.42	3.39
		Other	.93	.789	.642	-.92	2.78
	Other	Support	-.90	.723	.605	-2.60	.80
		Management	.55	.841	.912	-1.42	2.53
		Research	-.93	.789	.642	-2.78	.92
Act as Source Inspiration	Support	Management	1.19	.741	.388	-.56	2.93
		Research	.21	.681	.990	-1.39	1.81
		Other	.47	.718	.915	-1.22	2.16
	Management	Support	-1.19	.741	.388	-2.93	.56
		Research	-.98	.811	.627	-2.88	.93
		Other	-.72	.843	.829	-2.70	1.26
	Research	Support	-.21	.681	.990	-1.81	1.39
		Management	.98	.811	.627	-.93	2.88
		Other	.26	.790	.988	-1.60	2.12
	Other	Support	-.47	.718	.915	-2.16	1.22
		Management	.72	.843	.829	-1.26	2.70
		Research	-.26	.790	.988	-2.12	1.60
Satisfied with Vision	Support	Management	1.36	.666	.185	-.20	2.93
		Research	.53	.611	.821	-.91	1.97
		Other	.40	.645	.926	-1.12	1.91
	Management	Support	-1.36	.666	.185	-2.93	.20
		Research	-.83	.729	.667	-2.54	.88
		Other	-.96	.757	.584	-2.74	.82
	Research	Support	-.53	.611	.821	-1.97	.91
		Management	.83	.729	.667	-.88	2.54
		Other	-.13	.710	.998	-1.80	1.54
	Other	Support	-.40	.645	.926	-1.91	1.12
		Management	.96	.757	.584	-.82	2.74
		Research	.13	.710	.998	-1.54	1.80

*. The mean difference is significant at the .10 level.

Table 8: Comparison of Means with Respect to Staff Type

Staff Type	Aware of Vision	Impact Your Behaviour	Impact Your Decisions	Satisfied with Vision	Committed to Vision	Impact Others Behaviour	Act as Source Inspiration
	0 =”Yes” 1=”Vaguely” 2=”No”	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent
Support	.61	5.40	5.35	5.76	5.65	5.10	5.29
Management	.85	4.00	3.90	4.40	5.40	3.50	4.10
Research	.15	5.25	5.50	5.42	6.58	5.00	5.33
Other	.58	4.45	4.45	5.36	6.27	4.82	4.82

Table 9: Analysis of Variance with Respect to Experience Bracket

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Aware of Vision	Between Groups	2.320	3	.773	1.657	.186
	Within Groups	26.598	57	.467		
	Total	28.918	60			
Committed to Vision	Between Groups	10.640	3	3.547	1.568	.209
	Within Groups	113.064	50	2.261		
	Total	123.704	53			
Impact Your Behaviour	Between Groups	8.350	3	2.783	.736	.535
	Within Groups	188.983	50	3.780		
	Total	197.333	53			
Impact Others Behaviour	Between Groups	1.475	3	.492	.134	.939
	Within Groups	176.275	48	3.672		
	Total	177.750	51			
Impact Your Decisions	Between Groups	4.857	3	1.619	.405	.750
	Within Groups	199.680	50	3.994		
	Total	204.537	53			
Act as Source Inspiration	Between Groups	7.605	3	2.535	.673	.573
	Within Groups	192.104	51	3.767		
	Total	199.709	54			
Satisfied with Vision	Between Groups	12.391	3	4.130	1.374	.261
	Within Groups	153.354	51	3.007		
	Total	165.745	54			

Table 10: Comparison of Means with Respect to Experience Bracket

Years Brackets	Aware of Vision	Committed to Vision	Impact Your Behaviour	Impact Others Behaviour	Impact Your Decisions	Act as Source Inspiration	Satisfied with Vision
	0 ="Yes" 1="Vaguely" 2="No"	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent
1-2 Years	.84	5.44	4.50	4.76	4.56	4.94	5.28
3-5 Years	.39	6.19	5.44	4.93	5.31	5.44	5.44
6-10 Years	.67	6.67	5.00	4.78	4.89	4.56	6.11
11+ Years	.08	5.73	4.64	4.45	4.91	4.50	4.58

Table 11: Comparison of Means with Respect to Departments

Department	Aware of Vision	Committed to Vision	Impact Your Behaviour	Impact Others Behaviour	Impact Your Decisions	Act as Source Inspiration	Satisfied with Vision
	0 ="Yes" 1="Vaguely" 2="No"	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent	1=Not at All, 7= Greatest Extent
IT	.91	5.36	4.73	5.00	5.18	4.82	5.18
Admin	.00	6.50	5.50	5.50	6.50	5.67	5.33
Preventive Oncology	.76	5.71	3.94	3.73	3.88	4.12	4.82
HR	.00	5.00	4.00	5.00	5.00	4.00	5.00
OCGN	2.00						
OBSP	.00	7.00	6.50	6.50	5.00	6.50	6.50
Finance	.67	7.00	7.00	4.50	6.50	6.50	6.50
Radiation Coordinators Office	.00	6.75	6.25	6.25	6.50	5.50	6.75
Research	.00	6.50	6.00	5.00	6.25	5.75	5.50
Systemic Therapy	.00	6.00	6.00	5.00	6.50	6.00	5.50
ACCU	.00	7.00	7.00	6.00	6.00	7.00	6.00
CQCO	.00	5.00	5.00	7.00	5.00	5.00	7.00
Surgical Oncology	.00	7.00	7.00	7.00	7.00	7.00	5.00

Appendix C: Interviews at Cancer Care Ontario

Appendix D: Interviews at the Hamilton Regional Cancer Centre

References

[1] "Ministry of Health and Long-Term Care. Report of the Cancer Services Implementation Committee." (December 2001). Retrieved January 31, 2003 from the World Wide Web: http://www.health.gov.on.ca/english/public/pub/ministry_reports/hudson/hudson.html

[2] "Operations Report: Regional Implementation of the Cancer Care Ontario Strategic Plan" 2000, 3.

[3] "Operations Report: Regional Implementation of the Cancer Care Ontario Strategic Plan" 2000, 35.

[4] "Dr. Alan Hudson named president and CEO" Toronto: Cancer Care Ontario. Retrieved 1 April 2003 from the World Wide Web: http://www.cancercare.on.ca/pubs/winter2002/story2news.html

[5] Hudson, Alan, "The First 200 Days: Cancer Leadership Ontario." *Hospital Quarterly,* Fall 2002, 30-35.

[6] Hudson, Alan, "The First 200 Days: Cancer Leadership Ontario," 30-35

[7] Hudson, Alan, "The First 200 Days: Cancer Leadership Ontario," 30-35

[8] Hudson, Alan "The First 200 Days: Cancer Leadership Ontario," 30-35

[9] "A New look for a new direction" (n.d) Toronto: Cancer Care Ontario. Retrieved March 28, 2003 from the World Wide Web: http://www.cancercare.on.ca

[10] Partners in Cancer Care: Building A Quality Improvement Coalition. 2002-2007 Information Management Strategic Plan. http://www.cancercare.on.ca/about/IMStrategy02-07.pdf ,1.

[11] Partners in Cancer Care: Building A Quality Improvement Coalition. 2002-2007 Information Management Strategic Plan. http://www.cancercare.on.ca/about/IMStrategy02-07.pdf ,2.

[12] Partners in Cancer Care: Building A Quality Improvement Coalition. 2002-2007 Information Management Strategic Plan. http://www.cancercare.on.ca/about/IMStrategy02-07.pdf ,i - ii.

[13] Bart, C. and Baetz, M.C., "The Relationship between Mission Statements and Firm Performance: An Exploratory Study" Journal of Management Studies, Vol. 35, No. 6, Nov 1998

[14] Bart, Christopher. "Creating Effective Mission Statements" Health Progress, Sept/Oct 2002 , 41.

[15] Bart, Christopher"Creating Effective Mission Statements," 42.

[16] Christopher Bart, Business P710 Lecture, (Hamilton, Ontario: McMaster University, 8 January, 2003).

[17] Bart, Christopher. "Mission Possible" CA Magazine, September 1997, 33.

[18] George Browman, VP, Hamilton Regional Cancer Center, Interviewed by Charmaine Chui and Alex Drossos, February 25th, 2003, Hamilton, Ontario.

[19] Bill Evans, Executive Vice President, CCO, Interviewed by Alex Drossos, March 11, 2003, Toronto, Ontario.

[20] Bart, Christopher, "Making Mission Statements Count," CA Magazine, March 1999, 37-38.

[21] Cancer Care Ontario. "Executive Summary of the October 1997 Strategic Plan". October 1997.

[22] Cancer Care Ontario. "Executive Summary of the October 1997 Strategic Plan". October 1997.

[23] Cancer Care Ontario. "Executive Summary of the October 1997 Strategic Plan". October 1997.

[24] Bart, Christopher, Corporate Reputation Management Seminar, February 27, 2003.

[25] "Cancer Care Ontario Memorandum of Understanding."(n.d) Retrieved March 7, 2003 from the World Wide Web at http://www.cancercare.on.ca

[26] Operations Report, " Regional Implementation of the Cancer Care Ontario Strategy Plan", April 1997-2000

[27] Operations Report 1997-2000, 6.

[28] Operations Report 1997-2000, 9.
[29] Operations Report 1997-2000, 12.
[30] An Information Management Strategy (IM Strategy) , "Partners in Cancer Care: Building a Quality Improvement Coalition" , www.cancercare.on.ca/about/IMStrategy02-07.pdf
[31] IM Strategy, www.cancercare.on.ca/about/IMStrategy02-07.pdf, 23.
[32] IM Strategy, www.cancercare.on.ca/about/IMStrategy02-07.pdf, 29.
[33] Cancer Care Ontario Human Resources department data.
[34] CCO Employee Handbook pg III-3
[35] Mission, Vision, Values sheet. CCO Internal Document
[36] "The Ontario Cancer Care Registry – Introduction" (July 31, 2002). Retrieved March 3, 2003 from the World Wide Web: www.cancercare.on.ca/ocr/ontcancerreg.html
[37] "Research Unit in the Division of Preventive Oncology" (November 2000). Retrieved March 3, 2003 from the World Wide Web: www.cancercare.on.ca/prevention/researchunit/researchunit.html
[38] "Research and Statistical Information" (June 1999). Retrieved March 3, 2003 from the World Wide Web: www.cancercare.on.ca/research/home.html
[39] "Research Unit in the Division of Preventive Oncology", World Wide Web.
[40] "Media network" (September 2000). Retrieved March 3, 2003 from the World Wide Web: www.cancercare.on.ca/prevention/medianetwork.html
[41] "Prevention and Screening" (June 1999). Retrieved March 3, 2003 from the World Wide Web: http://www.cancercare.on.ca/prevention/home.html
[42] "Publications" (June 1999) Retrieved March 3, 2003 from the World Wide Web: www.cancercare.on.ca/pubs/home.html
[43] "Ontario Breast Screening Program" (October 2000). Retrieved March 3, 2003 from the World Wide Web: www.cancercare.on.ca/obsp/obspinfo.html
[44] IM Strategy, www.cancercare.on.ca/about/IMStrategy02-07.pdf, 16.
[45] IM Strategy, www.cancercare.on.ca/about/IMStrategy02-07.pdf, 23.
[46] IM Strategy, www.cancercare.on.ca/about/IMStrategy02-07.pdf, 15.
[47] Aczel, Amir. Complete Business Statistics (Irwin/McGraw-Hill, 1999), 395-401.
[48] Bart, C, "Accepting the Mission," Accepting the Mission
[49] Bart, C, "Mission Possible," 33-34.
[50] Sandra Palmer, CCO, email message to Alex Drossos, 20 March 2003.
[51] "Hamilton Regional Cancer Centre Mission Statement" (n.d.)Retrieved 20 March 2003 from the World Wide Web http://www.hrcc.on.ca/statement.htm
[52] "Program in Evidence Based-Care" (June 12, 1998) Retrieved 18 March 2003 from the World Wide Web: http://www.ccopebc.ca/ebc.html
[53] Sandra Palmer, CCO, email message to Alex Drossos, 20 March 2003.
[54] "2002 CCO Annual Report" (n.d) Retrieved 7 March 2003 from the World Wide Web: http://www.cancercare.on.ca/index.html
[55] Bart, Business P710 Lecture.
[56] Bart, C., "Mission Matters," CA Magazine, March 1998, 31-32.
[57] Bart, "Mission Matters," 31-32.
[58] Bart, "Mission Matters," 31-32.
[59] Bart, "Making Mission Statements Count," 37-38.
[60] Christopher Bart, Corporate Reputation Management Seminar, February 27, 2003
[61] Bart, "Making Mission Statements Count," 37-38.
[62] Bart, "Making Mission Statements Count," 37-38.
[63] Bart, Christopher. A Tale of Two Employees & the Person Who Wanted to Lead Them. (Corporate Missions Inc. Press:2002)
[64] Bart, C., "Accepting the Mission," Accepting the Mission