AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

THURSDAY, 7:00 p.m.
2013 January 17

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Mr. David Bolton
Ms. Denise Brown
Mr. Al Edmondson
Mr. Marcel Meyer
Mr. Stephen Orser
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

SECRETARY-TREASURER

Dr. Bryna Warshawsky

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

7:25 – 7:40 p.m.	Mr. Chirag Shah, Partner, and Mr. Scott Gilfillan, Senior Manager of the Audit and Assurance Group for PricewaterhouseCoopers, Item #2 - Report No. 002-13 re "Shared Services Review - Proposal"
7:40 - 7:55 p.m.	Mr. Ross Graham, Manager, Special Projects, Item #3 - Report No. 003-13 re "Board of Health Code of Conduct: Second Draft"
7:55 – 8:10 p.m.	Mr. Ross Graham, Manager, Special Projects, Item #4 - Report No. 008-13 re "Annual Performance Report on the Strategic Directions"

REPORTS

	Report No. and Name	Link to Appendices and Key Additional Information	Delegation	Recommendation	Information	Brief Overview
1.	Report No. 001-13 re "Election of 2013 Board of Health Executive and Other Procedures for the First Meeting of the Year"	Appendix A Appendix B		X		To conduct the election of the 2013 Board of Health Executive and complete other procedures required by the Board of Health Bylaws
2.	Report No. 002-13 re "Shared Services Review - Proposal"	Appendix A	X	X		To present the Shared Services Review proposed project plan for Board of Health approval
3.	Report No. 003-13 re "Board of Health Code of Conduct: Second Draft"	Appendix A	X	X		To present a second draft of the Code of Conduct for Board of Health review and feedback
4.	Report No. 008-13 re "Annual Performance Report on the Strategic Directions"		X		X	To provide an annual update on progress regarding the strategic directions
5.	Report No. 004-13 re "Ontario Ministry of Transportation's Draft Cycling Strategy"	Appendix A Appendix B Appendix C Appendix D		X		To request that the Board of Health endorse and convey its comments regarding the Ontario Ministry of Transportation's draft Cycling Strategy
6.	Report No. 005-13 re "Changes to the Staff Complement for the Oral Health Team"			X		To request Board of Health approval of changes to the staff complement for the Oral Health Team
7.	Report No. 006-13 re "November 2012 Board of Health Self-Assessment Survey Results"	Appendix A			X	To provide a summary of the results of the November 2012 Board of Health Self-Assessment Survey
8.	Report No. 007-13 re "Overview of Health Unit Administrative Functions"	Appendix A Other Appendices attached to report			X	To provide an overview of the administrative functions of the Health Unit in preparation for discussions regarding the Shared Services Review report
9.	Report No. 011-13 re "ONA Pay Equity Maintenance"				X	To provide information regarding upcoming negotiations with the Ontario Nurses Association (ONA) regarding pay equity and implications for the Health Unit
10.	Report No. 009-13 re "Middlesex-London Health Unit Maintains Highest Standard of Accreditation"	Appendix A			X	To report that the Health Unit has been awarded the highest standard of accreditation: Unconditional Accreditation Status for 2012-2013
11.	Report No. 010-13 re "Media Summary Report – January 2012 to December 2012"	Appendix A			X	To provide a summary of media coverage of Health Unit programs, services and activities in 2012
12.	Report No. 012-13 re "Significant Influenza Activity To-date in the 2012-2013 Season"				X	To provide information on the significant amount of influenza activity in the community and the role of the Health Unit in responding
13.	Report No. 013-13 re "Acting Medical Officer of Health Activity Report – December 6, 2012 - January 9, 2013"				X	To provide an overview of the activities of the Acting Medical Officer of Health from December 6, 2012 to January 9, 2013

OTHER BUSINESS

Next proposed scheduled Board of Health Meeting – **7:00 p.m. - February date to be determined**

CORRESPONDENCE RECEIVED

a) Dated 2012 November 29 (Received 2012 December 17) A copy of correspondence from Dr. Lynn Noseworthy, Medical Officer of Health, Haliburton Kawartha Pine Ridge District Health Unit, to The Honourable Dalton McGuinty, Premier of Ontario, advising that the Haliburton Kawartha Pine Ridge District Board of Health passed the following resolutions:

WHEREAS oral health has been linked to overall health and the ability to get and maintain a job and live a confident, fulfilled life; and

WHEREAS OHIP pays to treat infection in every part of the body except the mouth and one in four Ontarians do not visit a dentist because of cost; and

WHEREAS those most likely to report poorer oral health and barriers to accessing care include lower income earners, the uninsured, older adults and those with lower educations; and

WHEREAS working adults and seniors on fixed incomes do not have a government program to assist them with any dental care expenses; and

WHEREAS there are four provincial dental programs for children 0-17, and Healthy Smiles Ontario, the preventive and early dental treatment program, is underutilized provincially due to the low income cut off; and

WHEREAS local Ontario Works (OW) recipients are eligible for limited discretionary coverage mostly to get them out of pain, and Ontario Disability Support Program (ODSP) recipients are eligible for basic dental care and limited discretionary coverage for dentures; and

WHEREAS a recently invoked capping of funding for both non-health related and health related discretionary benefits decreases the amounts of funds available to assist individuals and families and places increased financial pressure on Municipalities; and

WHEREAS a number of recent provincial reports and initiatives have indicated the urgent need to move forward to transform the current oral care health system;

THEREFORE BE IT RESOLVED THAT the Haliburton, Kawartha, Pine Ridge District Health Unit Board of Health call on the provincial government to streamline children's dental treatment programs to make them more efficient, effective and equitable as recommended in Oral Health – More Than Just Cavities. A Report by Ontario's Chief Medical Officer of Health, April 2012; and

Strongly endorse the need for provincial and municipal governments to enact recommendations made in the Brighter Prospects: Transforming Social Assistance in Ontario report, (#47 and #48) which recommend extending health related benefits like dental to all low income Ontarians (those on and off social assistance) and making these benefits consistent across the province

AND FURTHER THAT copies of this resolution be forwarded to the Premier of Ontario, the Minister of Health and Long-Term Care, Local Members of Provincial Parliament, Member Municipalities, the Association of Local Public Health Agencies and all Boards of Health of Ontario.

b) Dated 2012 December 7 (Received 2012 December 7) Correspondence from the Ministry of Health and Long-Term Care, Corporate Management Branch, to Dr. Bryna Warshawsky, Acting Medical Officer of Health & CEO, advising that Board of Health member, Ms. Viola Poletes Montgomery has been reappointed to the Middlesex-London Board of Health for a period of one year, commencing on March 1, 2013 to and including February 28, 2014.

c) Dated 2012 December 11 (Received 2012 December 18) Correspondence from the Honourable Dalton McGuinty, Premier of Ontario, to Dr. Bryna Warshawsky, Secretary-Treasurer, thanking the Board for its letter of November 22, 2012, supporting a provincial nutrition strategy.

d) Dated 2012 December 19 (Received 2012 December 31) Correspondence from The Honourable Deb Matthews, Minister of Health and Long-Term Care, to Ms. Viola Poletes Montgomery, Board Chair, advising that the Ministry of Health and Long-Term Care will provide one-time funding up to $50,000 for the 2012-2013 funding year to support the Healthy Communities Fund Partnership Stream.

e) Dated 2012 December 21 (Received 2012 December 31) Correspondence from The Honourable Deb Matthews, Minister of Health and Long-Term Care, to Ms. Viola Poletes Montgomery, Board Chair, advising that the Ministry of Health and Long-Term Care will provide up to $1,009,300 in annual based funding beginning 2012 to support the Smoke-Free Ontario Strategy.

f) Dated 2012 December 21 (Received 2012 December 31) Correspondence from The Honourable Deb Matthews, Minister of Health and Long-Term Care, to Ms. Viola Poletes Montgomery, Board Chair, advising that the Ministry of Health and Long-Term Care will provide up to $100,300 over two years, effective for the 2012-13 to 2013-14 funding years, to support the workplace-based cessation demonstration project and advance the Smoke-Free Ontario Strategy.

Copies of all correspondence are available for perusal from the Secretary-Treasurer.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 001-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

ELECTION OF 2013 BOARD OF HEALTH EXECUTIVE AND OTHER PROCEDURES FOR THE FIRST MEETING OF THE YEAR

Recommendations

1. ***It is moved by , seconded by that be elected Chair of the Middlesex-London Board of Health for the year 2013; and further***

2. ***It is moved by , seconded by that be elected Vice-Chair of the Middlesex-London Board of Health for the year 2013; and further***

3. ***It is moved by , seconded by that Dr. Bryna Warshawsky be elected Secretary-Treasurer of the Middlesex-London Board of Health until the selection of permanent Medical Officer of Health; and further***

4. ***It is recommended that the Board of Health establish Standing Committees for 2013; and further***

5. ***It is recommended that the schedule of regular Board of Health meetings for 2013 highlighted in Appendix B of Report No. 001-13 be approved following resolution of the outstanding dates.***

6. ***It is recommended that the Board of Health provide direction with regard to an Education Session in 2013.***

Background

The Board of Health consists of the three individuals appointed by the City of London, three individuals appointed by Middlesex County and five individuals appointed by the Province of Ontario. Traditionally, the three Middlesex County representatives and two of the three City of London representatives have been elected officials. The third City of London representative has traditionally been a citizen appointment. However, City Council voted on November 20, 2012 (London Council Minutes - see Item 4 of the 16th Report of the Strategic Priorities and Policy Committee) to rescind the resolution requiring a citizen appointment to the Board of Health and to replace the impending vacancy with a member of London City Council.

There have been several changes to the Board of Health composition since January 2012. These changes have included:

1) **Provincial Appointees:** Two provincial appointees, Ms. Doreen McLinchey and Dr. Francine Lortie-Monette, have left the Board of Health after eight and six years of service respectively. Mr.

Ian Peer has been appointed to the Board of Health and Ms. Viola Poletes Montgomery has been re-appointed to the Board of Health. There is currently a vacancy among the provincial appointees on the Board of Health.

2) **City of London Appointed Members:** Ms. Pat Coderre, the citizen appointee, has left the Board after six years of service. Councillor Sandy White has been appointed to the Board of Health, as per the change in City representation noted above.

3) **Middlesex County Appointed Members**: There has been no change in membership since January 2012.

The current Board of Health therefore consists of:

1) **Provincial Appointees:** Mr. Ian Peer, Ms. Viola Poletes Montgomery; Ms. Nancy Poole and Mr. Mark Studenny. There is one vacant position.

2) **City of London Appointed Members:** Councillor Denise Brown, Councillor Stephen Orser and Councillor Sandy White.

3) Middlesex County Appointed Members: Mayor David Bolton, Mayor Al Edmondson and Deputy Mayor Marcel Meyer.

The terms of Board of Health Members can be found in Appendix A.

Procedures for the First Meeting of the Year

Bylaw No. 3 of the Board of Health regulates the proceedings of the Board. Section 18.0 of this Bylaw addresses Elections and Appointment of Committees. It reads as follows:

18.1 *At the first meeting of each calendar year, the Board shall elect by a majority vote a Chair and a Vice-Chair for that year.*

18.2 *The Chair of the Board shall rotate on an annual basis to one of the representatives of the City of London, the County of Middlesex and the Province of Ontario.*

18.3 *At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other boards, bodies or commissions where appropriate.*

18.4 *The Board may appoint committees from time to time to consider such matters as specified by the Board. (e.g., Human Resources, Planning, etc.).*

Election of Executive Officers

Chair: As per Bylaw No. 3 Section 18 as stated above, the position of Chair rotates annually among the three representative bodies. The rotation has traditionally been as follows: County of Middlesex, City of London, Province of Ontario. Since the 2012 Chair, Ms. Viola Poletes Montgomery, is a provincial appointee, it is expected that the 2013 Chair will be selected from among the Middlesex County appointees.

Vice-Chair: Bylaw No. 3 Section 18 stipulates that the Vice-Chair is elected for a one year term, but does not further stipulate how this position is selected. Mr. Marcel Meyer, a Middlesex County representative, was the 2012 Vice-Chair.

Secretary-Treasurer: Traditionally the Secretary-Treasurer functions have been served by the Medical Officer of Health and CEO. With the retirement of Dr. Graham Pollett at the end of September 2012, the role was designated to Dr. Bryna Warshawsky until the end of 2012 (Report No. 099-12).

Establishment of Standing Committees

In Section 1.3 (ii) of Board of Health Policy No. 2-010 "Structure and Responsibilities of the Board of Health", the Board determines whether it wishes to establish one or more Standing Committees at its inaugural meeting of the year. Historically, the Board of Health has not operated with Standing Committees but has had all matters dealt with directly by the Board, forming *Ad hoc* committees, when necessary (for example, the *Ad hoc* Medical Officer of Health Search Committee). In previous Board of Health reports in 2012, the possibility of establishing a Finance Committee or changing the financial oversight of the Board has been discussed (February 2012 - Report No. 033-12; March 2012 - Report No. 042-12) . If the Board is interested in exploring this direction further, a report can be provided at the next Board meeting with additional information regarding this option.

Approval of 2013 Meeting Schedule

The meeting schedule for the coming year is set at the first meeting of each year. Traditionally, Board meetings have been held the 3rd Thursday of each month with the exception of the December meeting which has been held on the 2nd Thursday. Meetings for the months of July and August have been held on an as needed basis, at the call of the Chair. A proposed meeting schedule for 2013 is presented in Appendix B with dates for discussion due to a possible conflict.

Continuing Education for 2013

Board of Health Policy 2-020 "Orientation for Board of Health Members" states that …*The MOH will arrange a half to full day Board of Health retreat be held annually in March or April with the focus being on a Board identified continuing education topic.* The Board of Health is requested to consider if they would like to proceed with this education session at this time, and if so, what topic they would like to address.

Bryna Warshawsky, MDMC, CCFP, FRCPC
Acting Medical Officer of Health

This report addresses Bylaw #3 as outlined in the MLHU Administration Policy Manual.

MIDDLESEX-LONDON HEALTH UNIT

2013 Middlesex-London Board of Health (BOH)
Date of Member Appointments/Term Expirations

	Name of Board Member	Appointed By	First Appointed to BOH	Expiration Date
1	Ms. Nancy Poole	Province of Ontario	July 28, 2010	July 27, 2013
2	Mr. Ian Peer	Province of Ontario	November 14, 2012	November 13, 2013
3	Ms. Viola Poletes Montgomery	Province of Ontario	March 1, 2006	February 28, 2014
4	Mr. Mark Studenny	Province of Ontario	April 11, 2006	April 10, 2014
	Vacant	Province of Ontario		
5	Ms. Denise Brown	City of London	December 1, 2010	November 30, 2014
6	Mr. Stephen Orser	City of London	October 4, 2011	November 30, 2014
7	Ms. Sandy White	City of London	December 15, 2012	November 30, 2014
8	Mr. David Bolton	County of Middlesex	December 21, 2011	December 31, 2014
9	Mr. Al Edmondson	County of Middlesex	December 1, 2002	December 31, 2014
10	Mr. Marcel Meyer	County of Middlesex	January 1, 2011	December 31, 2014

Appendix A

Appendix B

PROPOSED MIDDLESEX-LONDON BOARD OF HEALTH
MEETING DATES FOR 2013

DATE OF MEETING		
January	17	
February	3rd Thursday is the 21st; however this date presents a conflict for Secretary-Treasurer and a Board member. For consideration: Wed. Feb. 27 or Tues. Feb 19	
March	21	(March break for is March 11-15 for the School Boards)
April	18	(Easter Sunday is March 31)
May	16	
June	20	
July		(at call of Chair)
August		(at call of Chair)
September	19	
October	17	
November	21	
December	12	(Early due to year-end holidays)

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON BOARD OF HEALTH

BYLAWS

IMPLEMENTATION DATE: September 25, 1986

REVISED and RE-ENACTED on November 21, 1996
REVISED and RE-ENACTED on February 19, 1998
REVISED and RE-ENACTED on March 16, 2000
REVISED and RE-ENACTED on March 15, 2001
REVISED and RE-ENACTED on November 18, 2004
REVISED and RE-ENACTED on February 21, 2008
REVISED and RE-ENACTED on February 17, 2011
REVISED and RE-ENACTED on April 19, 2012

Board of Health bylaws, policies and procedures will be reviewed and revised as necessary, and at least every two years.

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 1**

Pursuant to Section 56(1) (a) of the *Health Protection and Promotion Act*, R.S.O. 1990, as amended, chapter H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No. 1 to provide for the **management of property.**

1. In this bylaw:

   (a) "Act" means the *Health Protection and Promotion Act*, R.S.O. 1990 (as amended), Chapter H.7.

   (b) "Agreement" means an agreement between the Board and the Councils for the Corporation of the City of London and the Corporation of the County of Middlesex.

   (c) "Board" means the Board of Health for the Middlesex-London Health Unit.

2. The Board shall hold title to any real property acquired by the Board for the purpose of carrying out the functions of the Board and may sell, exchange, lease, mortgage, or otherwise charge or dispose of real property owned by it, subject to Section 52(4) of the Act.

3. (a) In accordance with the Agreement, the Secretary-Treasurer shall be responsible for the care and maintenance of all properties as required by the Board.

   (b) The Secretary-Treasurer shall keep a written inventory of all properties possessed by the Board and shall update this inventory list annually.

4. Pursuant to the Act and the terms of any leasing or rental agreements, the responsibility of the Secretary-Treasurer shall include, but not be limited to, the following:

   (a) the replacement of, or major repairs to, capital items such as the heating, cooling, and ventilation systems; roof and structural work; plumbing; lighting & wiring;

   (b) the maintenance and repair of the parking areas and the exterior of the building;

   (c) the care and upkeep of the grounds of the property;

   (d) the cleaning, maintaining, decorating and repairing of the interior of the building;

   (e) the maintenance of up-to-date insurance including both property and personal liability coverage, fire, theft, malpractice, errors and omissions and automobile insurance.

5. The Board shall ensure that all such properties comply with applicable statutory requirements contained in local, provincial, and/or federal legislation (e.g., Building Code and Fire Code).

First Reading – April 19, 2012
Second Reading - April 19, 2012
Third Reading - April 19, 2012

This Bylaw to be in force and effect from April 19, 2012, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **19th day of APRIL, 2012.**

_____	_____
Ms. Viola Poletes Montgomery Chair	Dr. Graham L. Pollett Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 2**

Pursuant to Section 56(1)(b) of the *Health Protection and Promotion Act*, R.S.O. 1990(as amended), chapter H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No. 2 to provide for **banking and finance.**

1. In this bylaw:

   (a) "Act" means the *Health Protection and Promotion Act*, R.S.O. 1990, as amended, Chapter H.7;

   (b) "Board" means the Board of Health for the Middlesex-London Health Unit.

2. The Board through the Secretary-Treasurer will enter into an agreement with a recognized chartered bank or trust company which will provide the following services:

   (a) a current chequing or savings account(s) for the Board;

   (b) provision for cancelled cheques on a monthly basis, together with a statement showing all debits and credits;

   (c) payment of interest at a rate to be negotiated between the Board and the bank or trust company for all surplus funds temporarily held in such account(s);

   (d) provide advice and other banking services as required by the Board.

3. The Board will maintain a formal list of names, titles, and signatures of those individuals who have signing authority.

4. Two signatures shall be required on each cheque, comprising one Board Member and the Secretary-Treasurer. These signatures shall be on a signature plate in the keeping of the Director, Finance and Operations.

5. Notwithstanding item 4 of this bylaw, signing authorities shall be restricted to the Chair of the Board of Health, Medical Officer of Health, Associate Medical Officer of Health, and Director, Finance and Operations, any two of whom may sign cheques in the absence of the Chair and/or Secretary-Treasurer.

6. The Secretary-Treasurer is hereby authorized on behalf of the Board to:

   (a) deposit or negotiate or transfer to the bank or trust company (but only for the credit of the Board) all or any cheques, promissory notes, bills of exchange or orders for payment of monies;

   (b) receive all paid cheques and vouchers and to arrange, settle, balance and certify all books and accounts at the bank or trust company;

(c) sign the bank's or trust company's form of settlement of balances and releases;

(d) receive all monies and to give acquittance for the same;

(e) invest excess or surplus funds in interest-bearing accounts or short-term deposits.

7. The Secretary-Treasurer of the Board, shall:

(a) prepare and control the Annual Budget under the jurisdiction of the Board for submission to the Board;

(b) prepare financial and operating statements for the Board in accord with established Ministry policies indicating the financial position of the Board with respect to the current operations;

(c) act as custodian of the books of account and accounting records of the Board required to be kept by the laws of the Province;

(d) in conjunction with the Auditor, arrange for an annual audit of all accounting books and records;

(e) report to the Board on all financial and banking matters;

(f) perform other duties as the Board may direct.

8. The Board of Health is a corporation without share capital.

First Reading – April 19, 2012
Second Reading - April 19, 2012
Third Reading - April 19, 2012

This Bylaw to be in force and effect from April 19, 2012, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **19th day of April 2012**.

_____ _____

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 3**

Pursuant to Section 56(1) (c) of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No.3 to regulate **the proceedings of the Board of Health.**

1. In this bylaw:

(a) "Act" means the *Health Protection and Promotion Act*;

(b) "Board" means the Board of Health for the Middlesex-London Health Unit;

(c) "Chair" means the person presiding at the meeting of the Board;

(d) "Chair of the Board" means the Chairperson elected under Section 57(2) of the Act;

(e) "City" means the Corporation of the City of London;

(f) "County" means the Corporation of the County of Middlesex;

(g) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

(h) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

(i) "Council" means the Council of the City of London and/or the Council of the County of Middlesex;

(j) "Majority" means a simple majority of members present;

(k) "Meeting" means a meeting of the Board;

(l) "Member" means a member of the Board;

(m) "Quorum" means a majority of the members of the Board;

(n) "Secretary-Treasurer" means the Secretary-Treasurer of the Board.

(o) “In-camera” means deliberations of the Board are closed to the public and the media.

1.0 General

1.1 In all the proceedings at or taken by this Board the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committees thereof.

1.2 Except as herein provided, Robert's Rules of Order shall be followed for governing the proceedings of the Board and the conduct of its members.

1.3 A person who is not a member of the Board shall not be allowed to address the Board except upon invitation of the Chair or the members.

1.4 No persons shall smoke in the Board meeting room.

2.0 Convening Meeting

2.1 The regular meetings shall be held at a date and time as determined by the Board at its first regular meeting of the year.

2.2 The Board may, by resolution, alter the time, day or place of any meeting.

3.0 Special Meetings

3.1 A special meeting may be called by the Chair of the Board of Health.

3.2 Any three Board members by written communication to the Secretary-Treasurer may initiate a special meeting.

3.3 A special meeting shall not be summoned for a time which conflicts with a regular meeting or a meeting previously called of the Council(s) of the City of London and/or the County of Middlesex.

4.0 Notifying Board Members of Meetings

4.1 The Secretary-Treasurer shall give notice of each regular and special meeting of the Board and of each Committee to the members thereof.

4.2 The notice shall be accompanied by the "Agenda" and any other matter, so far as known, to be brought before such meeting.

4.3 The notice shall be delivered or sent by ordinary mail to the residence or place of business of each member so as to be received no later than the Friday of the week before the scheduled Board meeting.

4.4 Lack of receipt of the notice shall not effect the validity of holding the meeting or any action taken thereat.

4.5 The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that

stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

5.0 Notifying the Public of Board Meetings

5.1 The Board shall give reasonable notice to the public of every of its meetings by posting in a publicly accessible location and by publishing on its website or any other print or electronic medium of mass communication:

(a) the date, time and location of the meeting;

(b) a clear, comprehensive agenda of the items to be discussed at the meeting.

5.2 If an electronic or telephone meeting is to be held, the Board will ensure that the public can exercise, without difficulty, their right to attend the meeting.

6.0 Meetings Open to the Public

6.1 The Board shall ensure that its meetings are open to the public except where a closed meeting is permitted by law. See Item 7.0 re Convening In-Camera (Closed) Meeting(s).

7.0 Convening In-Camera (Closed) Meeting(s)

7.1 Pre-requirements for in-camera sessions

Before holding a meeting or part of a meeting that is closed to he public, the Board shall state by resolution,

(a) the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting; or

(b) in the case of a meeting for education or training, the fact of the holding of the closed meeting, the general nature of its subject-matter and that it is to be closed under that subsection.

7.2 Criteria for in-camera meetings

In accordance with Section 239 (2) of the *Municipal Act,* R.S.O ,as amended, a meeting or part of a meeting may be closed to the public if the subject matter being considered is:

(a) the security of the property held by the Middlesex-London Board of Health;

(b) personal matters about an identifiable individual, including Board employees;

(c) a proposed or pending acquisition of land by the Middlesex-London Board of Health;

(d) labour relations or employee negotiations;

(e) litigation or potential litigation, including matters before administrative tribunals, affecting the Middlesex-London Health Unit;

(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;

(g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act.

7.3 Criteria for in-camera voting

A meeting shall not be closed to the public during the taking of a vote, except:

(a) When item 7.2 permits or requires the meeting to be closed to the public; and/or

(b) The vote is for a procedural matter or for giving directions or instructions to officers, employees or agents or persons retained under contract of/with the Board.

7.4 In-camera record keeping requirements

The Board shall record without note or comment all resolutions, decisions and other proceedings at a meeting, whether it is closed to the public or not.

8.0 Preparation of the "Agenda"

8.1 The Secretary-Treasurer shall prepare for the use of members at the regular meetings the "Agenda" as follows:

(a) Call to Order and Declarations of Interest;

(b) Minutes of Previous Meeting;

(c) List of Items to be dealt with in open session including delegations;

(d) List of Items to be dealt with in-camera;

(e) Other Business from the Floor;

(f) Date of Next Meeting;

(g) Adjournment

8.2 For special meetings, the "Agenda" shall be prepared when and as the Chair may direct or, in default of such direction, as provided in the last preceding section so far as applicable.

8.3 The business of each meeting shall be taken up in the order in which it stands on the "Agenda", unless otherwise described by the Board.

9.0 Commencement of Meetings

9.1 As soon as there is a quorum after the hour fixed for the meeting, the Chair or Vice-Chair, or person appointed to act in their place and stead, shall take the chair and call the members to order.

9.2 If the person who ought to preside at any meeting does not attend by the time a quorum is present, the Secretary-Treasurer shall call the members to order and a presiding officer shall be appointed by the members present, to preside during the meeting or until the arrival of the person who ought to preside.

9.3 If there is no quorum within ten minutes after the time appointed for the meeting, the Secretary-Treasurer shall call the roll and take down the names of the members then present, and the meeting shall then adjourn until the next day of meeting unless the Board otherwise decides.

9.4 Upon any member directing the attention of the Chair, to the fact that a quorum is not present, the Secretary-Treasurer, at the request of the Chair, shall within three minutes following such request, record the names of those members present and advise the Chair if a quorum is, or is not, present.

10.0 Rules of Debate and Conduct of Members of the Board

10.1 The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on points of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

10.2 Each delegation will be allowed a maximum of 10 minutes, but a member of the Board may introduce a delegation in addition to the speaker or speakers. Normally, a delegation will not be heard on an item unless there is a report from staff on the item.

10.3 The Board shall render its decision in each case no later than the day following the next meeting where possible.

10.4 When a member finds it impossible to attend any meeting, the onus is upon the member to advise the Secretary-Treasurer prior to the holding of

such meeting, and to advise of his wishes with respect to having an agenda item tabled.

10.5 If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall call on the Vice-Chair or another member in his absence, or refusal to fill his place until he resumes the chair.

10.6 Every member, previous to speaking to any question or motion, shall respectfully address the Chair.

10.7 When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak.

10.8 A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

10.9 No member shall speak to the same question at any one time for longer than five minutes except that the Board upon motion therefore may grant extensions of time for speaking of up to five minutes for each time extended.

10.10 Any member may require the question or motion under discussion to be read at any time during the debate, but not so as to interrupt a member while speaking.

10.11 When a member desires to address the Board upon a matter that concerns the rights or privileges of the Board collectively or of himself as a member thereof, he shall be permitted to raise such matter of privilege, and a matter of privilege shall take precedence over other matters.

10.12 When a member desires to call attention to a violation of the rules of procedure, he shall ask leave of the Chair to raise a point of order and after leave is granted, he shall state the point of order with a concise explanation and then not speak until the Chair has decided the point of order.

10.13 Unless a member immediately appeals to the Board the decision of the Chair shall be final.

10.14 If the decision is appealed, the Board shall decide the question without debate and its decision shall be final.

10.15 When the Chair calls a member to order, he shall immediately cease speaking until the point of order is dealt with and he shall not speak again without the permission of the Chair unless to appeal the ruling of the Chair.

11.0 Motions and Order of Putting Questions

11.1 Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, and seconded, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

11.2 When a matter is under debate, no motion shall be received other than a motion:

(a) to adopt;

(b) to amend;

(c) * to table;

(d) to refer;

(e) to receive;

(f) * to adjourn the meeting; or

(g) * that the vote be now taken.

* these items are to be voted on without debate.

11.3 A motion to refer or table shall take precedence over any other amendment.

11.4 When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

11.5 A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

12.0 Voting

12.1 Only one amendment at a time can be presented to the main motion and only one amendment can be presented to an amendment, but when the amendment to the amendment has been disposed of, another may be introduced, and when an amendment has been decided, another may be introduced.

12.2 The amendment to the amendment, if any, shall be voted on first, then if no other amendment to the amendment is presented, the amendment shall be voted on next, then if no other amendment is introduced, the main motion, or if any amendment has carried, the main motion as amended, shall be put to a vote.

12.3 Nothing in this section shall prevent other proposed amendments being read for the information of the members.

12.4 When the question under consideration contains distinct propositions, upon the request of any member, the vote upon each proposition shall be taken separately.

12.5 After the Chair commences to take a vote, no member shall speak to or present another motion until the vote has been taken on such motion, amendment or sub amendment.

12.6 Every member present at a meeting of the Board when a vote is taken on a matter shall vote thereon unless prohibited by statute; and, if any member present persists in refusing to vote, he shall be deemed as voting in the negative.

12.7 If a member disagrees with the announcement by the Chair of the result of any vote, he may object immediately to the Chair's declaration and require that the vote be retaken.

12.8 After any matter has been decided, any member may move for a reconsideration at the same meeting or may give notice of a motion for reconsideration of the matter for a subsequent meeting in the same year, but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried, and no matter shall be reconsidered more than once in the same calendar year.

13.0 Minutes

13.1 Minutes shall be taken at all regular and special meetings by the Secretary-Treasurer/Designate.

13.2 The names of all Board members and Health Unit employees who attend the meeting shall be recorded.

13.3 All Board motions shall become effective immediately upon approval, unless otherwise stated. All approved and defeated motions shall be recorded.

13.4 There shall be a motion to approve the minutes or amended minutes of each Board meeting.

13.5 All Board of Health minutes shall be ratified by signature of the Board Chair and Secretary-Treasurer.

14.0 Adjournment

14.1 A motion to adjourn the Board Meeting or adjourn the debate shall be in order, except:

(a) when a member is in possession of the floor;

(b) when it has been decided that the vote be now taken;

(c) during the taking of the vote; but no second motion to the same effect shall be made until after some intermediate proceedings shall have taken place.

15.0 Communications

15.1 Every communication intended to be presented to the Board must be written dated and signed.

15.2 Every such communication shall be delivered to the Secretary-Treasurer before the commencement of the meeting of the Board.

16.0 Proceedings on Bylaws

16.1 Every bylaw shall be introduced by a member upon motion for leave specifying the title of the bylaw, and a bylaw shall not be in form blank or incomplete.

16.2 Every bylaw shall receive three readings at different meetings before being passed, except that the Board may by a majority vote provide for two or more readings at one meeting.

16.3 The question "shall this bylaw be now read for a first time" shall be decided without amendment or debate.

16.4 Every bylaw may be considered by the Committee of the Whole after the second reading thereof.

16.5 All amendments made in the Committee of the Whole shall be reported by the Chair thereof to the Board which shall receive the same forthwith without debate.

16.6 The Secretary-Treasurer shall endorse on all bylaws read at the Board the dates of the several readings and of the passing thereof and shall be responsible for the correctness of such bills should they be amended.

16.7 Every bylaw which has been passed by the Board shall be sealed with the seal of the Board, signed by the Chair of the Board or by the Chair of the meeting at which the bylaw was passed and by the Secretary-Treasurer and deposited with the Secretary-Treasurer for custody.

16.8 All bylaws adopted by the Board shall be kept in a separate volume.

17.0 Secretary-Treasurer and Board Solicitor

17.1 It shall be the duty of the Secretary-Treasurer:

(a) to attend or cause an assistant to attend all meetings of the Board;

(b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of Bylaws and Resolutions passed by it;

(d) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same; and

(e) to forward all reports of the Board requiring City/County Council approval to the appropriate official so that the same may be considered by the Council at the next regular meeting.

17.2 It shall be the duty of the Board Solicitor:

(a) To examine reports of the Board on request and to report whenever any matter contained therein is beyond the power of the Board or otherwise illegal.

(b) To advise the Board and Committees as to the legality of all matters considered by the same bodies of which he shall have notice.

(c) To act on other matters as decided by the Board.

18.0 Elections and Appointment of Committees

18.1 At the first meeting of each calendar year the Board shall elect by a majority vote a Chair and a Vice- Chair for that year.

18.2 The Chair of the Board shall rotate on an annual basis to one of the representatives of the City of London, the County of Middlesex, and the Province of Ontario. In the event that one or more Aboriginal council(s) of the band have entered into an agreement with the Board (see policy 2-010), their appointed member shall have the option to be included in this rotation.

18.3 At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other boards, bodies, or commissions where appropriate.

18.4 The Board may appoint committees from time to time to consider such matters as specified by the Board (e.g., Human Resources, Planning, etc.).

19.0 Conduct of Business in Committees

19.1 The rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable.

19.2 It shall be the duty of the Committee:

(a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

(b) to forward to the Board the minutes of meetings;

(c) to forward to the incoming Committee for the following year any matter indisposed of.

19.3 The procedures of the Board with respect to:

(a) incurring of liabilities and paying of accounts;

(b) contracts and expenditures;

(c) petty cash;

(d) tenders and quotations;

shall be in accordance with the Agreement.

20.0 Corporate Seal

20.1 The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Executive Officer or the Secretary-Treasurer of the Board.

21.0 Execution of Documents

21.1 The Board may at any time and from time to time direct the manner in which and the person or persons who may sign on behalf of the Board and affix the corporate seal to any particular contract, arrangements, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, bylaw, conveyances, mortgages, obligations or documents.

22.0 Duties of Officers

22.1 The Chair of the Board shall:

(a) preside at all meetings of the Board;

(b) represent the Board at public or official functions or designate another Board member to do so;

(c) be ex-officio a member of all Committees to which he has not been named a member;

(d) perform such other duties as may from time to time be determined by the Board.

22.2 The Vice-Chair shall have all the powers and perform all the duties of the Chair in the absence or disability of the Chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

23.0 Remuneration

23.1 Board of Health members shall receive equal, daily remuneration, as well as payment for any reasonable and actual expense incurred as a Member of the Board. However, the rate of the remuneration paid shall not exceed the highest rate of remuneration of a member of a standing committee of a municipality within the health unit. Where no remuneration is paid to members of such standing committees, the rate shall not exceed the rate fixed by the Minister and the Minister has power to fix the rate.

23.2 However, Board of Health members, other than the chair, who are a member of the council of a municipality and are paid annual remuneration or expenses, by the municipality will not receive any remuneration of expenses.

24.0 Board of Health Performance Assessment

24.1 Board of Health members shall conduct self-evaluations of the Board's governance practices and outcomes at least twice annually.

24.2 The results of the self-evaluations shall be summarized by Health Unit staff and will translate into recommendations for improvements in the Board's effectiveness and engagement. This may be supplemented by evaluation(s) from key partners and/or stakeholders.

24.3 The self-evaluation process shall include a record of Board member attendance and consideration of whether:

(a) Decision-making is based on access to appropriate information with sufficient time for deliberations;

(b) Compliance with all federal and provincial regulatory requirements is achieved;

(c) Any material notice of wrongdoing or irregularities is responded to in a timely manner;

(d) Reporting systems provide the board with information that is timely and complete;

(e) Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers; and

(f) The board as a governing body is achieving its strategic outcomes.

25.0 Amendments

25.1 Any provision contained therein may be repealed, amended or varied, and additions may be made to this bylaw by a majority vote.

26.0 General

26.1 In this bylaw, words importing the singular number or the masculine gender only shall include more persons, parties or things of the same kind than one and females as well as males and the converse.

First Reading – April 19, 2012
Second Reading - April 19, 2012
Third Reading - April 19, 2012

This Bylaw to be in force and effect from April 19, 2012, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **19th day of April, 2012.**

_____ _____

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 4**

Pursuant to Section 56(1)(d) of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, the Board of Health for the Middlesex-London Health Unit enacts Bylaw No. 4 to provide for the **duties of the Auditor** of the Board of Health, namely:

1. (a) The Board shall appoint an Auditor who shall not be a member of the Board and shall be licensed under the *Public Accountancy Act,* R.S.O. 1990, c. P.37.

   (b) The Auditor shall be the same Auditor as the City of London may from time to time appoint.

2. The Auditor shall:

   (a) audit the accounts and transactions of the Board of Health;

   (b) perform such duties as are prescribed by the Ministry of Municipal Affairs and Housing with respect to local boards under the *Municipal Act*, S.O. 2001, c. 25 and the *Municipal Affairs Act*, R.S.O. 1990, c. 25;

   (c) perform such other duties as may be required by the Board that do not conflict with the duties prescribed by the Ministry of Municipal Affairs and Housing as set out in clause (b) of this bylaw;

   (d) have a right of access at all reasonable hours to all books, records, documents, accounts and vouchers of the Board and is entitled to require from the members of the Board and from the Officers of the Board such information and explanation as in his/her opinion may be necessary to enable him/her to carry out such duties as are prescribed by the Ministry of Municipal Affairs and Housing and under the *Health Protection and Promotion Act*.

First Reading – April 19, 2012
Second Reading - April 19, 2012
Third Reading - April 19, 2012

This Bylaw to be in force and effect from April 19, 2012, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **19th day of April, 2012.**

_____ _____

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **Bylaw No. 5**

Being a Bylaw to designate a head of the Middlesex-London Board of Health for the purposes of the ***Municipal Freedom of Information and Protection of Privacy Act***, R.S.O. 1990 (as amended), c. M. 56.

WHEREAS under Section 3(1) of the *Municipal Freedom of Information and Protection of Privacy Act*, the Board may by bylaw designate from among its members an individual or a committee of the Board to act as head of the Middlesex-London Board of Health for the purposes of the Act;

AND WHEREAS the Board deems it necessary and expedient to designate a head for the purposes of the Act;

NOW THEREFORE THE MIDDLESEX-LONDON BOARD OF HEALTH ENACTS AS FOLLOWS:

1. The Chair of the Board to be designated as "Head" for the purposes of the *Municipal Freedom of Information and Protection of Privacy Act*.

2. The Chair of the Board to provide for all other institutional requirements regarding access and privacy as set out in *the* ***Municipal Freedom of Information and Protection of Privacy Act*** and the ***Personal Health Information and Protection Act 2004,*** *R.S.O. 2004*, c.3 Sched. 4.

First Reading – April 19, 2012
Second Reading - April 19, 2012
Third Reading - April 19, 2012

This Bylaw to be in force and effect from April 19, 2012, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **19th day of April, 2012.**

_____ _____

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

BOARD OF HEALTH DESIGNATION OF "HEAD" FOR THE PURPOSES OF THE *MUNICIPAL FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT*

I,_____, Chair of the Middlesex-London Board of Health, having been designated "Head" per Board of Health Bylaw No. 5 for the purposes of the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M. 56, delegate all powers and duties under the Act to the Medical Officer of Health and Chief Executive Officer of the Middlesex-London Health Unit. I understand that as "Head" for the purposes of the Act, I remain accountable for actions taken and decisions made under the Act.

This Bylaw to be in force and effect from April 19, 2012, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this **19th day of April, 2012.**

_____

Ms. Viola Poletes Montgomery
Chair

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: **STRUCTURE AND RESPONSIBILITIES OF THE BOARD OF HEALTH** **POLICY NUMBER: 2-010**

SECTION: Board of Health Page 1 of 7

IMPLEMENTATION DATE: July 8, 1992 **APPROVED BY:** Board of Health
REVISION DATE: June 1, 1995 **SIGNATURE:**
December 18, 1996
July 20, 2000
November 18, 2004
June 21, 2006 (Directors Committee)
2008 October 16 (Board of Health)
2010 January 21 (Board of Health)
2010 November 18 (Board of Health)
2011 February 17 (Board of Health)
2012 April 19 (Board of Health)

PURPOSE

To outline the structure and responsibilities of the Board of Health.

POLICY

The Board of Health is an autonomous body responsible for the governance of the Health Unit in accordance with Section 49 (1), (2), (3) of the *Health Protection and Promotion Act (HPPA)*, R.S.O.1990 as amended, which outlines the composition of boards of health and R.R.O. 1990, Regulation 559 re Designation of Municipal Members of Boards of Health

PROCEDURE

1.0 Board of Health Structure

1.1 Board of Health Appointments

The Board of Health consists of municipal and provincial appointees. Each member's term of office is determined by the appointing body.

The number of Board members and their representation is as follows:

- City of London – 3 appointees
- County of Middlesex – 3 appointees
- Province of Ontario – 5 appointees

An Aboriginal council of the band that has entered into an agreement with the Board has the right to appoint a member of the band to be one of the members of the Board of Health. Councils of the bands of two or more bands that have entered into agreements have the right to jointly appoint a person to be one of the members of the Board of Health instead of each appointing a member

No person whose services are employed by the Board of Health is qualified to be a member of the Board of Health.

1.2 Vacancies and Re-appointments

Vacancies on the Board will be filled by appointment by the body represented, that is the municipality or province.

Terms of office for provincial appointees may be renewed by applying to the Public Appointments Unit of the Ministry of Health and Long-Term Care. **Appendix B, Provincial Appointee Reappointment Process**, will be followed with respect to reappointment of provincially appointed board members.

1.3 Committee Structure

Each year at its inaugural meeting, the Board will:

i. Elect a Chair, Vice Chair and Secretary-Treasurer

ii. Decide whether to establish standing committees or to have the Board deal with all matters directly.

The Chair of the Board rotates on an annual basis to one of the appointees of the County of Middlesex, the City of London or the Province of Ontario.

The Board will enact bylaws (See **APPENDIX A**) to provide for the management of property; banking and finance; Board of Health proceedings; the duties of the Auditor and power designation related to the Municipal Freedom of Information and Protection of Privacy Act.

Bylaws will be reviewed by the Board of Health in the calendar year following a municipal election (every four years).

2.0 Responsibilities

The Board of Health oversees the interpretation, implementation, management and advocacy for the health programs and services described in the Health Protection and Promotion Act for persons in the City of London and County of Middlesex.

2.1 Leadership

The Board of Health shall provide direction to the administration and ensure that the board remains informed about the activities of the organization regarding:

- Delivery of the Ontario Public Health Standards (including the program, foundational, and organizational standards);

- Organizational effectiveness through evaluation of operational and strategic plans;
- Stakeholder relations and partnership building;
- Research and evaluations, including ethical review;
- Compliance with all applicable legislation and regulations;
- Workforce issues, including recruitment of the Medical Officer of Health and any other senior executives;
- Financial management, including procurement policies and practices; and
- Risk management.

2.2 Advocacy and Policy Development

The Board of Health advocates for the Health Unit, which includes programs and services, budgetary issues and broader public health issues. The Board of Health contributes to the development of healthy public policy by facilitating community involvement and engaging in activities that inform the policy development process.

2.3 Appointment and Performance Management of a Medical Officer of Health:

When a vacancy occurs, the Board of Health will recruit a Medical Officer of Health according to Health Unit policy (see policy 5-030). The decision to extend an offer of employment lies with the Board of Health as a whole. The appointment of a Medical Officer of Health must also be approved by the Minister of Health and Long Term Care. A Medical Officer of Health must:

- Possess the qualifications and requirements set out in the Health Protection and Promotion Act and its regulation No. 566; and
- Fulfill the responsibilities for the management of the public health programs and services as set out in the position description for a Medical Officer of Health.

The Board of Health shall assess the performance of a Medical Officer of Health according to Health Unit policy (see policy 5-060).

The Board of Health may appoint a physician as acting Medical Officer of Health when:

- A Medical Officer of Health is vacant or a Medical Officer of Health is absent or unable to act, and there is no associate Medical Officer of Health or the associate Medical Officer of Health is also absent or unable to act.

The Board of Health may enter into an agreement with qualified physicians to temporarily fulfill the duties of a Medical Officer of Health during short absences of

the Medical Officer of Health, any acting Medical Officer of Health and any associate Medical Officer of Health.

2.4 Dismissal of a Medical Officer of Health

The Board of Health may only dismiss a Medical Officer of Health or an associate Medical Officer of Health if:

- The Board's decision is carried by a vote of two-thirds of the members; and
- The Minister has consented in writing to the dismissal.

The Board of Health can only vote on the dismissal of a Medical Officer of Health if the Board has given:

- Reasonable written notice to a Medical Officer of Health of the time, place and purpose of the meeting at which the dismissal is to be considered;
- A written statement of the reason for the proposal to dismiss a Medical Officer of Health; and an opportunity to attend and to make representations to the Board at the meeting.

2.5 Medical Officer of Health Reporting

The Medical Officer of Health reports directly to the Board of Health on issues relating to public health concerns and regarding public health programs and services.

The Medical Officer of Health is responsible to the Board for the management of all public health programs and services.

The Medical Officer of Health is entitled to notice of, and to attend, each meeting of the Board (including committees). However, the Board may require the Medical Officer of Health to withdraw from any part of a meeting where the Board intends to consider a matter related to the remuneration or the performance of the Medical Officer of Health.

2.6 Provision of Services on Aboriginal Reserves

The Board of Health may enter into a one, two or three year written agreement with the council of the band on an Aboriginal reserve within the geographic area of the Health Unit where:

- The board agrees to provide health programs and services to the members of the band; and
- The council of the band agrees to accept the responsibilities of the council of a municipality within the Health Unit.

3.0 Access to the Board of Health

The Medical Officer of Health/Chief Executive Officer (Medical Officer of Health/CEO) prepares the agenda for all Board meetings. Requests for community or staff presentations to the Board are made to the Medical Officer of Health.

Directors may attend all Board of Health meetings.

Agendas, reports and minutes of all regularly scheduled meetings of the Board are available to all staff and the public and are posted to the Health Unit's website.

Board meetings are open to the public. Whenever practicable, the Board of Health will provide appropriate alternate means of public attendance at Board meetings, including but not limited to internet streaming of meetings through the Health Unit website. Further details regarding public presentations to the Board are documented under Bylaw No. 3 (See **APPENDIX A**).

The Board of Health believes that physical presence of members at meetings greatly enhances its deliberations. Physical attendance is therefore the desirable, usual and expected method of participation in meetings. However, the Board also recognizes the usefulness and effectiveness of providing for electronic meetings and electronic participation in Board meetings by individual board members. Electronic participation at regularly scheduled board meetings is at the discretion of the Chair and is considered an exceptional measure intended to cater for unavoidable conflicts and emergencies.

Board meetings may also be conducted electronically* (i.e., by videoconference or teleconference) where time or circumstances make this a better means of conducting Board of Health business, provided that the proceedings ensure public access and otherwise comply with the provisions of Board of Health By-law No.3. (See APPENDIX A). At the subsequent meeting of the Board of Health after any meeting(s) that had been held by teleconference or video conference, the Board will approve the minutes of any preceding electronic meeting(s).

Further details regarding electronic participation in Board meetings are documented in Appendix C: Electronic Participation in Board Meetings.

*** A meeting is determined to have been conducted electronically when a majority of board members in attendance are not physically present.**

4.0 Informing Municipalities of Financial Obligations

The Board of Health shall annually give written notice to the City of London and the County of Middlesex regarding:

- The estimated total annual expense that will be required to pay for the Board of Health to deliver the mandatory program and services under the Ontario Public Health Standards.

- The specific proportion of the estimated amount for which each municipality is responsible, in accordance with the agreement respecting the proportion of the expenses to be paid by each municipality.

- The time at which the Board of Health requires payment to be made by each municipality and the amount of each payment required.

5.0 Recognition and Access to Collective Agreements

The Board of Health recognizes a) Canadian Union of Public Employees (CUPE) and its Local 101 is the exclusive bargaining agent for all union staff who are not represented by ONA, and b) The Ontario Nurses' Association (ONA) and its Local 36 is the exclusive bargaining agent for unionized staff registered nurses and public health nurses.

Appropriate current collective agreements are provided to employees by their union, and to management by the Human Resources and Labour Relations (HRLR) Director. Original collective agreements are maintained in the HRLR office. Copies of all current collective agreements are maintained in the Health Unit library and posted on the Health Unit intranet.

6.0 Ratification of Collective Agreements

The Board of Health shall ensure that the collective bargaining process with CUPE Local 101 and ONA Local 36 are completed in a legal and binding manner by following the subsequent process:

- Collective bargaining is successfully undertaken with both parties agreeing and signing a Memorandum of Settlement.

- The Memorandum of Settlement is presented in the form of a confidential Board report to the Board of Health at the next scheduled meeting or specially called meeting at which time the Board, by vote, will agree or disagree with the Memorandum of Settlement.

- If the Board agrees, the union is then notified of the Board’s ratification of the Memorandum of Settlement, both by telephone and in writing, by the HRLR Director.

- If the Board does not agree, the union is then notified of the Board’s non-ratification of the Memorandum of Settlement, both by telephone and in writing, by the HRLR Director.

- Each union will be responsible for following its ratification procedure and notifying the HRLR Director of the outcome.

The Board of Health and the union must ratify a negotiated contract in order for it to be legally binding and enforceable.

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT:	**ORIENTATION FOR BOARD OF HEALTH MEMBERS**	**POLICY NUMBER: 2-020**
SECTION:	Board of Health	Page 1 of 3
IMPLEMENTATION DATE:		**APPROVED BY:** Board of Health
REVISION DATE:	July 8, 1992 July 20, 2000 June 17, 2004 February 17, 2011 April 19, 2012	**SIGNATURE:**

PURPOSE

To ensure new members to the Board of Health are provided with a comprehensive orientation to the Board, the role of public health and the mandate of the Health Unit.

POLICY

Each member of the Board of Health will receive orientation from the Medical Officer of Health (MOH) and will participate in continuing education activities on an on-going basis, including information on the following topics:

- The structure, vision, mission goals and objectives of the public health unit;
- Overview of the strategic plan, the operational planning process, and performance monitoring;
- The state of the Health Unit with respect to programs and services, the staff complement and management;
- Community demographics overview, including organizational emergency preparedness planning;
- Provincial government structure and the funding streams of the three ministries;
- The duties and responsibilities of board members, including requirement to attend board meetings, advance review of meeting materials, understanding of board of health policies and procedures, and understanding of public health issues;
- Board members; fiduciary responsibilities in terms of trusteeship, due diligence, avoiding conflict of interest, maintaining confidentiality, strategic oversight, ethical and compliance oversight, stakeholder engagement, MOH compensation, risk management oversight and succession planning; and
- Opportunities of board members to participate in conferences or seminars that are sponsored or hosted by other organizations.

Upon appointment to the Board of Health, each new Board member will be provided with an orientation session and receive materials that provide an overview of the organization.

PROCEDURE

1. Upon appointment, each new Board member will be contacted by the Office of the Medical Officer of Health to arrange for orientation to the Board of Health.

2. The MOH will arrange a follow-up session with each new Board Member six to eight months after the initial orientation.

3. The Secretary-Treasurer notifies each Board member of upcoming events which may be attended by Board members for the purposes of public health orientation, planning and policy discussion e.g., Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA).

4. The MOH will arrange a half to full day Board of Health retreat be held annually in March or April with the focus being on a Board indentified continuing education topic.

5. Throughout the calendar year, each Director may report to the Board of Health on programs and services.

BOARD OF HEALTH ORIENTATION HANDBOOK: TABLE OF CONTENTS

1. Structure and Responsibilities of the Board of Health
   - Board meeting dates
   - List of current Board members and contact information
   - Board of Health Remuneration and Expense Reimbursement Form
   - Board of Health – Role Description
   - Policy 1-10 Structure and Responsibilities of the Board of Health
     - Appendix A – Bylaws
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2. Organizational Background and Planning Documents
   - Strategic Plan
   - Planning Cycle
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3. Community Demographics and Emergency Preparedness
   - Link to Community Health Status Report
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   - Budget Summary

5. Legal Documents
   - Summary of Legislation
   - The Health Protection and Promotion Act
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   - The Immunization of School Pupils Act
   - Smoke Free Ontario Act
   - Safe Drinking Water Act
     - Chapter 32 – Bill 195
     - Regulation 170/03 – Drinking Water Systems
     - Regulation 169/03 – Ontario Drinking Water Quality Standard

6. Recommended Reading
   - Initial Report on Public Health - August 2009 Public Health Division, MOHLTC
   - The Development of Public Health in London and Middlesex County

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 002-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

SHARED SERVICES REVIEW - PROPOSAL

Recommendations

It is recommended that:

1) The Board of Health approve PricewaterhouseCoopers's proposal for the Shared Services Review project as outlined in Appendix A; and further

2) Any 2012 municipal surplus from the cost-shared programs, to a maximum of $135,000, be retained to fund the review.

Key Points

- PricewaterhouseCoopers has submitted a proposal to perform the Shared Services Review as requested by the Board, at a cost of $105,000 - $135,000 as detailed in Appendix A.
- 2012 anticipated surplus from the cost-shared programs could be retained by the Board to pay for the review.

PricewaterhouseCoopers's Proposal – Shared Services Review

At the November 15, 2012 Board of Health meeting, the Board of Health endorsed the following recommendation:

"That the Consulting Firm of PricewaterhouseCoopers be asked to submit a written proposal, including a project plan and cost estimates for conducting the review, to the Board of Health for review and approval prior to the commencement of the project and that this language be incorporated into the Terms of Reference."

At the December 13, 2012 Board of Health meeting, an update was provided (Report No. 140-12) regarding the work that had begun with representatives from PricewaterhouseCoopers (PWC). Since the December Board of Health meeting, PWC has submitted its proposal for the Shared Services Review. It is attached as Appendix A. The proposal reviews the background of the project and key considerations, and provides a suggested approach to perform the work. It also provides an estimated cost of the project for each of the three phases.

As can be seen from the written proposal in Appendix A, Phase I and II consist of gathering and integrating the information required to make preliminary recommendations and provide the Board of Health with an interim report. This is expected to take approximately seven weeks to complete, at an estimated cost of $65,000 - $75,000. The interim report will identify any potential efficiencies or cost savings in existing administrative functions, and will also identify which functions the Board may want to consider investigating further for potential sharing with the City of London and/or Middlesex County. Phase III of the review will involve a more in-depth analysis of the areas the Board decides should be

explored further. Phase III is anticipated to cost as much as $40,000 - $65,000, but this will depend on decisions the Board makes with respect to areas for further exploration in response to the findings of the interim report.

As per the Terms of Reference for this project, the PWC proposal has been presented to both the City of London and the County of Middlesex for their review.

Mr. Chirag Shah, Partner, and Mr. Scott Gilfillan, Senior Manager of the Audit and Assurance Group, for PricewaterhouseCoopers will be in attendance at the January 17th Board meeting to provide an overview of their proposal and to answer any questions Board members may have.

Potential Sources of Funding for the Review

There currently is no identified funding source for this project. The following identifies considerations regarding funding the Shared Services Review:

1) In the past, the Health Unit had a budget to respond to corporate initiatives like this review. However in 2013, a budget reduction of $145,000 was made to achieve a 0% municipal tax increase, thereby significantly reducing this budget as a potential source of funding. The remaining budget of $108,356 has been earmarked for other projects.
2) In the past, one-time costs such as these could have been accommodated from within the operating budget through anticipated savings in salary and benefit, including those that arise from delays in filling vacancies (gapping). However, the need to find $325,833 from position gapping has already been identified in developing the 2013 cost-shared budget. As the operating year has just begun, this amount of money from gapped positions has not yet been saved and further savings from gapped positions is not anticipated at this time.
3) A potential source of funding could be from savings identified by the review itself. As any potential savings through efficiencies is not known at this time, it is not recommended to rely on this as a source of funding for the review.
4) At the December 2012 Board of Health meeting, the Board received Report No. 145-12 which provided an update on the 2012 operating budget. The report identified an anticipated year end surplus of approximately $220,000 which could be used as a source of revenue for the project. This would involve establishing a reserve fund to cover the cost of the review to a maximum of $135,000.

Conclusion

Representatives from PricewaterhouseCoopers have provided a proposal for performing the Shared Services Review which is anticipated to cost approximately $105,000 to $135,000 to complete. It is recommended that the Board of Health approve the proposal and retain 2012 municipal surplus from the cost-shared programs to fund the project.

This report was prepared by Mr. John Millson, Director, Finance & Operations.

Bryna Warshawsky, MD, FRCPC
Acting Medical Officer of Health

Middlesex-London Health Unit: Shared services review project

Discussion document for the proposed scope of the project

December 2012

pwc

Agenda

I. Defining the issue

II. Suggested approach

III. Our experience and qualifications

IV. Financial proposal

Defining the issue

Context and Background

MLHU has increased its cost-shared budget from about $12m in 2003 to about $23m in 2012 due to increased funding from the provincial government

- This was based on a response from the provincial government as a result of the SARS epidemic and an increased focus on public health
- In 2003, MLHU was 34th in per capita funding out of 37 provincial health units, and so there was a need to improve funding to support public health in the region
- MLHU continues to be in the bottom half of health units in terms of funding per capita (23rd out of 36 provincial health units)
- The increase in budget has been borne entirely by the province, with municipal assistance staying flat or declining over this same period
- MLHU relies on municipal government for approximately 31% of its funding, versus the proposed model of 25% municipal/75% provincial – it should be noted, however, that a large number of health units are still funded greater than 25% from municipalities

Key Observation: MLHU has been asked to move more quickly towards a 25/75 model in order to help the municipalities achieve their fiscal objectives

Key Project Drivers

MLHU continues to be under budget pressures

- The City of London has achieved two consecutive 0% property tax increase budgets and is working on the budget process with a goal of another 0% increase
- In order to achieve this, the City and the County are asking MLHU to reduce the funding required from the municipalities
- At the same time, the provincial increases in funding to public health have continually decreased over the past ten year from 5% to 2%
- Further pressures are expected on provincial funding for public health as the province works to improve its fiscal situation

Key Outcomes: MLHU will need to continue to identify ways to become more cost-efficient in order to meet increasing budget pressures for the current and future years

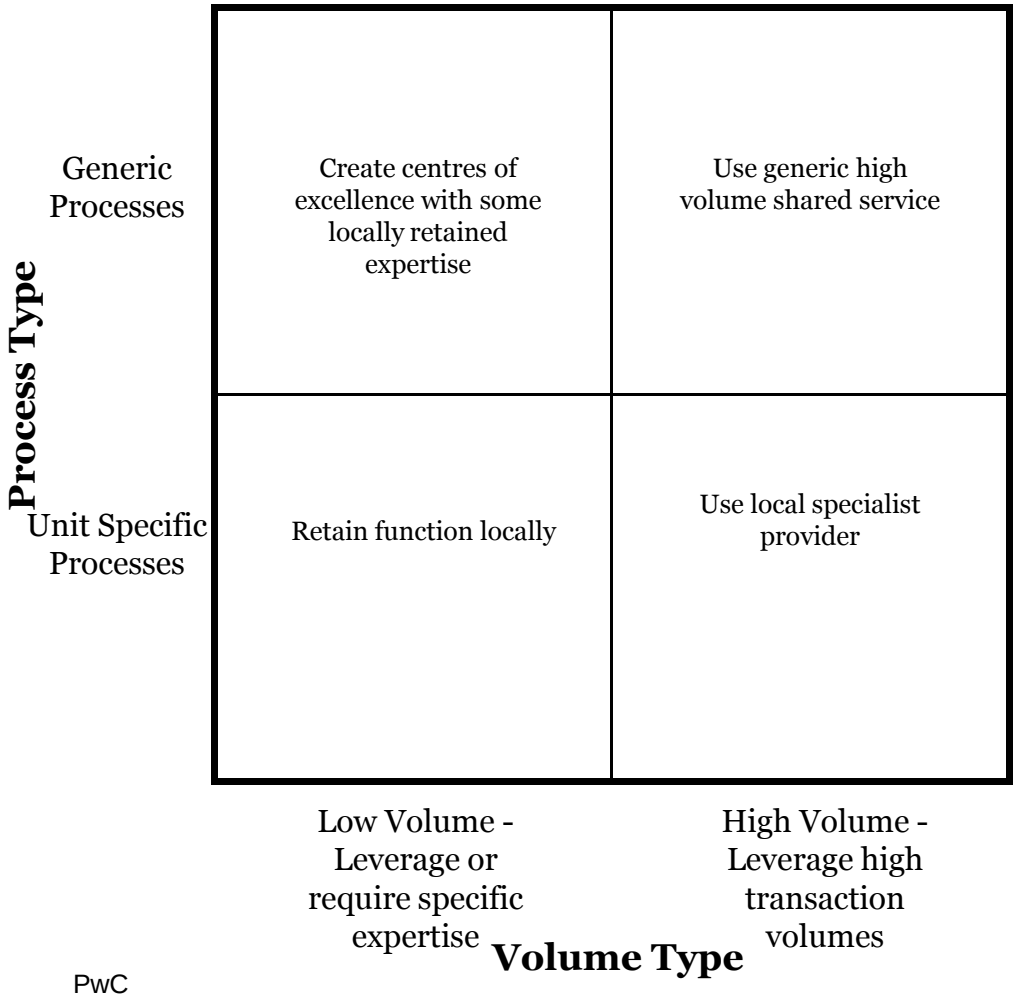
Current State Observations

MLHU currently has its own in-house back office functions

- In-house functions include finance, purchasing, payroll, human resources, information technology, the office of the Medical Officer of Health, and other administrative functions
- The Board of Health have requested that a review be performed over the above-listed administrative functions with the following focuses:
  - i. Identify potential efficiencies or cost savings in existing functions at MLHU; and
  - ii. Consider shared service options for the County or City to provide one or more of the administrative services for MLHU, as both the County and the City have similar separate administrative functions
- In conducting the review, PwC will keep in mind all pertinent legislation to MLHU
- PwC will also appropriately include the Board of Health, the City and the County in the process, as outlined in the November 19, 2012 Terms of Reference

Key Considerations

Shared Services is not a "one-size-fits-all" solution, it is only appropriate when certain conditions are met

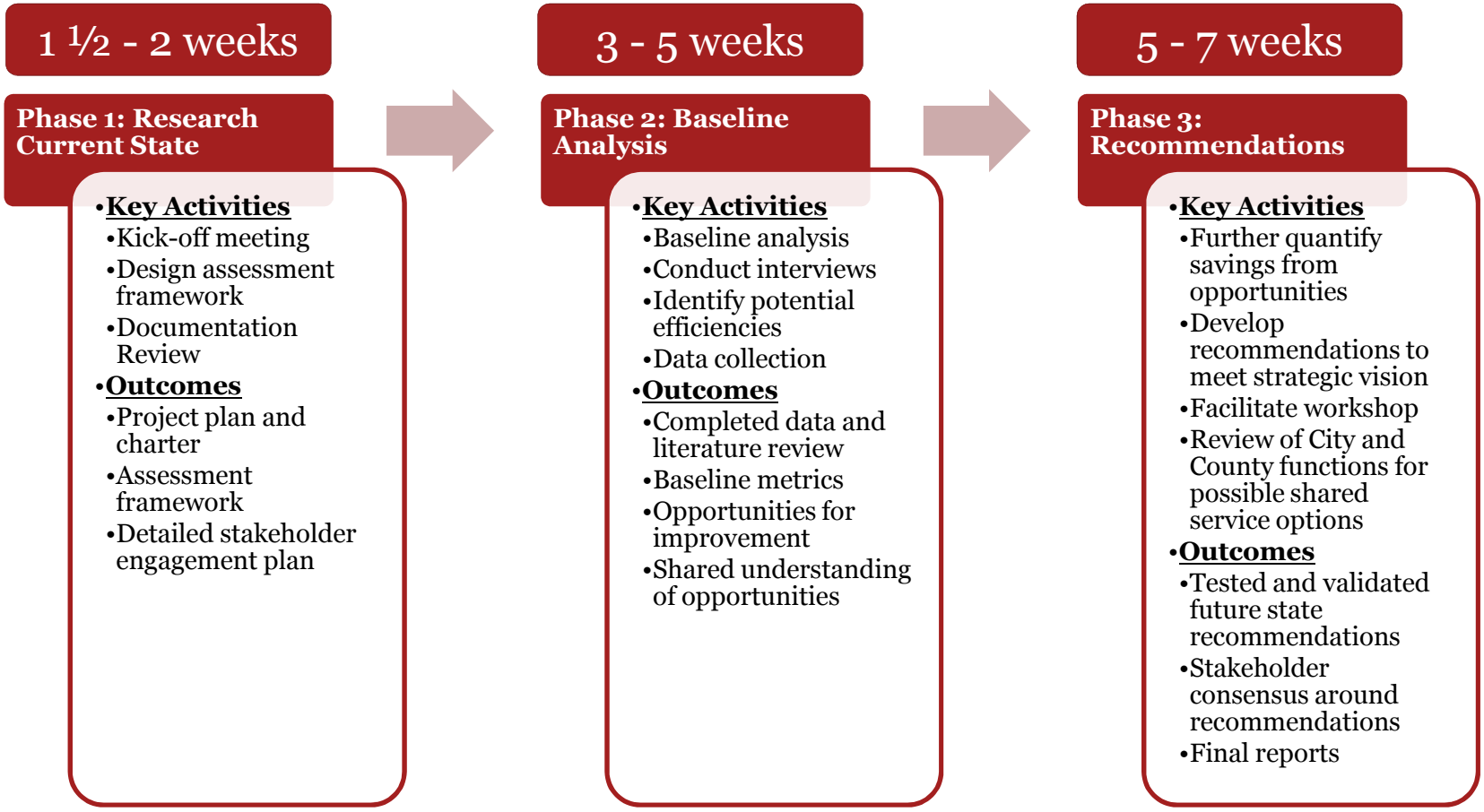


- Two key considerations are pertinent to our discussion – the nature or "type" of process, and the volume of transactions involved
- Processes may be generally categorized into either generic – whereby the process is not specially adapted to any particular business unit, or specific – whereby the process has been developed uniquely for a business unit
- Volume may be either low or high in terms of number of transactions
- At a high level, shared services is better suited to generic processes which run in high volumes.

Suggested Approach

High Level Approach

PwC's approach includes three phases at the high level: 1. Research Current State 2. Baseline Analysis and 3. Recommendations

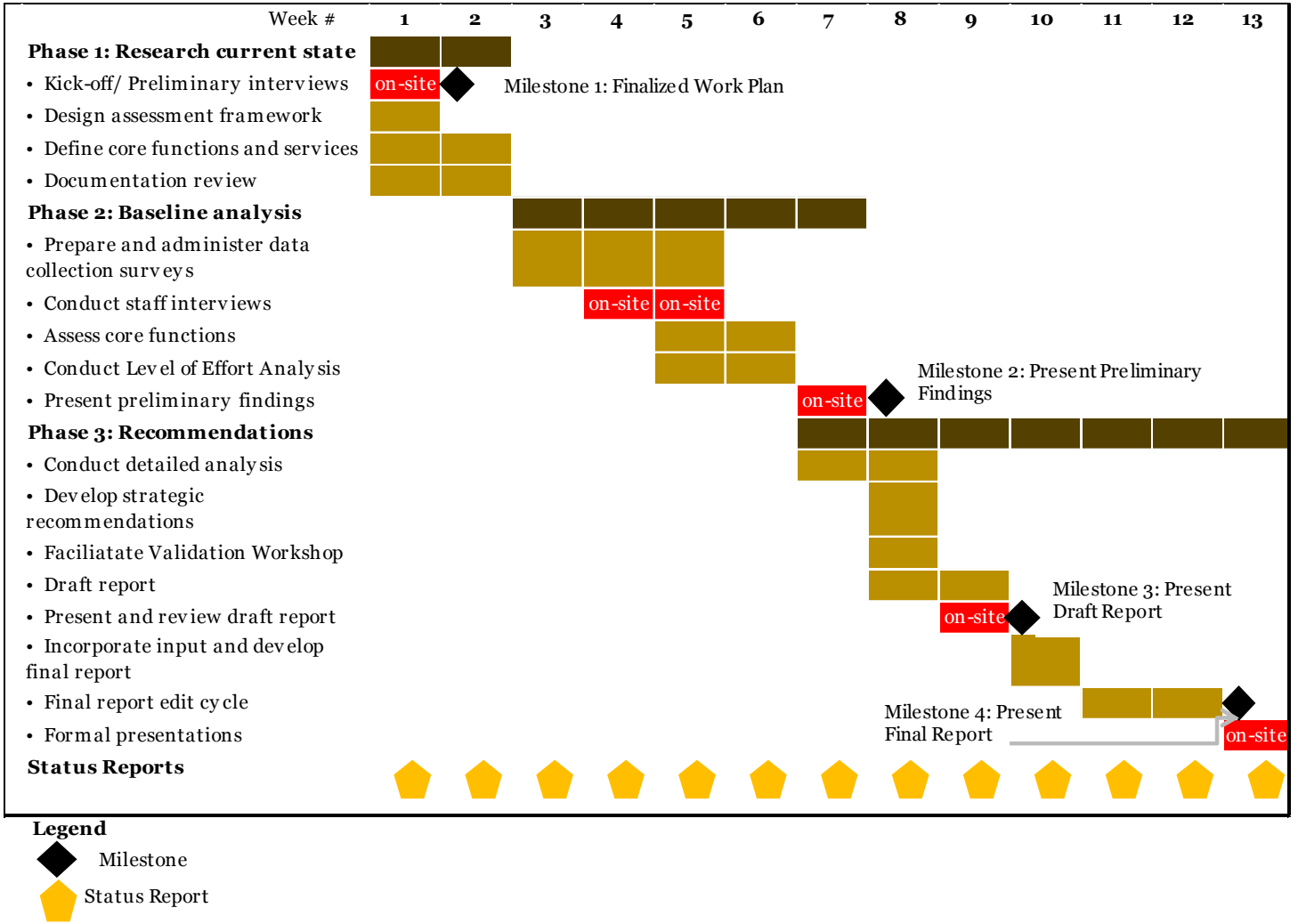


Proposed Deliverables

After Phase 2 we will provide an interim report which can be used to decide how to proceed with Phase 3

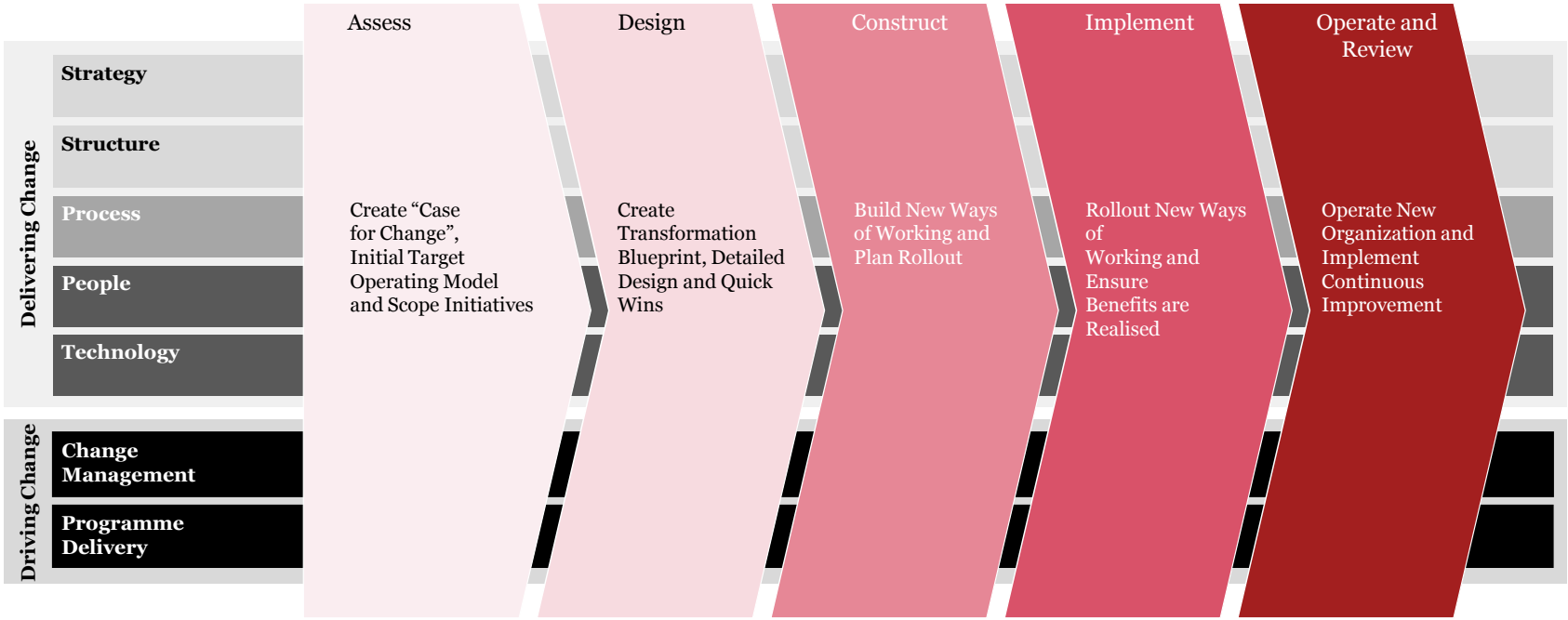
- Phase 2 will provide a baseline analysis of the MLHU's administrative functions
- This will identify any potential efficiencies or cost savings in existing functions at MLHU and also identify which functions to consider investigating further for a shared service model as part of Phase 3
- The Board of Health will be able to use this interim report to determine which areas to focus on for phase 3, considering preliminary estimates of possible savings and potential implications for the organization
- Phases 1 and 2 will primarily require assistance from MLHU with touch-points with the City and County
- Phase 3 will require more direct analysis at the City and County to further identify shared service opportunities and produce viable recommendations

Proposed Timeline



Transform Framework

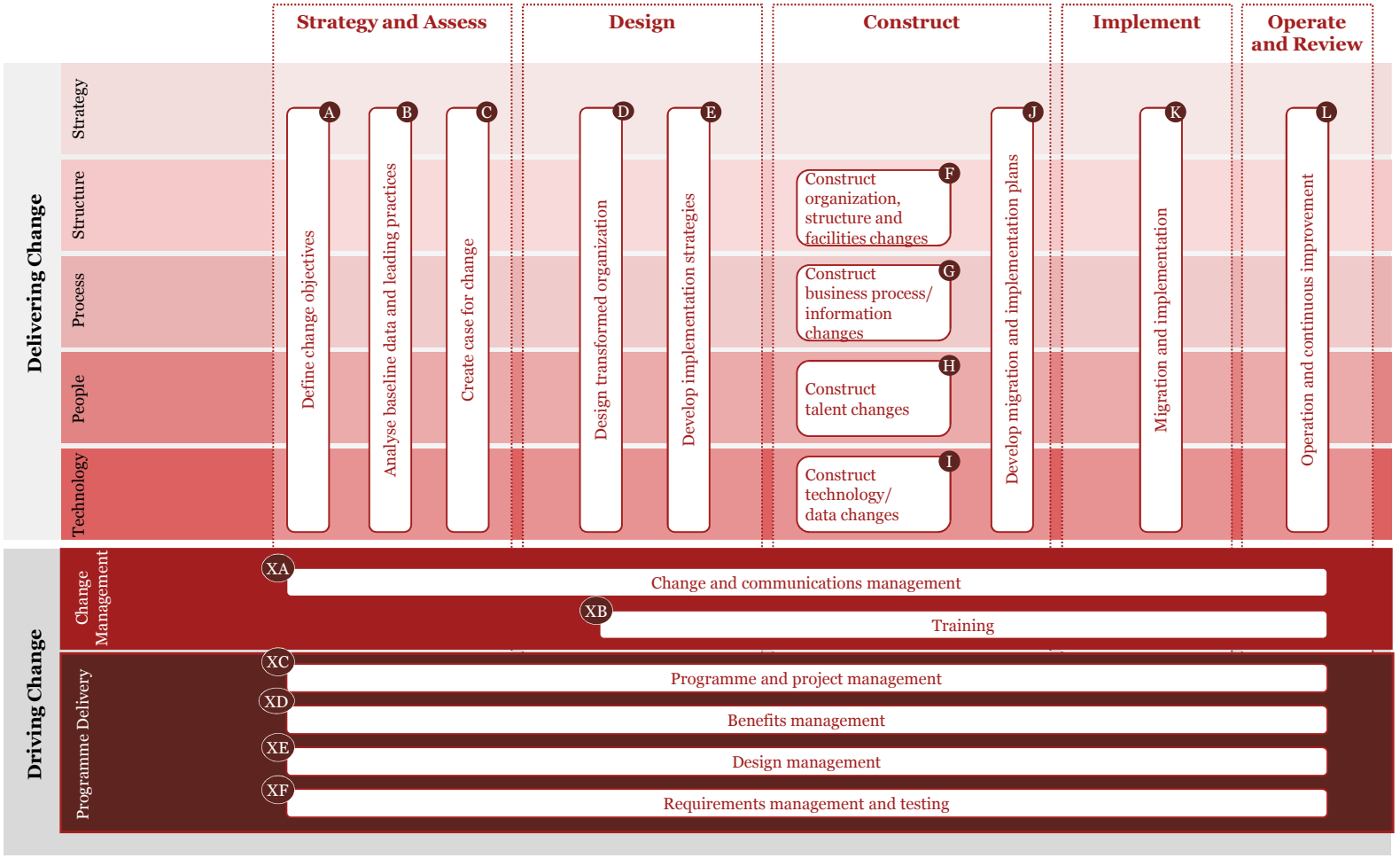
PwC's Transform methodology will be used as the framework for analysis, focusing on the Assess *stage*



Value to MLHU: Transform is a proven methodology that has been applied successfully to similar projects, including those in the health and public sectors. Our focus will be on the *Assess* stage, which determines if there is a "case for change" and defines the initial target operating model and scope initiatives. The Transform methodology is comprehensive, yet detailed at the same time. The methodology includes detailed steps that the project team will follow – this ensures a rapid deployment and a consistency in our approach.

Assess stage

Within the Assess stage of the Transform Framework, there are further steps that help define the change objective, detailed analysis and the case for change



Our experience and qualifications

Experience in Shared Services

PwC has conducted a number of similar engagements with clients in the health and public sectors

Some of the public sector we have been working with:

- Plexxus / Hospital Business Shared Services
- Central West LHIN Back-Office Integration
- HNHB LHIN
- Alberta Health Services
- Ontario Shared Services
- Vancouver School Board
- Mybonsecours - a US based private hospital group

Good understanding of health sector, culture and environment

- Complex operating models within health units
- Large number of diverse stakeholders to consider
- Challenges to drive change within
- Change program must address fundamental organization and cultural issues in the way people interact and work together
- Any change must be sustainable

Financial Proposal

Financial Proposal

PwC is pleased to submit our competitive pricing for this opportunity.

We will complete this project based upon the methodology and detailed approach outlined in this response.

Based on the scope, objectives, and deliverables outlined in this proposal, PwC is proposing to complete this engagement for **an estimated fee of $65,000 - $75,000 for Phases 1 and 2.**

*Note: we have provided a fee estimate of $40,000 - $60,000 for Phase 3 – the fees for this phase will be dependant on the decisions made by the Board of Health in relation to our preliminary findings presented at the completion of Phase 2.

This amount is inclusive of our professional fees, but does not include applicable taxes and administrative and out-of-pocket expenses.

Proposed Invoicing Schedule	
Phase 1	$25,000
Phase 2	$40,000 - $50,000
Phase 3	$40,000 - $60,000*
Payment Terms	Net 30 days

Appendix A - Samples of select biographies

Maurice Chang, P.Eng., MBA

Role	As Engagement Director, Maurice will manage all aspects of the engagement. Maurice's role includes overall project management, facilitation with senior management and staff members, strategic options development and acting as the day-to-day point of contact for the MLHU project team.
Experience	Maurice is a Director of PwC and a leader of the Education Consulting Practice. Maurice specializes in assisting education sector and other public clients in strengthening governance, organizational design and policy frameworks to support operational excellence. Over the last six years, Maurice assisted a range of provincial/state government Ministers of Education, universities and nearly 50 district school boards and standardized testing agencies across Canada, and in Australia. Maurice has expertise in education reform, particularly in the areas of decentralising administrative functions to local schools/authorities, designing organizational structures to support modernized operating models, and implementing shared services models. Maurice has developed new organizational structures to assist school boards in the implementation of shared services or other operating models with varying degrees of centralisation/decentralisation. Maurice earned his MBA at the Richard Ivey School of Business, and his B.Sc. from the university of Toronto. Maurice is a professional engineer by training.
Value to MLHU	Maurice brings knowledge and experience working with the education sector from across Canada and abroad. He has deep knowledge of all facets of the business and administration of public sector institutions, and has first-hand experience working with stakeholders in a number of shared services reviews.

Dipak Pandya

Role	As finance effectiveness and healthcare subject matter specialist, Dipak will support the shared service review and any financial aspects. Dipak will provide direction and contribute his insights to the team.
Experience	Dipak is a director in the Consulting and Deals practice at PwC, working in the Toronto office. He specializes in financial effectiveness and management. Before joining PwC Canada, Dipak advised a broad range of PwC UK clients for more than eight years. At the UK firm, he helped health care organizations improve their financial management and effectiveness processes and address their financial deficits by developing and implementing robust turnaround plans. Dipak sat on the PwC UK advisory team who helped the Department of Health roll out its payment by results financial system and reviewed the department's financial regime for health care bodies. He also worked extensively to help the Monitor, a UK-based independent regulator for foundation trusts, improve its application process and compliance regimes. He also spearheaded a team to create a free thought leadership portal for UK health care bodies.
Value to MLHU	Dipak offers previous experience in developing future state operating models, involving the assessment of delivery and support organizations, with a view to improving both efficiency and effectiveness of services. As an experienced finance function transformation consultant, he is comfortable operating in complex transformational environments and is very familiar with the challenges of operating in complex unionized and non-unionized environments. He has extensive healthcare experience to support the rest of the team as a subject matter expert.

Chirag Shah, CA, MBA

Role	Chirag will bring a local leadership presence to the engagement and will be responsible for the quality of service provided to MLHU. Chirag will also be able to provide input from his role as the engagement leader of the City of London's internal audit.
Experience	Chirag is a Partner in the Audit and Assurance group and is also the London Market Leader. Chirag has over 21 years of audit experience across a broad range of clients and industries. Chirag's experience extends through municipal, public, private as well as not-for-profit enterprises from diverse industries including manufacturing, retail, education, financial services and investment management. Chirag has led a variety of engagements including internal audit reviews, acquisition and divestiture assistance, controls assurance reviews, due diligence exercises, financial modeling and financing assistance. Chirag graduated from the University of Western Ontario with a B. Sc., and from Wilfred Laurier University with an MBA, he is also a licensed Chartered Accountant.
Value to MLHU	Chirag will bring his knowledge of high performance organizations to this project team. He will be able to contribute his knowledge around performance management and help instill this discipline into the future state operating model.

Scott Gilfillan, CA, MAcc

Role	Scott will be the main local point of contact for coordinating the proposed services and will share his knowledge from internal audit projects he has managed for the City.
Experience	Scott is a senior manager in the Audit and Assurance Group in the London office. With more than ten years of accounting and auditing experience, working with both private and public company clients from various sectors including education, not-for-profit, manufacturing and technology. Scott's experience includes managing financial statement audits from the planning phase through completion, financial reporting, coordinating with firm specialists to deliver an effective audit, and communicating with those charged with governance. Scott is currently the lead manager on the internal audit function of the City of London and has extensive experience with other smaller municipalities in south western Ontario. Scott manages the financial statement audits, and compliance audits of programs that are funded by the Ontario Government. Scott holds an Accounting Degree and Masters of Accounting from the University of Waterloo and is a licensed Chartered Accountant.
Value to MLHU	Scott will bring his knowledge of municipal administrative functions to the team. He will be a key local contact point as the team works through this project.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

BOARD OF HEALTH CODE OF CONDUCT: SECOND DRAFT

Recommendation

It is recommended that Report No. 003-13 re "Board of Health Code of Conduct: Second Draft" be reviewed and feedback provided.

Key Points

- Feedback from the December 13, 2012 Board meeting has been incorporated into the second draft of the Board of Health Code of Conduct. Board members now have the opportunity for further review and to provide additional feedback.

Background

A draft Board of Health Code of Conduct, which was requested in September 2012, was presented at the December 13, 2012 Board of Health meeting (see Report No. 141-12, Appendix B). The draft Board of Health Code of Conduct was written to comply with the Public Health Accountability Agreement, which requires a Code of Conduct for all levels of the organization. The draft Code of Conduct is intended to support the Board of Health in its governance role. It was developed following a scan of similar Codes for local governance bodies. Feedback provided by Board members at the December 13, 2012 Board of Health meeting has been incorporated into the second draft which is attached as Appendix A to this report.

Summary of Revisions

Changes have been made in six areas of the draft Code of Conduct:

1. Statements that Board members will "always act in the best interest of the Board of Health and the Health Unit" have been supplemented with "…to support the delivery of public health programs and services." This language was included to reflect the role of the Board of Health to support the Health Unit in order for it to achieve its mandate of providing public health programs and services.

2. The relationship between Board members and the Board's Executive Assistant has been clarified.

3. Under Section 7, "Interactions with Staff Members", text has been added to support the distinction between governance and operational responsibilities: Board members will "not involve themselves in the operations of the Health Unit". This concept is covered in other Code of Conducts but was not captured in the first draft.

4. The "Acting in the Interests of Other Entities" section has been revised to provide better clarity.

5. Text has been added to support recordkeeping during a complaint process: "The Board of Health member to whom the complaint is directed should also keep a written record of when they were

approached by the complaint, the discussion(s) that took place, and what they have done to address the complaint."

6. Under the Section 11, Formal Complaints, the option of the following remedy for contravention of the Code of Conduct has been removed: "a resolution of the Board of Health requesting the resignation of the Board of Health member which shall be non-binding on the Board of Health member in question".

In addition, under Section 11, the Informal Complaints process, there was discussion as to whether the complainant should be "A person" as currently written, or "A Board of Health member". This was not changed pending further discussion.

Next Steps

Board members now have an opportunity to review the second draft and provide additional feedback to staff. Feedback will be incorporated into a third draft, which will be presented to the Board either for further discussion or for approval.

This report was prepared by Mr. Ross Graham, Manager, Special Projects.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health

Middlesex-London Board of Health
CODE of CONDUCT

December 23, 2012

With revisions following December 13, 2012 Board of Health Meeting

BACKGROUND:

Purpose: This Code of Conduct is intended to address issues that Board of Health members may encounter when discharging their duties as a board member. The Code of Conduct supports effective governance by clearly documenting the expected conduct of Board of Health members.

This Code serves as a supplement to the duties and responsibilities of Board of Health members under the Health Protection and Promotion Act, the Ontario Public Health Organizational Standards, any Public Health Accountability Agreement between the Board of Health and the Province, the Health Unit's Corporate Code of Conduct and other legal obligations.

Statutory Provisions: The following provincial legislation, standards and agreements apply to the Board of Health and require compliance from Board of Health members when discharging their duties:

(a) Health Protection and Promotion Act;
(b) Personal Health Information Protection Act;
(c) Ontario Public Health Organizational Standards;
(d) Public Health Accountability Agreement between the Board of Health and the Province;
(e) Municipal Freedom of Information and Protection of Privacy Act;
(f) Municipal Conflict of Interest Act;
(g) Municipal Act; and
(h) any other legislation, regulations, agreements and standards regulating the Board of Health.

Expected Conduct of Board of Health Members

Board of Health members have a fiduciary duty as well as a duty of loyalty and good faith to the Board of Health. When acting in their capacity as Board of Health members, their actions must be discharged in the best interests of the Board of Health without regard to the interests of themselves or any other entity.

Board of Health members shall comply with the following:

1. **Acting in the Best Interests of the Board of Health and Health Unit:**

- Always act in the best interest of the Board of Health and the Health Unit to support the delivery of public health programs and services in compliance with fiduciary duties and the duties of loyalty and good faith to the Board of Health.

2. **Public Meetings and Confidential Information:**

- Comply with the open meeting provisions of the Municipal Act.
- Not disclose and keep confidential all information considered by the Board of Health in closed session and information that is prohibited from being disclosed by law.

3. **Real and Perceived Conflicts of Interest:**

- Always act in the best interest of the Board of Health and the Health Unit to support the delivery of public health programs and services.
- Not take advantage of membership on the Board of Health for personal gain or that of a third party.
- Notify the Secretary-Treasurer of any real (or reasonably perceived) conflicts of interest either prior to, or at the beginning of a Board of Health meeting.
- Declare neutrality, abstain from voting, refrain from taking part in any discussions and/or leave the room when a conflict of interest exists.

4. **Serving on Other Boards / Councils:**

- Comply with "Real and Perceived Conflicts of Interest" provisions as noted above.
- Disclose information relevant to Health Unit business, subject to the qualifications set out in this Code of Conduct.

5. **Conduct at Meetings:**

- Regularly attend and be prepared for meetings.
- Conduct themselves with decorum.

6. Media Interactions and Public Discussions:

- Not speak on behalf of or represent the Board of Health unless authorized to do so by the Chair.
- When contacted by the media regarding a Board of Health-related topic:
    - Refer media inquiries requesting a statement from the Board of Health to the Chair through the Secretary Treasurer;
    - Inform the Chair and Secretary Treasurer of any media inquiries related to Board of Health or Health Unit matters;
    - Consider the impact that a comment made to the media will have on the Board of Health and/or the Health Unit;
    - Only comment to the media once it has been clarified that the comment is not on behalf of the Board of Health, unless authorized to speak on behalf of the Board of Health by the Chair.

7. Interactions with Staff Members:

- Contact the Medical Officer of Health (MOH) through the Executive Assistant to the Board or directly if they wish to contact Health Unit staff.
- Ensure that interactions and communications with staff members are respectful and constructive.
- Not involve themselves in the operations of the Health Unit.

8. **Election Campaigns:**

- Not use Health Unit resources or Board of Health meetings to advance an election campaign.

9. Post-Board of Health Membership:

- Not take advantage of past membership on the Board of Health for personal gain or that of a third party.
- Not disclose and keep confidential all Confidential Information obtained while a member of the Board of Health.

10. Legal Advice:

- Make a request through the Secretary-Treasurer when legal advice is necessary.

11. Compliance:

- Hold each other accountable for complying with the Code of Conduct, including raising compliance issues, collaborating to develop solutions, and being aware of consequences of failing to comply.

EXPLANATION:

1) Acting in the Best Interests of the Board of Health and Health Unit:

Board of Health members shall always:

- act in the best interests of the Board of Health and Health Unit to support the delivery of public health programs and services;
- when making decisions relating to the business of the Board of Health, do so in compliance with each Board of Health Member's duty of care, loyalty and good faith to the Board of Health;
- serve (and be seen to serve) the Board of Health in a conscientious and diligent manner;
- be committed to performing their functions with integrity and shall avoid conflicts of interest, both perceived and real;
- perform their duties and arrange their private affairs in a manner that promotes public confidence;
- seek to serve the Board of Health's interest and the public's interest by upholding the intent and the spirit of all laws applicable to the Board of Health;

Therefore, Board of Health members shall:

- Always act in the best interest of the Board of Health and the Health Unit to support the delivery of public health programs and services in compliance with fiduciary duties and the duties of loyalty and good faith to the Board of Health.

2) Public Meetings and Confidential Information:

Board of Health members shall comply with the open meeting provisions of the Municipal Act. Board of Health members may, but are not required, to meet in closed session when considering issues outlined in Section 239 of the Municipal Act.

When receiving information, Board of Health members are also required to comply with the Municipal Freedom of Information and Protection of Privacy Act and the Personal Health Information Protection Act. "Confidential Information" includes:

(i) information that is considered by the Board of Health in closed session; or

(ii) information in the possession of Board of Health members that the Board of Health is either prohibited from disclosing, or is required to refuse to disclose, under the Municipal Freedom of Information and Protection of Privacy Act or Personal Health Information Protection Act.

No Board of Health member shall disclose or release by any means to any member of the public, any Confidential Information acquired by virtue of being a Board member, in either oral or written form, except when required by law, or authorized to do so by the Board of Health. No Board of Health member shall use Confidential Information for personal or private gain, or for the gain of or to advance the interests of any other third parties.

When a matter has been discussed at a closed meeting, the subject matter of the meeting is Confidential Information and shall remain confidential. No Board of Health member shall disclose the content of any such matter or the substance of deliberations of the closed meeting until the Board of Health discusses the Confidential Information at a meeting that is open to the public or releases the Confidential Information to the public.

Therefore, Board of Health members shall:

- Comply with the open meeting provisions of the Municipal Act.
- Not disclose and keep confidential all information considered by the Board of Health in closed session and information that is prohibited from being disclosed by law.

3) Real and Perceived Conflicts of Interest

Board of Health members may be under public and media scrutiny. This means that any conflicts of interest (or even the perception of a conflict) may reduce the public's confidence in the Board of Health. Types of conflicts include:

- **Personal Gain** - When Board of Health members (or their relatives) benefit financially from a Board decision; when Board of Health members (or their relatives) accept gifts for services that may influence a Board decision or when Board of Health members act in a way that is driven by self-interest.
- **Information Relevant to Health Unit Business** – Subject to the guidelines below for serving on other Boards and Councils, Board of Health members must disclose information that is relevant to the Health Unit's affairs. If they are unwilling or unable to do so, this may constitute a conflict of interest (see #4 for more information).
- **Acting in the Interests of Other Entities** - ~~When considering Health Unit matters,~~ Board of Health members do not have a legal duty to the entity that appointed them to the Board of Health. Furthermore, they ~~Board of Health members~~ must disclose when they cannot ~~are not prepared to~~ disregard the interests of other entities when considering Health Unit business (this is particularly important, but not limited to, the entity that appointed them to the Board of Health) ~~when considering Health Unit business~~. When considering issues fundamental to the Health Unit, Board of Health members must also~~, when considering issues fundamental to the Health Unit,~~ disclose whether they have an actual or perceived duty to another entity that may have an interest in, or ~~may have~~ taken positions on a matter before the Board of Health.

Therefore, Board of Health members shall:

- Always act in the best interest of the Board of Health and the Health Unit to support the delivery of public health programs and services.
- Not take advantage of membership on the Board of Health for personal gain or that of a third party.
- Notify the Secretary Treasurer of any real (or reasonably perceived) conflicts of interest either prior to, or at the beginning of a Board meeting.
- Declare neutrality, abstain from voting, refrain from taking part in any discussions and/or leave the room when a conflict of interest exists.

4) Serving on Other Boards / Councils:

Board of Health members have a responsibility to make decisions that are in the best interest of the Health Unit, ~~as well as~~ in order to support their legislated responsibility for ensuring the delivery of provincially mandated public health services in the City of London and Middlesex County. Outside of this role, Board of Health members are often leaders in the community and must be aware that a conflict may arise where a Board of Health member serves as a director / member / councillor on another board / council that has a competing interest or transaction with the Health Unit.

Board of Health members do not have a conflict of interest solely as a result of being appointed to the Board of Health by any particular organization, even if the appointing organization takes a position on a matter before the Board of Health. However, where a Board of Health member is not prepared to consider Board of Health business in a manner that is consistent with the best interests of the Board of Health, the member has contravened their duty to act in the best interest of the Board of Health. Further, where a Board of Health member uses his or her position as a Board of Health member for the purpose of advancing the interests of any other entity (whether or not they were appointed by that entity), the Board of Health member has contravened their duty to act in the best interest of the Board of Health.

Board of Health members may be in possession of information received in one capacity that is related to a matter before the Board of Health. If certain information is relevant to Board of Health business and is not confidential, Board of Health members shall disclose this information to the rest of the Board. If information is confidential and is relevant to Board of Health business, a Board of Health member must request consent to release this information to the Board of Health from the entity that originally provided the Board of Health member with this information.

- If such consent is granted, the Board of Health member shall disclose this information to the Board of Health.
- If such consent is not granted and the information remains relevant to Health Unit business, this constitutes a conflict of interest and the Board of Health member shall declare the conflict, shall not participate in the discussion pertaining to this issue and shall not vote on this issue.
- If the matter before the Board of Health is fundamental to the Board of Health and the Board of Health member has conflicting duties with respect to this Confidential Information, the Board of Health member shall seek legal advice and consider resigning from the Board of Health.

Therefore, Board of Health members shall:

- Comply with “Real and Perceived Conflicts of Interest” provisions as noted above.
- Disclose information relevant to Health Unit business, subject to the qualifications set out in this Code of Conduct.

5) Conduct at Meetings:

Board of Health members shall regularly attend Board of Health meetings, as well as orientation and educational sessions, as appropriate. Board of Health members shall also exercise due diligence by reviewing the materials and being prepared for Board of Health meetings.

Board of Health members shall conduct themselves with decorum at Board of Health meetings in accordance with the provisions of the Board of Health procedural bylaw and this Code of Conduct. All debates at Board of Health meetings shall be respectful and there shall be no profanity, no attempts to intimidate, threaten, coerce or otherwise engage in discreditable conduct at Board of Health meetings.

Therefore, Board of Health members shall:

- Regularly attend and be prepared for meetings.
- Conduct themselves with decorum.

6) Media Contact Interactions and Public Discussions:

In order to speak with a unified voice, the Chair is the designated spokesperson for the Board of Health. This means that only the Chair (or designate) may speak on behalf of the Board. Similarly, only the Medical Officer of Health (or designate) may speak on behalf of the Health Unit. Board of Health members may speak in public and to the media, but must clarify that their views do not represent the views of the Board of Health. Furthermore, Board of Health members must carefully consider the impact of their media comments on the Board of Health and the Health Unit.

Therefore, Board of Health members shall:

- Not speak on behalf of or represent the Board of Health unless authorized to do so by the Chair.
- When contacted by the media regarding a Board of Health-related topic:
    - Refer media inquiries requesting a statement from the Board of Health to the Chair through the Secretary Treasurer;
    - Inform the Chair and Secretary Treasurer of any media inquiries related to Board of Health or Health Unit matters;
    - Consider the impact that a comment made to the media will have on the Board of Health and/or the Health Unit;
    - Only comment to the media once it has been clarified that the comment is not on behalf of the Board of Health, unless authorized to speak on behalf of the Board of Health by the Chair.

7) Interactions with Staff Members:

Health Unit staff members and Board of Health members should work together in a respectful manner to address local public health issues. However, the accountability structure is that the Medical Officer of Health (MOH) is the only employee accountable to the Board, and all Health Unit staff members are accountable to the MOH. Board of Health members must respect this structure and contact the MOH if they wish to contact staff members. This contact can occur through the Executive Assistant to the Board of Health or directly. The Executive Assistant to the Board of Health should be contacted with regard to Board Administrative matters.

No Board of Health member shall falsely injure the professional or ethical reputation of Health Unit staff members and all Board of Health members shall show respect to Health Unit staff, recognizing that Board of Health members do have the right and obligation to diligently examine and debate Board of Health issues at meetings. Board of Health members also have the right and the obligation to request clarification and further information from Health Unit staff.

Board of Health members will respect the right of Health Unit staff members to manage the operations of the Health Unit and will not involve themselves in these matters.

Therefore, Board of Health members shall:

- Contact the Medical Officer of Health (MOH) through the Executive Assistant to the Board or directly if they wish to contact Health Unit staff members.
- Ensure that interactions and communications with staff members are respectful and constructive.
- Not involve themselves in the operations of the Health Unit.

8) Election Campaigns:

Some members of the Board are municipally elected officials. These members are under additional scrutiny and have additional responsibilities (both campaign work and responsibilities under the Municipal Elections Act). Board of Health Members who are elected officials cannot act in self-interest or use Health Unit resources or Board of Health meetings to advance their election campaign.

Therefore, Board of Health members shall:

- Not use Health Unit resources or Board of Health meetings to advance an election campaign.

9) Post-Board of Health Membership:

Board Members will have access to Confidential Information. While on the Board of Health and after leaving, they must not disclose Confidential Information indefinitely, and shall not use Confidential Information for their own benefit or the benefit of any third party. Board of Health members must also return or shred / delete all materials containing Confidential Information, upon request from the Board of Health or the Health Unit.

Therefore, Board of Health members shall:

- Not take advantage of past membership on the Board of Health for personal gain or that of a third party.
- Not disclose and keep confidential all Confidential Information obtained while a member of the Board of Health.

10) Legal Advice:

Outside legal advice is occasionally necessary given the complex nature of public health practice and governance. However, in the interest of resolving issues and conflicts effectively without unnecessary expense, Board of Health members seeking legal advice will make a request through the Secretary-Treasurer.

Therefore, Board of Health members shall:

- Make a request through the Secretary-Treasurer when legal advice is necessary.

11) Compliance:

Board of Health members are responsible to hold each other accountable in maintaining compliance with this Code of Conduct. This includes raising potential compliance issues as well as collaborating to develop solutions to resolve compliance issues. Board of Health members should be aware that there are consequences for failing to comply with this Code of Conduct (see below).

Therefore, Board of Health members shall:

- Hold each other accountable for complying with the Code of Conduct, including raising compliance issues, collaborating to develop solutions and being aware of consequences of failing to comply.

MECHANISMS TO MANAGE COMPLIANCE ISSUES:

If a Board of Health member is alleged to have contravened this Code of Conduct, a person (the "complainant") may pursue either the informal complaint process or the formal complaint process as set out below:

I. Informal Complaints:

Any person who has identified or witnessed behaviour or activity by a Board of Health member that appears to be in contravention of the Code of Conduct may address their concerns in the following manner:

(a) Advise the Board of Health member that their behaviour or activity contravenes the Code of Conduct;

(b) Encourage the Board of Health member to stop the prohibited behaviour or activity;

(c) If applicable, confirm to the Board of Health member your satisfaction or dissatisfaction with his or her response to the concern identified;

(d) Keep a written record of the incident(s), including date, time, location, other persons present or any other relevant information, including steps taken to resolve the matter.

The Board of Health member to whom the complaint is directed should also keep a written record of when they were approached by the complainant, the discussion(s) that took place, and what they have done to address the complaint.

If the complainant is not satisfied with the response received through the informal process, the complainant may still proceed with the formal complaint process set out below.

II. Formal Complaints:

If a complainant has identified or witnessed behaviour or activity by a Board of Health member that appears to be in contravention of this Code of Conduct, the complainant may address their concerns through the process set out below:

(a) A formal written complaint shall be submitted the Board of Health Chair (the "complaint"). The complaint shall set out the specific section of the Code of Conduct that is alleged to have been contravened together with an explanation as to why such actions may be a contravention of the Code of Conduct. The complaint must include the name of the Board of Health member alleged to have breached the Code of Conduct, the date, time and location of the alleged contravention and any other information and evidence in support of the allegation. Any witnesses in support of the allegation must be identified in the complaint.

(b) Once the complaint is submitted to the Board of Health Chair, the Board of Health member that is alleged to have contravened the Code of Conduct shall meet with the Board Chair and the Secretary-Treasurer to discuss the complaint and provide information on whether there has been a contravention of this Code of Conduct.

In the event that the Board Chair and the Secretary-Treasurer agree that there has been no contravention of the Code of Conduct, no action shall be taken and a report shall be delivered to the Board of Health with full disclosure of the relevant information and findings. As this matter may involve an identifiable individual, the report is permitted to be delivered in closed session.

In the event that the Board of Health Chair and the Secretary-Treasurer agree that there has been a contravention of the Code of Conduct or, alternatively, cannot unanimously agree that there has not been a contravention of the Code of Conduct, the matter shall be referred to the Board of Health with a full report to determine whether there has been a contravention of the Code of Conduct and, if so, what if any action might be appropriate in the circumstances.

The complaint and the full report shall be presented to a meeting of the Board of Health. As this matter may involve an identifiable individual, this discussion is permitted to occur in closed session. If the Board of Health determines that there has not been a contravention of the Code of Conduct, no action shall be taken. If the Board of Health determines that there

has been a contravention of the Code of Conduct, the Board has the right, in its sole and absolute discretion, to recommend and/or take the following actions:

(a) no action or other sanction should be taken against the offending member;

(b) a request for a public apology from the offending member, failing which other options will be considered;

(c) a public reprimand by the Board of Health of the offending member; and

~~(d) a resolution of the Board of Health requesting the resignation of the Board of Health member which shall be non-binding on the Board of Health member in question; and~~

(~~e~~d) all other remedies that may be available to the Board of Health at law.

When determining the appropriate action that might be taken under this Section, the Board of Health shall consider:

(i) the Board of Health member's past conduct;

(ii) the severity of the contravention of the Code of Conduct;

(iii) the implications of the Code of Conduct contravention to the Board of Health and the Health Unit;

(iv) the Board of Health member's co-operation in addressing the contravention;

(v) the Board of Health member's general level of remorse that the contravention of the Code of Conduct has occurred; and

(vi) such further and other criteria that may reasonably be considered by the Board of Health.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 004-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

ONTARIO MINISTRY OF TRANSPORTATION'S DRAFT CYCLING STRATEGY

Recommendations

It is recommended that the Board of Health submit a written communication to the Ontario Ministry of Transportation to convey the following:

a) Board of Health endorsement for developing a provincial Cycling Strategy (Appendix A);

b) Middlesex-London Health Unit comments/recommendations pertaining to the draft Cycling Strategy (Appendix B); and

c) Board of Health support for the City of London comments/recommendations pertaining to the draft Cycling Strategy.

Key Points

- The Ministry of Transportation (MTO) is developing a provincial Cycling Strategy to increase cycling opportunities and to make cycling safer, and is inviting comments from all stakeholders.
- Cycling helps to prevent the development of chronic diseases and is environmentally friendly, and safer cycling helps prevent injuries.
- Given that the MTO Cycling Strategy aligns with the goals of the Ontario Public Health Standards, the Health Unit supports its development, offers constructive comments/recommendations, and supports the comments/recommendations submitted by the City of London.

Background

Cycling is increasing in popularity for exercise, recreation, and as a mode of transportation. Cycling is an important means of active transportation, allowing individuals to purposely travel between destinations. In addition, it has shown to have a positive effect on the environment and human health. The Ontario Ministry of Transportation (MTO) has prepared a draft Cycling Strategy (Appendix A) to increase the number of people cycling in Ontario and improve the safety of all road users through a three-pronged approach aimed at:

1. Enhancing the cycling infrastructure in the province,
2. Enhancing cycling safety through education and legislation, and
3. Ensuring relevancy through monitoring, researching and coordination.

The Cycling Strategy

Cycling is encouraged as a means of increasing daily levels of physical activity, which in turn is an important component in preventing obesity, cardiovascular disease, cancer, diabetes and osteoporosis. Increased cycling also reduces reliance on the automobile resulting in a positive impact on the environment. In order to prevent injuries, an increase in cycling must be accompanied by an increased emphasis on cycling safety. The draft Cycling Strategy recognizes the shared responsibility between provincial and municipal governments to create environments supportive of cycling, and identifies the need for leadership, education, and funding to assist local municipalities. Key elements of the Strategy are outlined below.

Cycling Infrastructure: The draft Cycling Strategy will enhance cycling infrastructure by supporting municipalities in the development of local cycling networks. It will assist with infrastructure design, provide guidance documents, and increase available options for cycling infrastructure funding.

Enhancing Safety Through Education and Legislation: The draft Cycling Strategy includes the provision of public education for cyclists and drivers through the Ministry of Transportation (MTO) published guides, and through partnerships between the MTO and local road safety organizations for the development and implementation of cycling safety initiatives. In addition, the draft Cycling Strategy includes a commitment by the MTO to review the current *Highway Traffic Act* and to research other relevant transportation legislation with the goal of improving cycling safety.

Monitoring, Researching, and Coordination: The draft Cycling Strategy includes a commitment by the Ministry of Transportation (MTO) to monitor the strategy's implementation, as well as similar strategies in other jurisdictions. In addition, MTO will continue to gather and analyze data on cycling collisions, monitor and support research aimed at improved cycling safety, and encourage municipalities to collect and share local cycling-related data. And finally, under the draft Cycling Strategy, MTO will continue to coordinate local cycling initiatives through their Active Transportation Working Group and to liaise with cycling stakeholders and organizations across the province.

Comments on the Draft Cycling Strategy

The Ministry has invited comments on the draft Cycling Strategy, and in response, Health Unit staff members have prepared recommendations to be submitted by January 29, 2013. The comments/recommendations can be found in Appendix B. Further, Health Unit staff members support the comments made by the City of London – Environmental Programs & Solid Waste and Roads & Transportation Departments in response to the draft Cycling Strategy, contained within the report submitted to the Civic Works Committee on December 17, 2012 (Appendix C).

Other Related Health Unit initiatives

One of the Health Unit's strategic directions is to improve health outcomes by increasing physical activity levels among all population groups. As part of delivering the Ontario Public Health Standards, the Healthy Communities and Injury Prevention and Chronic Disease Prevention & Tobacco Control Teams have provided leadership in working with local, regional, provincial and national partners / stakeholders in developing, implementing and supporting numerous policy-focused initiatives that encourage improved health and safety through physical activity, active transportation, injury prevention, and the built environment. Appendix D provides a list of some of these initiatives. The draft Cycling Strategy is consistent with these initiatives.

Conclusion

The Ministry's draft Cycling Strategy is a positive step towards creating supportive environments for healthy, safe and active lives. The Health Unit supports the recommendations in the draft Cycling Strategy and the comments provided by the City of London, and provides some additional comments for consideration by the Ministry of Transportation.

This report was prepared by Ms. Joyce Castanza, Ms. Emily Hill, and Ms. Bernadette McCall, Public Health Nurses, and Ms. Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention Team.

Bryna Warshawsky, MD, FRCPC
Acting Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Chronic Disease Prevention Requirements: 6, 7, 11 and Prevention of Injury and Substance Misuse Requirements: 2, 4, 5 and Area of Focus: Improved Health Outcomes

DRAFT

Ontario Ministry of Transportation

Cycling Strategy

for Consultation
on the Environmental Registry
November 30, 2012

Ontario Ministry of Transportation's Draft Cycling Strategy

Cycling is an increasingly popular means of transportation, exercise and recreation. Our latest statistics estimate that 630,000 Ontarians ride a bicycle on a daily basis, and that 48 per cent of almost 13 million Ontarians ride at least once a week during the spring, summer and fall.

There has been some recent discussion about the different types of bikes that are found on Ontario's roads (see Appendix A for clarification), but what is not in question are the benefits that bikes can deliver. Cycling has a tremendous effect on our environment, reducing GHG emissions by getting cars off of our roads and easing gridlock. Cyclists also reap significant health benefits, which in turn save money for our health care system. There is no question that cycling is a mode of transportation that the government should continue to support.

The rate of cycling-related injury and fatality has dropped considerably over the last few decades; comparing 2009 to 1988, cyclist fatalities are down 70 per cent and major injuries are down 64 per cent. Ontario has the safest roads in North America, bar none, and the second safest in Canada for cyclists. Despite this, we know we need to do more.

We also recognize the potential economic benefits of cycling tourism through the development of a provincial cycling network. The Province of Quebec, for example, estimates that their network, known as "La Route Verte", generates an annual economic return of about $30,000 per kilometre, amounting to more than $100 million each year.

Our vision is for a safe cycling network that connects the province, for collision rates and injuries to continue to drop, and for everyone from the occasional user to the daily commuter to feel safe when they get on a bicycle in Ontario. Our cycling strategy will serve as a map for how we make that vision a reality.

This draft Strategy addresses a number of the recent Coroner's recommendations directed at the Ontario Ministry of Transportation (see Appendix B). It outlines our plans for infrastructure, education and legislation, including a separate consultation on potential legislative amendments to the *Highway Traffic Act* aimed at improving cycling safety, such as those proposed by the Coroner (i.e. mandatory helmets for all riders regardless of age and a minimum one-metre passing rule for vehicles passing cyclists)[1].

The enclosed plan sets out a map for ongoing work and describes in detail the government's plan and priorities. We recognize the important role of our many partners, and look forward to your feedback.

Sincerely,

The Honourable Bob Chiarelli
Minister of Transportation

[1] Consulting on these items would be a first step in evaluating recommendations 11 and 12 from the Coroner of Ontario's "Cycling Death Review" (the Coroner's Report), to make helmets mandatory for cyclists of all ages and introduce a one meter/three foot passing rule for vehicles when passing cyclists.

Contents

SECTION 1 – CONTEXT

Cycling in Ontario

Research commissioned by the Ontario Ministry of Transportation (the Ministry) in 2011 found that 48 per cent of Ontarians ride a bicycle at least once a week during the spring, summer and fall. Exercise and recreation are the main reasons that Ontarians ride their bicycles, but around 50 per cent of Ontario cyclists also do so as a mode of transportation – to ride to work or school, for shopping, to run errands, or to visit family and friends.

While most cycling takes place on municipal roads, the Province still has an important role to play in increasing both the number and safety of cyclists.

Benefits of Cycling

Cycling offers many potential benefits, including:

- Promoting active and healthy lifestyles – in *Enhancing Cycling Safety in Ontario* (2011), the Ontario Medical Association advocates that people increase their daily physical activity through cycling in response to concerns about obesity and related chronic disease. Cycling is an activity that can be incorporated into the daily tasks of life, and is a cost-efficient means to meet recommended physical activity guidelines.

- Reducing emissions of greenhouse gases and other harmful pollutants – according to the Environmental Commissioner of Ontario (2010), the transportation sector contributes over one-third of Ontario's greenhouse gas emissions and energy consumption. Passenger vehicles account for around 75 per cent of Ontario's greenhouse gas emissions from transportation, which makes encouraging people to choose cycling particularly compelling.

- Reducing congestion – like many urban areas, traffic congestion in the Greater Toronto and Hamilton areas costs billions of dollars to the economy each year. Increasing commuter cycling has the potential to reduce passenger vehicle traffic during peak periods.

- Providing economic development opportunities – the economic potential of cycling tourism is increasingly being recognized. For example, the Province of Quebec estimates that its province-wide cycling network, known as "La Route Verte", generates an annual economic return of about $30,000 per kilometre, totalling more than $100 million each year.

Creating an environment for encouraging cycling is a shared responsibility between the provincial government, municipalities, not-for-profit organizations and cycling associations.

What We Are Doing at the Provincial Level

The Ontario Government has established broad provincial planning objectives that encourage and support cycling and walking in Ontario. These objectives have been communicated through legislation such as the *Planning Act (1990)* and its supporting policy document the *Provincial Policy Statement (2005)*.

The *Provincial Policy Statement* represents the government's policy direction on land use planning. It provides direction for the entire province on matters of provincial interest related to land use

planning and development, and promotes a provincial "policy-led" planning system. The Provincial Policy Statement encourages healthy, active communities through the planning of public streets, spaces and facilities that meet the needs of pedestrians and non-motorized movement (such as cycling). A revised draft Provincial Policy Statement is being developed. More information is available from the Ministry of Municipal Affairs and Housing's website at: http://www.mah.gov.on.ca/.

Across the Ontario Government several ministries have taken actions to support cycling. For example:

- The Ministry of Tourism, Culture and Sport (MTCS) as the government lead for trails planning and coordination, currently oversees the implementation of the *Ontario Trails Strategy* (2005), which seeks to encourage on- and off-road cycling in order to promote sport/recreation, tourism and active transportation. MTCS has provided support for a range of cycling-related projects through its various funding programs towards achieving national physical activity targets.

- Through the Healthy Communities Fund Provincial Grants, the Ministry of Health and Long Term Care has provided funding to Green Communities Canada to support Walking and Wheeling: Healthy, Happy, Active School Travel, a project to promote walking and cycling to Ontario schools through key activities that build on the foundation of Active and Safe Routes to School.

- Under the Ontario Public Health Standards, public health units are required to deliver initiatives and programs related to healthy weights, physical activity, and prevention of injuries. This work includes active transportation (including cycling), access to recreation, and bike safety. As part of the Healthy Communities Fund Partnership Stream, public health units and host agencies are also developing policies to increase physical activity. In addition, cycling organizations, such as Share the Road Cycling Coalition have received $90,000 in funding through the Healthy Communities Grants Project Stream to deliver cycling promotion activities.

What We Are Doing at the Ministry of Transportation

The Ministry of Transportation's vision is "to be a world leader in moving people and goods safely, efficiently and sustainably, and to support a globally competitive economy and a high quality of life." Achieving this vision requires that we encourage cycling and improve the safety of cyclists in the Province.

The Ministry's support for cycling is consistent with its commitment to become a more sustainable organization, as described in its sustainability framework – *Sustainability InSight*. Through *Sustainability InSight*, the Ministry has established seven strategic sustainability goals, four of which relate to cycling - improving mobility choices, applying a context sensitive approach to Ministry projects, optimizing infrastructure design, and driving a cultural shift toward sustainability. Copies of *Sustainability InSight* can be downloaded at: http://www.mto.gov.on.ca/english/sustainability/strategy/MTO_sustainabilityreport-en.pdf

The actions the Ministry has taken to encourage cycling and improve safety can be grouped into the following four categories: infrastructure, safety, planning, and research.

Infrastructure

In 2008 Metrolinx, the Ministry's agency, released The Big Move, a 25-year regional transportation plan for the Greater Toronto and Hamilton Area (GTHA). That plan sets out a

vision for a sustainable, multi-modal transportation system across the GTHA, and includes cycling infrastructure within the definition of a transportation and/or transit system. The Big Move outlines active transportation targets, the need for a commitment of up to $20 million per year for active transportation infrastructure, which includes cycling, as well as measures to promote the development of communities that are pedestrian, cycling and transit-supportive. This includes the need for an integrated walking and cycling network in the GTHA, creating pilot bike-sharing programs in major urban centres, the inclusion of bicycle carrying devices on transit vehicles, and establishing bicycle storage facilities at major rapid transit stations. Metrolinx is developing an investment strategy to support The Big Move. More about The Big Move can be found at: http://www.metrolinx.com/thebigmove/en/default.aspx.[2]

The Ministry is in the process of updating its bikeways planning and design guidelines. This document contains a set of guidelines for designing bicycle facilities on Ministry highways.

For the benefit of all road users, the Ministry has paved a minimum one metre shoulder on Highway 6 for 46 kilometres on Manitoulin Island and 66 kilometres on the Bruce Peninsula, as a pilot project. The Ministry is planning on monitoring and collecting information over the next few seasons on the results of this pilot, in order to inform its decisions on how its transportation network can accommodate and support active transportation.

Safety

New Beginner Driver Education curriculum standards were introduced in September 2009 to provide a solid foundation for safe and responsible driving and to help develop positive driving attitudes and behaviours in new drivers. Driving schools are required to include information about courteously sharing the road with cyclists in their curriculum and during in-vehicle practice. New drivers are further tested when obtaining a class G2 or G driver's licence.

The Ministry has completed a stakeholder consultation on its suite of Driver Handbooks with a view to enhancing its "share the road with cyclists" section of the handbooks. Cycling safety groups were consulted as were representatives from enforcement, the insurance industry and the medical community. The Ministry plans to add new information and illustrations on bike lanes, road markings and right-of-way in future copies of the handbooks.

Specific to cycling, the Ministry publishes *Cycling Skills: Ontario's Guide to Safe Cycling* and the *Young Cycling Guide* that are strongly focused on safety. These can be found at http://www.mto.gov.on.ca/english/pubs/#cycling.

The Ministry also partners with, and provides funding to, local road safety organizations through its Road Safety Challenge and Road Safety Community Partnership Programs. These educational activities are tailored to the specific needs of communities and can involve public health units, police and members of the community working with Ministry staff to assist with the development and implementation of cycling safety initiatives across the province. A recent example is the Ministry's collaboration with the Share the Road Cycling Coalition and the Canadian Automobile Association, to develop a provincial multimedia public education campaign that rolled out in summer 2012. Other Ministry-supported cycling safety initiatives include a public education campaign by EnviroCentre and the City of Ottawa in spring 2012. The campaign features a video series promoting cycling training and safe riding practices, including how to properly use bike boxes and cycling lanes. Cycling

[2] Under The Big Move a transportation plan must (among other things) take into consideration all modes of transportation, including highways, railways, local transit systems, the regional transit system, cycling and walking.

safety was also a priority theme for the 2012 Road Safety Challenge which enabled the Ministry to support 27 community groups to promote cycling safety in their communities.

In Spring 2013, the Ministry will be piloting a new initiative to provide purchasers of new bicycles with cycling safety information at the point of sale.[3]

Planning

Led by the Ontario Traffic Council, the Ministry continues to work in partnership with municipalities, engineering and planning consultants, and tourism organizations to update *Ontario Traffic Manual Book 18: Bicycle Facilities.* Book 18 will serve as a primary reference document for engineers, planners and designers throughout Ontario. The Book contains information on legal requirements, standards, best practices, procedures, guidelines and recommendations for the justification, design, timing and operation of bicycle facilities and control measures.

The Ministry has also published its *Transit-Supportive Land Use Planning Guidelines* to share strategies, best practices, and case studies on building communities that support cycling and the integration of cycling with transit services with municipalities.

Research

The Ministry has led a comprehensive review of existing and planned cycling touring routes in the province, as well as consulting with key cycling and tourism stakeholders on the key elements of a potential province-wide cycle touring network. This research shows hundreds of on-and off-road routes across the province, most of which are maintained by municipalities. The Ministry will publish maps of existing cycling routes through the Ministry of Natural Resources Land Information Ontario online database.

The Ministry also undertook a Bicycle Survey for the Greater Golden Horseshoe to determine who is cycling, why and how useful the existing facilities are. The results will enhance the Ministry's forecasting for cycling, enabling the Ministry to produce more accurate forecasts in support of cycling, safe roads, and infrastructure planning and investment. The Ministry will share this information with municipal partners.

[3] Providing the purchasers of bicycles with cycling safety information would address recommendation 5 from the Coroner's Report. See Appendix B for further details.

SECTION 2 – A CYCLING STRATEGY FOR ONTARIO'S MINISTRY OF TRANSPORTATION

The Ministry is taking a three-pronged approach to its cycling strategy in order to increase the number of people cycling in Ontario and improve the safety of all road users. Some of this work is ongoing or underway, but enshrining this approach into the Strategy ensures that it will be a part of the Ministry's ongoing business.[4]

2.1 Enhancing Cycling Infrastructure in the Province

In Ontario, roads and highways are either owned by the provincial or the municipal/regional levels of government. Cyclists are allowed on all roads throughout the province, except those where cycling is expressly prohibited and where "no bicycling" signs have been erected (e.g. 400-series highways). In general, most utilitarian or daily cycling occurs on municipal roads, while long-range recreational cycling mostly takes place on provincial roads. Creating an environment for encouraging cycling is a shared responsibility between both provincial and municipal governments.

Cycling can be accommodated in many ways, including bike lanes, shoulder bikeways, off-road trails or paths, and through simple signage where traffic volume and speed is low enough.

Leading the Identification of a Province-Wide Cycling Network

The Ministry will identify a province-wide cycling route network to connect cycling destinations to create recreational cycling and tourism opportunities.

Using data collected on existing municipal or regional local cycling routes, the Ministry will identify how connections can be made between local cycling routes to form a province-wide cycling route network in order to maximize existing municipal investments. The Ministry will focus its cycling infrastructure investments on closing the gaps between existing cycling routes to create a provincial cycling network.[5]

When the Ministry plans infrastructure projects for future funding – either constructing new provincial highways or rehabilitating existing provincial highways – it will evaluate on a case-by-case basis whether the addition of a cycling component[6] is warranted based on outlined criteria and whether it can be accommodated without substantially altering the scope of the project. Priority will be given to projects that:

- Could form part of a province-wide cycling network.
- Have no viable alternative route.

[4] Developing the Cycling Strategy addresses recommendation 2 from the Coroner's Report. See Appendix B for further details.

[5] Leading the identification of a province-wide cycling network partially addresses recommendation 1 of the Coroner's Report. "Complete-streets" is a planning approach applied to urban settings to guide the redevelopment of existing communities and the creation of new communities, therefore the recommendation was jointly directed at the Ministry of Transportation (MTO) and Ministry of Municipal Affairs and Housing (MMAH).

[6] Examples of the ways that cycling can be accommodated include bike lanes in urban areas, shoulder bikeways in rural areas, off-road trails or paths, and, where traffic volume and speed is low enough, simple signage. Providing paved shoulders where appropriate could also improve the safety of all road users. While paving shoulders on provincial highways responds to recommendation 3 of the Coroner's Report, the *Highway Traffic Act* currently restricts driving on paved shoulders. It is the Ministry's intention to initiate consultation on legislative and/or regulatory changes regarding cycling on paved shoulders as part of its consultation on other legislative and/or regulatory changes.

- Would connect with other existing or planned cycling routes.
- Are consistent with local tourism goals.
- Connect population centres and/or places of interest.
- Allow access to services and accommodation.
- Have a demonstrated demand for cycling.
- Are, or can, reasonably be made safe.
- Have strong local support.
- Are cost effective.

When a municipality or stakeholder group requests the addition of a cycling component to a provincial highway construction project, the Ministry will consider partnership agreements with municipalities or other stakeholder groups for the additional costs, subject to available funding.

For the safety of all road users, the Ministry will prioritize the use of off-road trails or lower speed, low volume roads where possible, and will take steps to ensure that crossings of provincial highways are minimized when identifying the network.

When a provincial road project is within municipal boundaries, the Ministry's regional offices will consult with municipalities during the design of provincial highway rehabilitation and/or new construction projects to discuss cycling and other road issues.

Supporting Municipalities in the Development of Local Cycling Networks

The Ministry provides support for municipalities in developing and enhancing their cycling routes. The Ministry does not want its infrastructure to be a barrier to existing municipal routes.

Assisting with Infrastructure Design

Municipalities planning on developing municipal cycling networks work in partnership with the Ministry when that proposed route would cross or otherwise touch upon Ministry infrastructure. The Ministry works with municipalities to identify the most appropriate design to accommodate all road users safely in these situations.

In these circumstances, funding for the redesign and construction of cycling-related portion of the agreed-upon treatment will continue to be assessed on a project-by-project basis taking into account the impact of the redesign on overall project costs. Given the magnitude of the expenses entailed, where bridges or other structures need to be expanded to better accommodate cycling, incremental costs associated with the expansion will be the responsibility of the requesting municipality.

Providing Guidance Documents

The Ministry provides technical and guidance documents, including guidelines for designing cycling infrastructure, that can be used by municipalities.

Access to Funding for Municipalities

The Ministry recognizes that most cycling occurs on municipal infrastructure and encourages municipalities to ensure that their proposed cycling infrastructure investments are integrated into their asset management plans. Asset management is a cornerstone of the government's Municipal Infrastructure Strategy and helps prioritize needs to ensure the right investments are made at the right time. In this

context, the province has made cycling infrastructure eligible under the Municipal Infrastructure Investment Initiative, and will explore options to include cycling within other provincial funding programs.

2.2 Enhancing Cycling Safety through Education and Legislation

The Ministry seeks to improve the safety of road users, including cyclists.

Travelling safely on roads and highways in Ontario is the shared responsibility of all road users, including cyclists. The Ministry recognizes it has an important role to play in improving road safety.

In Ontario, cyclists are officially recognized in the *Highway Traffic Act* as legitimate road users. This includes all cyclists – from young children to seniors, occasional users, to experienced commuters. Cyclists have similar rights and responsibilities to other vehicle operators.

Public Education for Cyclists and Drivers

The Ministry publishes guides for the public on cycling skills that are focused on safety.

The Ministry partners with, and provides funding to, local road safety organizations to provide educational activities that assist with the development and implementation of cycling safety initiatives across the province.[7]

The Ministry updates its series of Driver Handbooks regularly to enhance the safety of all road users, including cyclists.[8]

Legislation that Provides for the Safety of Cyclists

The Ministry regularly reviews and updates the *Highway Traffic Act* and other relevant Ministry legislation and policies to improve cycling safety.[9]

In determining the need for updates to the *Highway Traffic Act*, regulations or policy, the Ministry will undertake its own research, review the approaches of other jurisdictions, listen to the comments and concerns of stakeholders, including the Coroner, and consider the recommendations of other government bodies. The overall objective of any amendments will be to improve the safety of Ontario's cyclists and other road users.

[7] Public education for drivers and cyclists, in collaboration with road safety organizations, addresses elements of recommendation 4 from the Coroner's Report. See Appendix B for further details.
[8] Updating the Driver Handbooks to enhance the safety of all road users, including cyclists, addresses recommendation 7. See Appendix B for further details.
[9] Reviewing and updating the *Highway Traffic Act* to improve cycling safety addresses recommendation 8 from the Coroner's Report. See Appendix B for further details.

2.3 Ensuring Relevancy through Monitoring, Researching and Coordinating

The Ministry will review the effectiveness of this Strategy on a timely basis to determine how it can be improved and updated.

Monitoring and Research

The Ministry will monitor the implementation of this Cycling Strategy, as well as the cycling policies of other leading jurisdictions to ensure that the Ministry follows best practices.

The Ministry will continue to gather and analyze data related to collisions involving cyclists and motor vehicles which in turn will help inform planning and policy decisions. Cycling related collision data will continue to be published each year in the *Ontario Road Safety Annual Report.*

The Ministry monitors and supports research aimed at improving knowledge related to cycling in Ontario. This may include activities that lead to improved cycling safety, provide a better understanding of the current cycling mode share and cycling usage across the province, or identify barriers to cycling in Ontario. This research will help determine additional actions that can be taken to reduce or eliminate barriers to cycling. It will also serve to identify opportunities and strategies to connect existing cycling routes together across the province.

The Ministry will encourage municipalities to collect cycling-related data within their jurisdiction and to share this data with interested parties, including the Ministry, in order to better understand the needs, patterns and barriers to cycling in the province.

Co-ordination

The Ministry will continue to coordinate cycling initiatives and share cycling information through regular meetings of the Ministry's Active Transportation Working Group, which includes representatives from all relevant Ministry divisions, including those with responsibility for road user education and highway design standards.

In addition, the Ministry will continue to share cycling information and coordinate cycling-related activities across all relevant provincial ministries and provincial agencies through regular meetings of the Inter-Ministerial Active Transportation Working Group.

The Ministry will continue to liaise with cycling stakeholders and organizations across the province on both local issues and broader Ministry activities as they relate to cycling as a mode of transportation.

Glossary

Below are definitions of terms as used in the draft Cycling Strategy.

Highway or Road – The term “highway” is interchangeable with the term “road.” A highway consists of the roadway itself and any adjacent land that lies between the lateral property lines.

Provincial Highway – A highway under the jurisdiction and control of the Ministry of Transportation. There are approximately 16,500 km of provincial highway in Ontario. Cycling is prohibited on about 2,000 kilometres of this network, mostly on controlled access (e.g. 400 series) highways. In addition to these, Ontario municipalities control a separate, much larger network of roads.

Municipal Highway – A highway under the jurisdiction and control of a municipality.

Roadway – The part of a highway that is improved, designed or ordinarily used for vehicular traffic, but does not include the shoulder.

Shoulder – The portion of a highway that provides lateral support to the roadway and that may accommodate stopped motor vehicles and emergency use.

Infrastructure – Examples of the ways that cycling can be accommodated include bike lanes in urban areas, shoulder bikeways in rural areas, off-road trails or paths, and, where traffic volume and speed is low enough, simple signage. Providing paved shoulders where appropriate could also improve the safety of all road users. While paving shoulders on provincial highways responds to recommendation 3 of the Coroner’s Report, the *Highway Traffic Act* currently restricts driving on paved shoulders. It is the Ministry’s intention to initiate consultation on legislative and/or regulatory changes regarding cycling on paved shoulders as part of its consultation on other legislative and/or regulatory changes.

Appendix A – Types of Bikes in Ontario

Bicycles

Can be operated on roads in Ontario, except those that are expressly prohibited and “no bicycling” signs have been erected (such as 400 series highways).

Under the *Highway Traffic Act* (HTA), the definition of bicycle includes tricycles, unicycles and power-assisted bicycles, but not motor-assisted bicycles. You do not need a driver's licence to operate a bicycle in Ontario.

Traditionally, a bicycle is a vehicle that:

- Has steering handlebars and is equipped with pedals;
- Is designed to be propelled by muscular power;
- Has no age restriction for operators;
- Can be operated on most roadways (e.g., not allowed to travel on 400 series highways); and
- Cannot be operated across a roadway within a pedestrian cross-over.

An operator must wear a bicycle helmet if under 18 and operating the bicycle on the road. If the operator is under 16 it is the duty of the operator's parent or guardian to ensure that he/she wears a helmet. If the person is 16 or 17 it is his/her personal responsibility to wear a helmet. No passengers are allowed if the bicycle is only meant for one person. When going slower than the rest of traffic, cyclists should stay as close to the right edge of the road as is practicable. Cyclists are allowed to safely use the full lane if staying close to the right edge of the road is unsafe.

Electric Bicycles ("e-bikes")

Can be operated on roads in Ontario except those that are expressly prohibited and “no bicycling” signs have been erected (e.g. 400 series highways).

Are considered a “bicycle” for the purposes of the HTA, but are defined as “power-assisted bicycles” under the HTA.

The HTA defines a power-assisted bicycle as:

- Having affixed to it pedals that are operable;
- Capable of being propelled solely by muscular power; and
- Meeting the federal definition of a power-assisted bicycle (*for the full definition, please see subsection 2(1) of the Motor Vehicle Safety Regulations under the Motor Vehicle Safety Act),* which includes:
    - Has steering handlebars and is equipped with pedals;
    - Is designed to travel on not more than three wheels;
    - Has an electric motor that has a power output rating of 500W or less. (Note: the motor is electric, and is incapable of propelling the cycle at speed of 32 km/h or greater on level ground, without pedaling); and
    - Bears a permanently affixed label by the manufacturer stating in both official languages that the vehicle conforms to the federal definition of a power-assisted bicycle.

Since October 3, 2009, e-bikes (both those resembling conventional bicycles and those resembling motor scooters) have been allowed on roads and highways where conventional bicycles are

currently permitted. They must follow the same rules of the road as set out in the HTA that currently apply to cyclists, with some exceptions.

In order to operate an e-bike:

- Operators must be 16 years of age or older; and
- All operators must wear an approved bicycle or motorcycle helmet at all times.

In addition:

- No person who is the owner or is in possession or control of an e-bike shall permit a person who is under the age of 16 years to ride on, drive or operate the e-bike on a highway.
- An e-bike must not be ridden on, driven or operated unless it is in good working order.
- Similar to bicycles and mopeds, power-assisted bicycles are prohibited from use on certain provincial controlled-access highways.
- Any municipal by-law prohibiting bicycles from highways under their jurisdiction also apply to e-bikes. Municipalities may also pass by-laws specific to e-bikes that prohibit them from municipal roads, sidewalks, bike paths, bike trails and bike lanes under their jurisdiction.

To operate an e-bike on Ontario roads, an e-bike must meet the following equipment requirements:

- Have a maximum unladen weight of 120 kg (includes the weight of vehicle and battery).
- Must be equipped with at least two independent braking systems that applies force to each wheel and is capable of bringing the e-bike, while being operated at a speed of 30 km/h, to a full stop within 9 metres from the point at which the brakes were applied.
- Must have wheels with a minimum diameter and width of 350 mm and 35 mm, respectively.
- Must have all electrical terminals completely insulated or covered and, along with the battery and motor, must be securely fastened to the bicycle to prevent them from moving while the bicycle is in motion.
- No modifications to the motor of an e-bike to permit it to exceed the federal requirements for motor output or speed for an e-bike (500W and a speed greater than 32 km/h) are allowed.

Motor-Assisted Bicycles (Mopeds)

Like limited-speed motorcycles, mopeds can be operated on roads in Ontario.

A restricted Class M licence for limited-speed motorcycle (LSM) and moped drivers was introduced on November 28, 2005. This restricted Class M licence has a condition that allows licence holders to drive limited-speed motorcycles and mopeds only. New moped drivers will be required to take road tests.

A motor-assisted bicycle is a bicycle that:

- Is fitted with pedals that are operable at all times to propel the bicycle;
- Weighs not more than 55 kg;
- Has no hand or foot operated clutch or gearbox driven by the motor and transferring power to the driven wheel;
- Has a piston displacement of not more that 50 cubic centimetres; and
- Does not attain a speed greater than 50 km/h on level ground within a distance of two km from a standing start.

To operate these vehicles on the roadway:

- The driver must hold the new restricted class M licence for limited-speed motorcycles/mopeds (Class M2 with L restriction or M with L restriction or a valid motorcycle licence (Class M1, M2 or M);
- Approved motorcycle helmet is required;
- The vehicle must be insured and registered and have a valid licence plate;
- No passengers are allowed;
- They must meet federal safety standards for a limited speed motorcycle; and
- Motor-assisted bicycles are not allowed to travel on 400 series highways.

Appendix B – Recommendations from the Chief Coroner of Ontario's "Cycling Death Review" Directed at the Ministry of Transportation[10]

Recommendations on Infrastructure

1. To the Ministry of Transportation and the Ministry of Municipal Affairs and Housing

A "complete streets" approach should be adopted to guide the redevelopment of existing communities and the creation of new communities throughout Ontario. Such an approach would require that any (re-)development give consideration to enhancing safety for all road users, and should include:

- Creation of cycling networks (incorporating strategies such as connected cycling lanes, separated bike lanes, bike paths and other models appropriate to the community.)
- Designation of community safety zones in residential areas, with reduced posted maximum speeds and increased fines for speeding.

2. To the Ministry of Transportation and the Ministry of Municipal Affairs and Housing

An Ontario Cycling Plan should be developed, building upon the 1992 Provincial Bicycle Policy. This Plan would establish a vision for cycling in Ontario, and would guide the development of policy, legislation and regulations and commitment of necessary infrastructure funding pertaining to cycling in Ontario. This plan should be publicly available.

3. To the Ministry of Transportation

The Ministry of Transportation should identify the development of paved shoulders on provincial highways as a high priority initiative.

Recommendations on Education

4. To the Ministry of Transportation

A comprehensive public education program should be developed to promote safer sharing of the road by all users. This initiative should be facilitated by the Ministry of Transportation, in collaboration with key stakeholder groups, including but not limited to, the Canadian Automobile Association, Share the Road Cycling Coalition, local cycling organizations and the Ontario Association of Chiefs of Police. Such a program should include:

- A targeted public awareness campaign, in the spring/summer months, with key messages around cycling safety. This could include changes arising from other recommendations from this Review (such as changes to the *Highway Traffic Act*).
- Education targeted at professional truck drivers regarding awareness and avoidance of cycling dangers.
- Education / regulation directed towards Beginning Driver Education (BDE) courses and driving instructors to include sharing the road and bicycle safety. This should be introduced in both classroom curricula and on-road training.
- Public safety campaigns around the dangers of distracted and impaired cycling (headphone use; carrying unsafe loads; cycling while under the influence of drugs or alcohol).

[10] Note: the numbers of the recommendations correspond to the Coroner's Report. Not all of the Coroner's recommendations are listed here since a number of them were not directed at the Ministry of Transportation (MTO).

5. To the Ministry of Transportation and the Ministry of Consumer Services

It should be a requirement that important bicycle safety information (such as rules of the road and helmet information) be provided to purchasers of any new or used bicycle. Such information could be included in a "hang tag" information card attached to the handlebar of every bicycle at the time of purchase which would include critical information and a reference to the Ministry of Transportation website and Service Ontario for additional bicycle safety information and publications.

7. To the Ministry of Transportation

The Official Driver's Handbooks (Driver's Handbook; Truck Handbook; Bus Handbook; Motorcycle Handbook) should be updated to provide expanded information around sharing the road with cyclists, and include cycling-related scenarios in driver examinations.

Recommendations on Legislation

8. To the Ministry of Transportation

A comprehensive review and revision of the *Highway Traffic Act* (HTA) should be conducted to ensure that it is consistent and understandable with respect to cycling and cyclists and therefore easier to promote and enforce.

11. To the Ministry of Transportation

The *Highway Traffic Act* should be amended to make helmets mandatory for cyclists of all ages in Ontario. This should occur in conjunction with an evaluation of the impact of mandatory helmet legislation on cycling activity in Ontario. Such an evaluation strategy should be developed and carried out in collaboration with the Ministry of Health and Long-Term Care and Public Health Ontario.

12. To the Ministry of Transportation

The *Highway Traffic Act* should be amended to include a one (1) meter / three (3) foot passing rule for vehicles when passing cyclists. This change in legislation should be reflected in the Ontario Driver's Handbook, Beginning Driver Education curricula and the driver's licence examination process.

Recommendations for the Ontario Ministry of Transportation Draft Cycling Strategy from the Middlesex-London Health Unit – January 2013

The Middlesex-London Health Unit (MLHU) Board of Health commends the Ontario Ministry of Transportation (the Ministry) for developing the draft Cycling Strategy and distributing it for public consultation. The MLHU appreciates that the draft strategy recognizes that the encouragement and support of cycling is a shared responsibility between the provincial government, municipalities, not-for-profit organizations and cycling associations.

Middlesex-London Health Unit supports and agrees with the following comments in the draft Cycling Strategy:

1. The overall direction of the Cycling Strategy as it pertains to enhancing infrastructure, increasing cycling safety through education and legislation, and ensuring relevancy through monitoring, research and coordination.
2. The Cycling Strategy as part of a sustainable, multi-modal policy approach with its numerous health and environmental benefits.
3. Cross ministerial support for the cycling strategy with strong provincial leadership. We particularly encourage collaboration between the Ministry of Transportation and the Ministry of Tourism, Culture and Sport; the Ministry of Education; and the Ministry of Health and Long-Term Care, as they are key for implementing successful cycling strategies.
4. The recognition that safe cycling is a shared responsibility and the plan to support local municipalities both through guidelines and funding.
5. Cycling infrastructure being eligible for funding under the Municipal Infrastructure Investment Initiative, as well as other provincial funding programs. We also encourage the funding to support the development of "complete streets".
6. Addressing the areas infrastructure, education and legislation as they correspond well with the three E's of the Canadian Injury Prevention and Control Curriculum (education, engineering and enforcement).
7. The inclusion of "Share the Road" concepts through the New Beginner Driver Education curriculum standards and drivers' examinations. We encourage the ongoing stakeholder consultation, participation and revision of the Driver Handbooks, and support the planned additions of information and illustrations on bike lanes, road markings and right-of-way in future copies of the handbooks.
8. The updating of the Ontario Traffic Manual Books. These documents will be very helpful for local municipal planners, engineers and designers, to assist in creating the safest infrastructure for cyclists across Ontario. We encourage regular updating of these documents.
9. The recommendations from the Chief Coroner of Ontario's "Cycling Death Review", particularly the:
    - adoption of a "complete streets" approach;
    - mandatory helmets for all ages; and
    - a minimum one-metre passing rule for vehicles passing cyclists.

To further enhance the draft Cycling Strategy, Middlesex-London Health Unit recommends the following:

1. Strengthen the message of "complete streets" within the Cycling Strategy to provide increased guidance for local municipalities.
2. The Province require local municipalities to invite public health units to participate in municipal planning review processes due to the strong link between land use, transportation and health.
3. A provincially lead safety campaign in partnership with municipalities, school boards, not-for-profit organizations, etc. in order to have a broad impact that reaches a larger population and contains a consistent message.
4. Monitoring and researching areas outside of the Greater Toronto and Hamilton area to make the results generalizable to more of the Province. Middlesex County is primarily rural and the City of London is a mid-sized city. We believe that broadening studies to include a variety of geographical areas will allow the results to be more applicable to, and therefore have a greater impact across the Province as a whole.

We congratulate the Ministry in creating the draft Cycling Strategy and requesting public input. We recognize Provincial leadership is integral to the enhancement of cycling within Ontario. Through improved safe cycling infrastructure, education and legislation, as well as ongoing monitoring and coordination guided by the Cycling Strategy, the cycling rates within Ontario have the potential to increase, and ultimately lead to health and safety benefits for Ontario residents.

TO:	CHAIR AND MEMBERS CIVIC WORKS COMMITTEE MEETING ON DECEMBER 17, 2012
FROM:	JAY STANFORD DIRECTOR, ENVIRONMENTAL PROGRAMS & SOLID WASTE & EDWARD SOLDO, P.ENG. DIRECTOR, ROADS & TRANSPORTATION
SUBJECT:	COMMENTS ON ENVIRONMENTAL BILL OF RIGHTS REGISTRY ONTARIO MINISTRY OF TRANSPORTATION'S CYCLING STRATEGY

RECOMMENDATION

That on the recommendation of the Director, Environmental Programs & Solid Waste and the Director, Roads & Transportation, the following comments **BE APPROVED** and submitted by London Municipal Council in its entirety to the Ministry of Transportation by January 29th, 2013 in response to the Environmental Bill of Rights Registry posting (EBR 011-7552) titled *Ontario Ministry of Transportation Cycling Strategy*.

PREVIOUS REPORTS PERTINENT TO THIS MATTER

The relevant report that can be found at www.london.ca under City Hall (Meetings) is:

- Report to the June 19th 2012 Civic Works Committee (CWC) Meeting, London 2030 Transportation Master Plan (Agenda Item #15)

BACKGROUND

PURPOSE:

The purpose of this report is to provide Committee and Council with:

- A summary of the Ontario Ministry of Transportation's proposed Cycling Strategy (found in its entirety in Appendix A), and
- The City of London's feedback on the strategy for approval and forwarding to the Environmental Bill of Rights Registry.

CONTEXT:

Research commissioned by the Ontario Ministry of Transportation in 2011 found that 48 per cent of Ontarians ride a bicycle at least once a week during the spring, summer and fall. Exercise and recreation are the main reasons that Ontarians ride their bicycles, but around 50 per cent of Ontario cyclists also do so as a mode of transportation – to ride to work or school, for shopping, to run errands, or to visit family and friends. While most cycling takes place on municipal roads, the Province still can play an important role in increasing both the number and safety of cyclists, through legislative and policy changes that affect municipal infrastructure design and operations.

The Ministry of Transportation's draft Cycling Strategy outlines the Province's plans for infrastructure, education and legislation, including a separate consultation on potential legislative amendments to the *Highway Traffic Act* aimed at improving cycling safety, such as those proposed in the Coroner of Ontario's "Cycling Death Review" report (i.e. mandatory helmets for all riders regardless of age and a minimum one metre passing rule for vehicles passing cyclists). The draft Cycling Strategy sets out a map for ongoing work and describes in detail the Ontario Government's plan and priorities.

The Ministry's vision is "to be a world leader in moving people and goods safely, efficiently and sustainably, and to support a globally competitive economy and a high quality of life." Achieving this vision requires that the Province encourage cycling and improve the safety of cyclists in Ontario.

The Ministry is requesting feedback on the draft strategy as part of a 60-day public review and comment period.

DISCUSSION:

Part A – How the proposed Cycling Strategy affects London

Over the past several years, the City of London has undertaken many initiatives to encourage and facilitate more trips by bicycle. In particular, London's 2011 Bike Summit, in partnership with Share the Road Cycling Coalition and several local partners, highlighted the role the Province could play in advancing cycling across Ontario but also specifically in London.

In June 2012, Municipal Council received and approved the London 2030 Transportation Master Plan which included numerous details on expanding cycling in London including:

- implementing priority on street bike routes
- establishing more continuous bike lane routes and an extensive bike network
- securing bike parking facilities at all key public destinations and at major employers

and specific recommendations included:

> *The Civic Administration BE DIRECTED to finalize a short-term Active Transportation and Transportation Demand Management Implementation Strategy that addresses recommendations in the plan and focuses on activities for the near term (2013 - 2015), and outlines the planned and proposed activities for the medium term (2016 - 2020);*
>
> *The cycling infrastructure recommendations of the Plan BE REFERRED to the 2013 Capital Works Budget development; it being noted that the there is an existing program for the Cycling infrastructure;*

It is widely acknowledged that there is still much more work to be done by the City of London, local organizations, businesses and individuals. As part of *A Green and Growing City*, which is one of the key result areas of Council's Strategic Plan, facilitating more trips by bike will contribute to Londoners' high quality of life.

The Province's proposed Cycling Strategy will address some of the local challenges that affect Londoners, but which are outside the City's jurisdiction. The areas under provincial jurisdiction include:

- Ensuring the Health Unit is fully part of the municipal planning review process to make the connection between our built environment, cycling (and walking) rates, and public health benefits.
- Ensuring the Ontario Driver Handbooks and related testing include more "share the road" concepts and educate drivers about bicycle road markings and signage. This will ensure that new drivers in London are well-versed in how to treat cyclists as both must share the road.
- Determining whether the *Highway Traffic Act* should be amended to include mandatory helmet use for all, adding a one metre passing rule for motorists passing cyclists, and exploring how cyclists can safely cross intersections (currently cyclists are not allowed to cycle along a crosswalk).
- Updating the Ontario Traffic Manuals to ensure that a menu of bicycle infrastructure treatments, bicycle signage, and signals are standardized and endorsed in municipal planning and engineering practices.

The benefits of the Province's draft Cycling Strategy to London are many:

- Economic returns from a Province-wide strategy have already been demonstrated through better public health (i.e., lower obesity) and increased tourism as demonstrated both in Quebec and in British Columbia.
- An Ontario-wide strategy would help further position London to tap into the bicycle tourism market (e.g., cycling routes to Port Stanley on Lake Erie, Grand Bend on Lake Huron, routes to St. Mary's and Stratford, etc.).
- It would help make it easier for Londoners to ride a bike for more trips.
- It would make it easier for the City to design and build useful and safe bike infrastructure and develop effective education and safety messaging.

Part B - Comments to be Submitted to the EBR Registry (#011-7552)

City of London staff recommends that the following comments be submitted to the EBR posting:

1. The City of London supports the overall directions in the draft strategy in the areas of infrastructure, safety, education, monitoring, research, and coordination.
2. The Ministry of Transportation and other ministries that have already taken actions to support cycling are to be commended.
3. The City of London encourages the Province to show leadership in providing safe and convenient infrastructure for cyclists (and pedestrians) to cross over provincial highways and to provide funding for the incremental costs associated with bridge expansion to accommodate cycling lanes. Funding must not be the sole responsibility of municipalities.
4. The City of London encourages the Province to act on the suggestions proposed for funding including making "cycling infrastructure eligible for funding under the Municipal Infrastructure Investment initiative, and will explore options to include cycling within other provincial funding programs." It is imperative that the Province not only becomes a partner locally but also becomes a leader when linking municipalities and key destinations by shared or dedicated bike routes or paths.
5. The City of London supports updating the Ontario Driver Handbooks and related testing to include more "share the road" concepts and introduce more bicycle road markings and signage.
6. The City of London supports amending the *Highway Traffic Act* to include a one metre passing rule for drivers when passing a cyclist.
7. The City of London encourages the Province to clarify the definition of an "e-bike" for the public by further working with e-bike dealers and municipalities across Ontario to provide the provincial regulations in addition to the municipal by-laws governing e-bikes at point of sale.
8. The Province should further recognize the needs and context of municipalities outside the Greater Toronto and Hamilton Area (GTHA). That is, the less significant level of congestion in London is not an economic reason for individuals to switch to cycling for more peak period trips. Rather, our shorter average trip distances (5.2 km based on the 2010 Transportation Master Plan Household Travel Survey) do make cycling more time-competitive compared to driving.

   Municipalities like London, are proactively encouraging bicycle trips to avoid the congestion issues that the GTHA faces. Infrastructure, safety and education needs are just as important in municipalities without major congestion issues as demonstrated in the GTHA. Also, resources for monitoring and research in these communities will provide data and findings that are applicable to many other Ontario jurisdictions. Whereas, a focus on GTHA research and monitoring has little application in other Ontario communities.

9. The City of London supports the work of public health units and host agencies in developing policies to increase physical activity. The Province should further enshrine the connection between providing bicycle infrastructure and health impacts by requiring public health units to be part of the municipal planning review process. An increase in physical activity levels due to the design of our built environment will lead to provincial healthcare savings from reduced chronic diseases, risk of physical injury and fatalities.

9. The Province should work with municipal partners and stakeholder organizations (such as the Share the Road Cycling Coalition) to cost-share the production of a series of cycling safety videos that are disseminated across the Province. These could have local branding added to them and be disseminated in each municipality. In-kind services can also be tapped into through local organizations in a municipality. In London, for example, there is the Thames Region Ecological Association, Our Street and several cycling clubs.

10. The City of London supports the Province encouraging a menu of options to assist cyclists (e.g., bike lanes, bike boxes, bicycle-actuated traffic signals, and segregated bike lanes) through its bikeways planning and design guidelines.

11. The Province should provide specific guidance for how cyclists are to be treated at and through intersections, as this is where most conflicts occur with motorized vehicles. There are many other jurisdictions that can be used as best practices for intersection treatments. Currently in Ontario municipalities, providing cycling infrastructure often focuses on the areas between blocks and cyclists are left to fend for themselves through intersections.

12. The City supports the further development of a Province-wide monitoring program, specifically conducting regular counts of cyclists, to establish baseline data and measure future increases in the number of trips made by bicycle. The City of London has recently become a leader in collecting data on bicycle use (and walking) both related to on and off-road facilities. This is data that can be shared with other Ontario municipalities and be part of provincial tracking to better understand cyclists' travel patterns, needs, and barriers to cycling more.

ACKNOWLEDGEMENTS:

This report was prepared with assistance from Jamie Skimming, Manager, Air Quality.

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Appendix A Ontario Ministry of Transportation Draft Cycling Strategy

Appendix D

Cycling and Safe Cycling Related MLHU Program Initiatives

- AlPHa resolution recommending all-ages bike helmet legislation (Board Report 053-12),
- Submission of the *Healthy City – Active London* report to the 2012 ReThink London Official Plan Review, http://www.healthunit.com/article.aspx?ID=18290 ,
- Submission of recommendations to the 2012 Middlesex County Official Plan Review, http://www.healthunit.com/articlesPDF/18574.pdf,
- City of London endorsement of the International Toronto Charter for Physical Activity (Board Report 013-12) (June 2012),
- Chair of London Middlesex Road Safety Committee – working towards a decrease in traffic related fatalities and injuries in London and Middlesex County for all road users,
- Chair of Healthy Communities Middlesex-London: Physical Activity Policy Action Team advocacy for a physical activity charter in London and Middlesex County,
- Chair of the in Motion ™ Executive Committee – physical activity multi-media strategy to encourage Middlesex County and London to be physically active,
- Co-chair of the Elgin, London, Middlesex, Oxford Active & Safe Routes to School Steering Committee – school travel plans piloted in 6 schools,
- Membership on the London Road Safety Strategy - the development of an integrated road safety strategy,
- Membership on the organizing committee for London's Bike Summit, December 1, 2011, and
- Education campaigns – Be Safe Be Seen; Share the Road; and in Motion ™ .

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 005-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 13

CHANGES TO THE STAFF COMPLEMENT FOR THE ORAL HEALTH TEAM

Recommendations

It is recommended that the Board of Health approve the following changes to the staff complement of the Oral Health Team:

1. ***The "Program Assistant" position be renamed "Dental Claims Analyst";***
2. ***Two "Dental Claims Assistant" positions be created (doing part Dental Assistant work and part dental claims work);***
3. ***The complement be decreased by 0.6 Dental Hygienists and 1.4 Dental Assistants.***

Key Points

- Changes in the work of the Oral Health Team have led to the need to re-organize the staff complement.
- The proposed changes in complement are within the existing budget and are not expected to result in any job loss.
- The changes will improve the scheduling ability of the team and improve its ability to pay dental claims to local dentists in a timely manner.

Background

The staff complement for the preventative component of the Oral Health Team currently consists of the following full-time equivalents (FTEs) (Note: this excludes the Dental Clinic Staff which consist of 1.0 Dentist and 2.0 Dental Assistants):

- Oral Health Manager: 1.0
- Dental Consultant: 0.4
- Dental Hygienists 4.6
- Dental Assistants 5.1
- Program Assistants 1.0

Total 12.1 FTEs

As a result of a number of developments within the Oral Health program there have been some changes to direct service delivery. These changes and their implications are as follows:

- The implementation of the Oral Health Information Support System (OHISS). Using this Ministry of Health and Long-Term Care database, staff members can directly enter information in the computer when checking children's teeth in the schools. This has led to improvements in the delivery of the

school screening program which, along with improvements in scheduling of school clinics, has allowed the program to be implemented more efficiently.

- Improving uptake of the Healthy Smiles Ontario (HSO) program and other dental programs offered by the Health Unit. The increased use of these programs has led to an increase in the volume of dental claims generated by local dentists. The Health Unit is responsible for reviewing and paying these claims. Timely processing of the claims to reimburse dental providers is key to maintaining their participation in the HSO and Children in Need of Treatment (CINOT) programs.

- The change in 2010 from a Dental Service to an Oral Health Team within the Oral Health, Communicable Disease and Sexual Health Service has led to the re-evaluation of the job of the Program Assistant to the Director of Dental Services. Through this re-evaluation process, the key role of this position in coordinating the processing of dental claim to local dentists was highlighted.

Proposed Changes to Staff Complement

The following describes the proposed changes in the preventative component of the Oral Health Team:

1. The Program Assistant Position be renamed "Dental Claims Analyst". The work of this position would not change as currently a large portion of this job already consists of managing dental claims.

2. Two "Dental Claims Assistant" positions be created. These positions would be Dental Assistants by training whose job would be doing Dental Assistant work part of the time and managing dental claims in the other part of the time. Currently some Dental Assistants already help with managing claims so there is experience with this type of blended role.

3. The staff complement be decreased by 0.6 Dental Hygienists and 1.4 Dental Assistants. However, since each of the two "Dental Claims Assistants" will be doing approximately half of their work as Dental Assistants, the functional decrease in Dental Assistants time will only be 0.4 FTEs.

This approach will allow for:
- Improved flexibility in scheduling school screenings, clinics, educational sessions and other Health Unit initiatives;
- Improved ability to process dental claims in a timely manner.

It should be noted that these changes in complement are re-arrangements within the existing budget and therefore, no changes in budget are needed. As well, because of existing vacancies in a Dental Hygienist position due a retirement, it is expected that the re-arrangement of positions will be done within the existing staff and therefore will not result in any job loss.

If the proposed amendments are accepted, the changes in the number of full-time equivalents for the preventative component of Oral Health Team will be as reflected in the table below:

Staff	Current	Proposed
Oral Health Manager	1.0	1.0
Dental Consultant	0.4	0.4
Dental Hygienists	4.6	4.0
Dental Assistants	5.1	3.7
Program Assistant	1.0	0.0
Dental Claims Analyst	0.0	1.0
Dental Claims Assistant	0.0	2.0
Total	**12.1 FTEs**	**12.1 FTEs**

Conclusion

Without a change in budget or job loss, the revised staff complement affords the Oral Health Team additional flexibility in scheduling program activities, and also improves its ability to pay dental claims to local dentists in a timely fashion.

This report was prepared by Mr. Chimere Okoronkwo, Manager, Oral Health, and Dr. Maria vanHarten, Dental Consultant.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health

This report addresses the Child Health Standard of the Ontario Public Health Standards

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

NOVEMBER 2012 BOARD OF HEALTH SELF-ASSESSMENT SURVEY RESULTS

Recommendation

It is recommended that Report No. 006-13 re 'November 2012 Board of Health Self-Assessment Survey Results' be received for information.

Key Points

- Six of nine (67%) of active Board Members responded to the survey.
- Detailed findings are presented in Appendix A.
- Further discussion of the findings will enhance the self-assessment process, including identification of opportunities and an action plan to improve performance and outcomes.

Introduction

Board of Health members completed a self-assessment survey in November 2012 to fulfill requirement 4.3 of the Ontario Public Health Organizational Standards according to which the Board must conduct a self-evaluation process of governance practices and outcomes at least every other year. Using agreement ratings to 20 statements, the following six concepts were assessed in the survey:

A. Knowledge and Information Needs: *Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers;*
B. Meeting and Decision-Making Processes: *Decision-making is based on access to appropriate information with sufficient time for deliberations;*
C. Response to Important Issues: *Any material notice of wrongdoing or irregularities is responded to in a timely manner;*
D. Reporting Systems to the Board: *Reporting systems provide the board with information that is timely and complete;*
E. Compliancy with Regulatory Requirements: *Compliance with all federal and provincial regulatory requirements is achieved; and*
F. Strategic Outcomes: *The board as a governing body is achieving its strategic outcomes.*

Results

Six of the nine active board members completed the survey - a 67% response rate. Across the 20 statements there were varying levels of agreement. The statements to which all (or nearly all) respondents agreed or disagreed are highlighted below. Please see Appendix A for detailed findings, including results for statements with more of a split between agreement and disagreement.

Agreement

All respondents **agreed** or **strongly agreed** to the following statements:

- The Board ensures that decisions are based on accurate, timely and the best available information.
- The Board ensures processes are in place to identify, assess and manage any risks to the Health Unit.
- The Board follows the process for handling urgent matters between meetings.
- The Board ensures that the Board bylaws are followed.
- The Board is in compliance with all regulatory requirements related to the BOH, the MOH, and all applicable regulatory requirements related to the Health Unit.
- The Board ensures the Health Unit is responsive to needs of local communities.

Nearly all (83% or 5) respondents **agreed** or **strongly agreed** with the following statements:

- The Board keeps abreast of relevant trends, events and emerging issues in public health.
- Board members come prepared to participate in the discussion and decision-making so that all necessary board business is addressed.
- All Board members participate in important board discussions.
- Board members do a good job of encouraging and dealing with different points of view.
- The Board has adequate information to monitor organizational performance (e.g. knowledge of programs and services offered; delivery of Ontario Public Health Standards and protocols; work force issues, MOH/CEO performance assessment, etc.).
- The Board focuses on strategic long-term results and substantial policy issues rather than operational detail.

Disagreement

Nearly all (83% or 5) respondents **disagreed** or **strongly disagreed** with the following statements:

- The Board has a common understanding of the Board's mandate, scope, and authority.
- The Board is able to interpret and assess financial information to oversee financial performance effectively.

Comments

Comments were provided by only four respondents and provide some further insight to the concepts noted above. Different perspectives/experiences represented by Board members were identified as both a strength and a challenge of the Board by several respondents. The ability to have challenging conversations was noted by two respondents as a strength of the Board however, two also noted that listening to opposing perspectives was a challenge. The budget and outside pressures were also identified as challenges.

When asked about the most important thing a Board Member could recommend for action or discussion, several respondents indicated conflicts of interest or the multiple 'hats' that each Board Member wears should be addressed. Other issues raised were concentrating on mandate and ensuring careful consideration of comments and their implications, including comments to the media.

Topics for further education or training included Robert's Rules, governance issues and conflict of interest. It is noteworthy that in the ranking section of the survey, half of the respondents disagreed with the statement that 'The board is satisfied with the ongoing education it receives in order to fulfill its responsibilities'.

Conclusion

The response rate to the survey was lower than usual. As well, there were a very small number of comments making it difficult to ensure that the comments represent the feelings of the Board as a whole.

By conducting this survey, the Board of Health has completed its requirement for self-assessment. However, the self-assessment process can be enhanced by discussion among Board Members about opportunities for improvement in performance and action to make those improvements.

This report was prepared by Ms. Sarah Maaten, Epidemiologist, Environmental Health and Chronic Disease Prevention Services.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Organizational Standard 4.3.

November 2012 Board Self-Assessment: Detailed Findings

6 of 9 potential respondents: 67% response rate

A. Knowledge and Information Needs

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total Responses
1. The Board has a common understanding of the Board's mandate, scope, and authority.	1 (17%)	4 (67%)	0 (0%)	1 (17%)	0 (0%)	6
2. The Board keeps abreast of relevant trends, events and emerging issues in public health.	1 (17%)	0 (0%)	2 (33%)	3 (50%)	0 (0%)	6
3. New Board members receive an effective orientation to their responsibilities as a Board member.	1 (17%)	1 (17%)	1 (17%)	3 (50%)	0 (0%)	6
4. The board is satisfied with the ongoing education it receives in order to fulfill its responsibilities.	0 (0%)	3 (50%)	2 (33%)	1 (17%)	0 (0%)	6

B. Meeting and Decision-Making Processes

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total Responses
5. Board members come prepared to participate in the discussion and decision-making so that all necessary board business is addressed.	1 (17%)	0 (0%)	4 (67%)	1 (17%)	0 (0%)	6
6. The Board uses its meeting time effectively and efficiently (i.e. discussion is focused, clear, concise and on topic, start/end on time).	1 (17%)	1 (17%)	3 (50%)	1 (17%)	0 (0%)	6
7. All Board members participate in important board discussions.	0 (0%)	1 (17%)	3 (50%)	2 (33%)	0 (0%)	6
8. Board members do a good job of encouraging and dealing with different points of view.	0 (0%)	1 (17%)	5 (83%)	0 (0%)	0 (0%)	6
9. Decisions by Board members are supported once made.	1 (17%)	2 (33%)	3 (50%)	0 (0%)	0 (0%)	6
10. Board members respect the rules of confidentiality.	0 (0%)	0 (0%)	3 (50%)	1 (17%)	2 (33%)	6
11. The Board ensures that decisions are based on accurate, timely and the best available information.	0 (0%)	0 (0%)	5 (83%)	1 (17%)	0 (0%)	6

C. Response to Important Issues

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total Responses
12. The Board ensures processes are in place to identify, assess and manage any risks to the Health Unit.	0 (0%)	0 (0%)	4 (67%)	2 (33%)	0 (0%)	6
13. The Board follows the process for handling urgent matters between meetings.	0 (0%)	0 (0%)	4 (67%)	2 (33%)	0 (0%)	6

D. Reporting Systems to the Board

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total Responses
14. The Board has adequate information to monitor organizational performance (e.g. knowledge of programs and services offered; delivery of Ontario Public Health Standards and protocols; work force issues, MOH/CEO performance assessment, etc.).	0 (0%)	1 (17%)	4 (67%)	1 (17%)	0 (0%)	6
15. The Board is able to interpret and assess financial information to oversee financial performance effectively.	0 (0%)	5 (83%)	1 (17%)	0 (0%)	0 (0%)	6

E. Compliance with Regulatory Requirements

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total Responses
16. The Board ensures that the Board bylaws are followed.	0 (0%)	0 (0%)	4 (67%)	2 (33%)	0 (0%)	6
17. The Board is in compliance with all regulatory requirements related to the BOH, the MOH, and all applicable regulatory requirements related to the Health Unit.	0 (0%)	0 (0%)	4 (67%)	2 (33%)	0 (0%)	6

F. Strategic Outcomes

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Total Responses
18. The Board focuses on strategic long-term results and substantial policy issues rather then operational detail.	0 (0%)	1 (17%)	4 (67%)	1 (17%)	0 (0%)	6
19. The Board ensures that the Health Unit is achieving its strategic plan.	0 (0%)	2 (33%)	3 (50%)	1 (17%)	0 (0%)	6
20. The Board ensures the Health Unit is responsive to needs of local communities.	0 (0%)	0 (0%)	4 (67%)	2 (33%)	0 (0%)	6

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 007-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

OVERVIEW OF HEALTH UNIT ADMINISTRATIVE FUNCTIONS

Recommendation

It is recommended that Report No. 007-13 "Overview of Health Unit Administrative Functions" be received for information.

Key Points

- An understanding of the functions of Finance and Operations, Human Resources and Labour Relations, Information Technology and the Office of the Medical Officer of Health are important for decisions that may be needed as a result of the shared services review.
- An overview of these areas of the Health Unit are provided in this report and more detailed information will be provided at upcoming Board of Health meetings.

Background

The Board of Health has requested a review to determine if there are any potential for cost savings by sharing administrative functions with the City of London and/or Middlesex County. The project plan for this review is being presented at this Board of Health meeting (see Report No. 002-13) and preparations for the review have been discussed at previous Board meetings (Report No. 102-12; Report No. 133-12; Report No. 140-12).

It is important for the Board of Health to understand the administrative structure and function of the Health Unit in order to be prepared to make decisions regarding the results of the review. This report will provide the Board of Health with an overview of the areas of the Health Unit being considered in the review: Finance and Operations; Human Resources and Labour Relations; Information Technology and the Office of the Medical Officer of Health. These areas are outlined in the attached organizational chart (Appendix A) The report will briefly outline the functions of each area, the number and roles of the full-time equivalents associated with each area, and the personnel and other costs associated with each area. More detailed reports on each of these areas will be provided at upcoming Board of Health meetings.

Although the above mentioned Services areas are generally considered administrative in nature, there are functions within these areas that are placed there more for organizational convenience. As opposed to standard administrative functions, these functions are more directly involved in front-line services or other professional / programmatic functions. These particular functions are noted in the Appendices to this report that outline the staffing within each area.

It should also be noted that the Ministry of Health and Long-Term Care defines administrative positions for their reporting purposes. The Ministry's reporting only includes salaries and benefits and not

programmatic and other costs (i.e. does not include travel, education, materials and supplies, equipment purchases, rent and utilities). Using the Ministry's reporting guidelines for 2012, the Health Unit has 30.8 full-time equivalents (FTEs) in these positions for a total of $2,442,540 (which represents 7.76% of a total health unit budget). (see Appendix B – page 6 for more details).

Finance and Operations:

***Description*:** This Service Area provides the financial management required by the Board of Health to ensure compliance with applicable legislation and regulations. This is accomplished through providing effective management and leadership for financial planning (developing budgets and forecasts), financial reporting (considering external and internal reporting requirements), treasury services (accounts payable/receivable, general accounting, and cash management), payroll administration, procurement, capital assets, and contracts and agreements.

This Service Area also oversees the "Operations" of the Health Unit which involve facility management type services including furniture and most general office equipment, leasehold improvements, insurance and risk management, security, janitorial, parking, on-site and off-site storage and inventory management, and the management of all building leases and property matters.

The programs and services of the Board of Health are provided through cost-shared grant funding, 100% grant funding (mainly provincial), and user-fees. The Board of Health receives funding from all levels of government. Funding from the provincial government is provided from two separate ministries. All of the funders have different reporting requirements and processes for budgeting, settlement, and in-year reporting, etc. In addition the Board has two different fiscal periods. Most programs operate on a calendar year (ending December 31st), however, some operate on a fiscal year (ending March 31st). This results in the need to maintain two separate general ledgers (or accounting "books").

Full-Time Equivalents (FTEs): 9.0 See Appendix C – page 7 for details.

Cost of Full –Time Equivalents (salary and benefits): $746,959

Other costs: $11,500 (e.g. professional development; travel; materials and supplies)

Organizational Chart: Please click here.

Human Resources and Labour Relations:

***Description*:** This Service Area provides a full range of human resources services to support the Managers and staff of the Health Unit; it also includes the volunteer program, reception services, coordinating student placements, and the Health Unit Library services.

Human Resource (HR) professional staff serve as internal consultants on matters related to the legislation, policies and collective agreements that govern all aspects of employment. These matters include: organizational design and staff planning; recruitment; orientation; benefits and pension administration; compensation; performance management and discipline; labour negotiations with two unions (Ontario Nurses Association – ONA, and Canadian Union of Public Employee - CUPE); grievances; job evaluation; attendance and leaves; Workplace Safety and Insurance Board (WSIB) claims; return to work plans and accommodations; human resources information management; human resource metrics; promoting a learning culture; and career and succession planning.

Human Resource (HR) staff require detailed knowledge of relevant legislation, as well a thorough understanding of the collective agreements for both CUPE and ONA, which have some different provisions. The day-to-day work of Human Resources (HR) is often unpredictable, as Managers or staff members may request immediate assistance from HR on matters related to any of the above topics.

Full-Time Equivalents (FTEs): Total of 9.4 FTE - 4.0 FTE human resources professionals; 0.5 FTE Administrative Assistant; 2.4 Receptionists (four part-time); 2 Librarians (1.0 FTE is funded 100% by Public Health Ontario); and 0.5 Student Coordinator. See Appendix D – page 8 for details.

Cost of Full –Time Equivalents (salary and benefits): $812,080

Other costs: $96,065 (e.g. journal subscription; professional development; travel; materials and supplies; and recruitment costs)

Organizational Chart: Please click here.

Information Technology:

***Description*:**

The Information Technology (I.T.) Service Area provides the technology services required to support the delivery of Health Unit services and programs.

These technology services are determined through effective I.T. leadership/direction-setting, strategic planning and Health Unit-wide operational planning. The outcomes of these planning processes, combined with Ministry of Health and Long-Term Care initiatives, legislative requirements and regular systems upgrades/maintenance are all inputs that I.T. leadership uses in developing its directions and operational plans.

I.T.'s operational plan initiatives generally fall into one of four categories:

- **Applications** – both the "common desktop" as well as program-specific applications. For many application this also includes the "server" (i.e. behind the scenes) part of the application;
- **Infrastructure** – the personal computers (PCs)/laptops, servers, network devices/cabling and inter-site and internet network connections;
- **Security** – policies, procedures and supporting technologies to ensure the protection and integrity of Health Unit data. Some requirements are uniquely dictated by legislative regulations (e.g. encryption);
- **Support/Operations** – ongoing operations, end-user training and support for the above.

I.T. expenditures, with limited exceptions, are entirely contained within the I.T. budget. This budget includes all software licensing, services, hardware upgrades and support (both in-house personnel and contractual). This centralized cost-centred approach enables standardization, improves inter-organizational equity and provides consolidation of I.T.-related services and costs. This helps to facilitate organization priority-setting and identification of opportunities for efficiencies.

All I.T. costs, whether recurring (e.g. personnel, inter-site network connectivity, etc.) or cyclical (e.g. hardware replacement, software upgrades, etc.) are expended from within the annual I.T. operating

budget. In lieu of a capital replacements reserve, I.T. leadership has been working towards leveling the annual budget requirements for these cyclical items with a planned, cost-effective approach.

Full-Time Equivalents (FTEs): 8.5 See Appendix E – page 9 for details.

Cost of Full –Time Equivalents (salary and benefits): $693,075

Other costs: $397,338 (e.g. computer/network hardware and software; purchased services such as external consulting and internet service provider services; materials and supplies; professional development and travel related costs)

Organizational Chart: Please click here

Office of the Medical Officer of Health (excluding the Travel Clinic):

***Description*:** This Office of the Medical Officer of Health provides key functions required by the Board of Health to ensure compliance with applicable legislation and regulations, and deliver and/or support the delivery of programs and services. This Service area consists of the following functions:

- The Medical Officer of Health and Chief Executive Officer
- Communications
- Privacy and Occupational Health and Safety
- Special Projects
- Emergency Preparedness
- Administrative support

The Travel Clinic is organizationally part of the Office of the Medical Officer of Health but functions entirely separately and is essentially a front-line service, so is excluded from this analysis.

Several of the functions of the Office of the Medical Officer of Health are considered programmatic (eg. provide direct programs and services as required in the Ontario Public Health Standards); these include parts of the roles of the Medical Officer of Health and of the Manager, Special Projects, as well as all of the roles of the Manager, Emergency Preparedness and the Manager, Communications as well as other communications functions. Parts of the Office of the Medical Officer of Health are involved in risk management for the organization; this includes providing internal consultation to ensure the agency's compliance with the relevant privacy and occupational health and safety legislation, as well as parts of the communications and emergency preparedness functions.

Full-Time Equivalents (FTEs): 9.8 See Appendix F – page 10 for details.

Cost of Full –Time Equivalents (salary and benefits): $1,142,796

Other costs: $186,974 (e.g. professional development; travel; materials and supplies; purchased services including program related consulting; general agency advertising; web-site maintenance costs, Community Emergency Response Volunteer (CERV) costs; accreditation; and corporate records storage costs)

Organizational Chart: Please click here.

Conclusion

This report provides an overview of the functions within the four service areas being considered for potential sharing with the City of London and/or Middlesex County: Finance and Operations; Human Resources and Labour Relations; Information Technology; and the Office of the Medical Officer of Health. Some of the roles within these areas are generic to many organizations, while others provide a service specifically designed to meet the unique needs of a public health unit. Additional information on the four areas of the Health Unit outlined in this report will be provided in future Board of Health reports.

This report was prepared by Mr. John Millson, Director, Finance & Operations; Ms. Louise Tyler, Director, Human Resources & Labour Relations; Mr. Rick Shantz, Director, Information Technology; and Dr. Bryna Warshawsky, Acting Medical Officer of Health.

Bryna Warshawsky, MDCM, CCFP FRCPC
Acting Medical Officer of Health

Appendix B
Ministry of Health and Long-Term Care Reported Administrative Full-Time Equivalents

Administrative Position	Full-time Equivalent / Total Costs
Director/Business Administrators	3.0
Manager/Supervisors	5.0
Secretarial/Admin staff	7.8
Financial staff	4.5
I & IT staff	6.5
Communications Manager/Media Coordinator	2.0
Volunteer Coordinator	0.5
Human Resources Staff/Coordinator	1.5
Employer Paid Benefits	---
Total	**30.8 / $2,442,540**

Note: Only reflects the salary and benefits of these positions and does not include programmatic and other costs (i.e. does not include travel, education, materials and supplies, equipment purchases, rent and utilities).

Appendix C
Finance and Operations Full-Time Equivalents

Finance and Operations	
FTE/position	**Functions**
1.0 FTE/ Director	Member of the senior leadership team providing financial and facilities management, counsel and leadership on business initiatives, policy development, strategic planning and corporate leadership. Provides day-to-day direction and advice to a highly motivated team for all financial, procurement and facility matters.
0.5 FTE/ Administrative Assistant to the Director	Performs administrative support to Service area.
1.0 FTE/ Accounting and Payroll Analyst	Employee benefit payments, Corporate purchase card program, Canada Savings Bonds program, Payroll payments and related liabilities, Annual T4 remittance, Employee pension reporting, and Supervises accounts payable processes and payments.
1.0 FTE/ Accounting and Budget Analyst	Prepares and monitors program budgets and provides forecasts, General accounting functions such as cash management, bank reconciliation, HST remittances, Financial reporting (Internal/External), Annual audits including financial statement preparations, Financial statement preparation.
1.0 FTE/ Purchasing and Operations Administrator	Contract management, Procurement processes, Insurance & risk management, Inventory management, leasehold improvements, health and safety, office furniture and equipment, security, janitorial and parking.
1.0 FTE/ Operations / Receiving	Supports the work of the Purchasing and Operations Administrator, but specifically maintains offsite storage, supplies and corporate records areas, facilities maintenance (interior), shipping and receiving, enforces parking policy.
3.5 FTE/ Accounts Payable Administrative Assistant	Maintains databases and issues parking passes, office and furniture keys, employee and access badges, petty cash disbursements, accounts payable entry and cheque preparation, mileage and payroll entries (hours worked), accounts receivable, general accounting entries, process dental claims for Healthy Smiles Ontario programs and the Children In Need of Treatment (payments to dentist)
Total FTEs - 9.0	

Appendix D
Human Resources and Labour Relations Full-Time Equivalents

Human Resources & Labour Relations		
FTE/position	**Functions**	**Comments**
1.0 FTE/ Director	Member of the Senior management team providing strategic and operational leadership to the organization, and direction to the Human Resources and Labour Relations (HRLR) Service area. On a day-to-day basis, is responsible for Union-management relations, grievances, and negotiations; organization and job design; job evaluation; policy development and administration, management and staff development, performance management, employment legislation	
0.5 FTE/ Administrative Assistant to the Director	Administrative assistance to the Director and other staff in HRLRS, including project work, records management for HR and development of HR internal procedures	
1.0 FTE/ Attendance, Benefits & Volunteer Officer	Attendance management, return to work and accommodation, Workers Safety and Insurance Board (WSIB) incident reports, volunteer program, benefits & Pension Administration, reception	
1.0 FTE/ Recruitment & Labour Relations Officer	Recruitment, orientation, policy & Collective Agreement interpretation, Casual Public Health Nurse (PHN) pool, Casual Program Assistant Pool, Personnel agencies	
1.0 FTE/ HR Coordinator	Projects for student placement, recruitment, orientation, absence records, records management; shares workload of HR Officers as needed	
1.0 FTE/ Library Services 1.0 FTE/ Library Services – Contract (100% funded by Public Health Ontario)	Literature searches, quick reference, interlibrary loans, collections (borrowing) current contents (subscriptions), Copyright Officer, Training on bibliographic databases	Non-human resource, programmatic function
1.2 FTE/ Reception Services	London – receives and gives directions to visitors and the public, answers switchboard, receives and ships courier packages, shipments, etc, handles external mail, oversees meeting room bookings, backs up vaccine clerk for vaccine pick-up	Non-human resource, front-line function
1.2 FTE/ Reception Services	Strathroy -receives and gives directions to visitors and the public, answers switchboard, receives and ships courier packages, shipments, etc, handles external mail, oversees meeting room bookings, administrative support for program staff and Family Planning Clinic, as required	Non-human resource, front-line function
0.5 FTE/ Student Coordination	Nursing preceptee program, medical student seminars and placements, other regulated healthcare student placements, unregulated health care student placements	Non-human resource, education function
Total FTEs – 9.4		

Appendix E
Information Technology Full-Time Equivalents

Information Technology	
Information Technology Services	
FTE/position	**Functions**
1.0 FTE/ Director	• Senior management leadership in organizational planning, initiatives and policies/operations. • Leadership and development of highly-committed I.T. team in delivering Application, Infrastructure, Security and Operational Support services. • Identification of technology-related opportunities for improvement and efficiencies.
1.0 FTE/ Administrative Assistant to the Director	• Project and operational support for Director and department. • 1st level technical support. • Asset management.
1.0 FTE/ Applications & Desktop Analyst	• Planning, design, implementation and support of personal computers (PCs) and laptops (including configuration and applications) used by all Health Unit staff. • Applications include standard corporate and program-specific applications. • 2nd level technical support for all desktop configuration and application issues.
1.0 FTE/ Business Analyst	• Process improvement assessment, design and implementation. • Project planning/project management.
0.5 FTE/ Corporate Information Services Trainer	• Assessment, planning, development and delivery of training for corporate technologies. • 2nd level support for application “how to” issues.
1.0 FTE/ Data Analyst	• Development of information/data gathering “systems”. • Data manipulation and analysis for Program Evaluator and Epidemiologist initiatives.
1.0 FTE/ Help Desk Analyst	• 1st level technical support for support requests. • Support provided by telephone and desk side for all sites. • Tape backup rotation storage management.
1.0 FTE/ Server Infrastructure Analyst	• Planning, design, implementation and support of server hardware and applications upon which all Health Unit computers and staff are dependent. • Backup/restore of all above systems. • 2nd level technical support for these systems.
1.0 FTE/ Telecommunications & Network Analyst	• Planning, design, implementation and support of the network and telephone systems used by all Health Unit staff and computers. • 2nd level technical support for all network and telephone issues.
Total FTEs – 8.5	

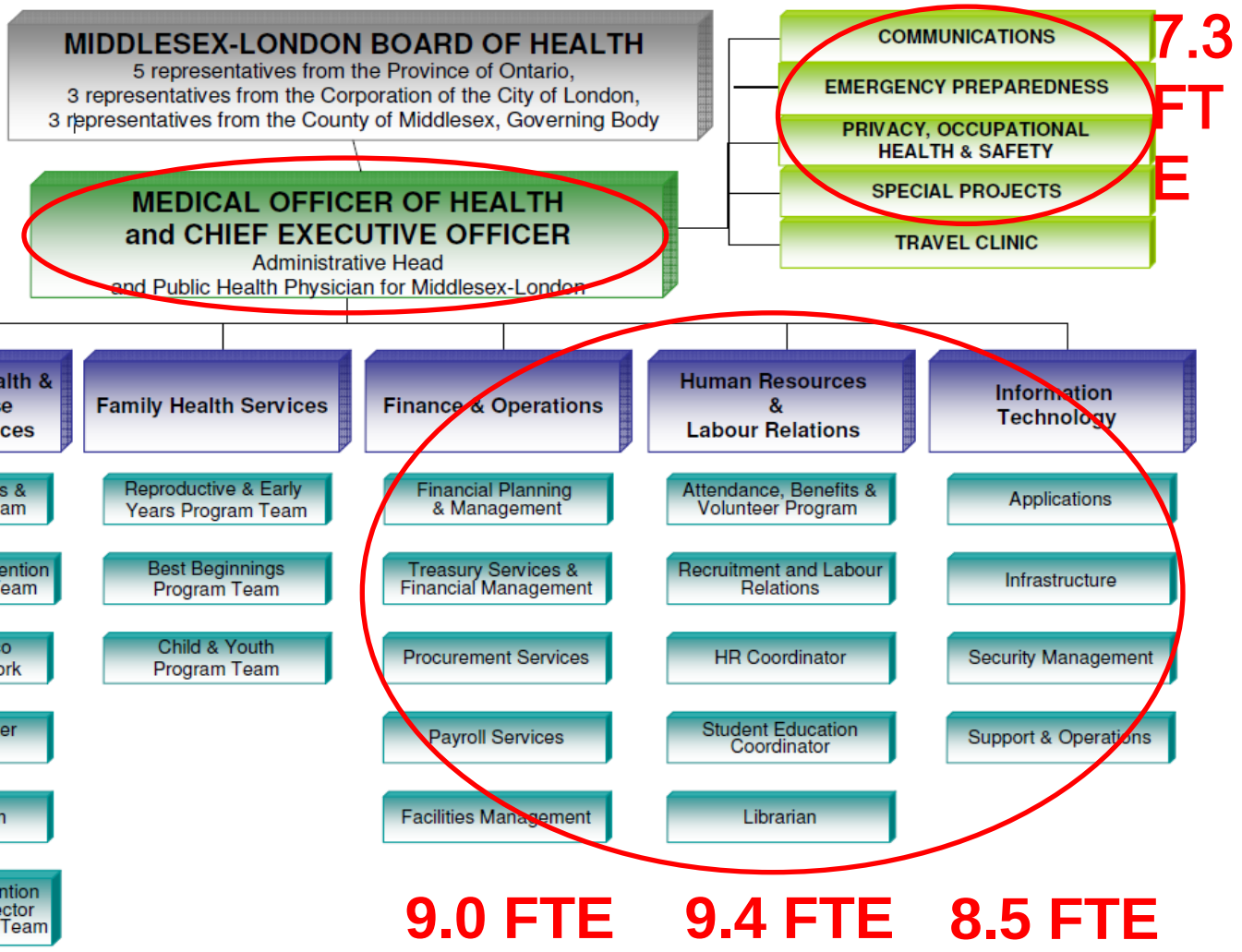
Appendix F
Office of the Medical Officer of Health Full-Time Equivalents (excluding Travel Clinic)

Office of the Medical Officer of Health		
FTE/position	**Functions**	**Comments**
1.0 FTE/ Medical Officer of Health and CEO	• Chief executive function • Secretary Treasures to the Board of Health • Medical consultant	Partly programmatic functions
1.0 FTE/ Executive Assistant to the Medical Officer of Health	• Administrative support to the Medical Officer of Health	
0.5/ Executive Assistant to the Board of Health	• Administrative support to the Board of Health	
1.0 FTE/ Manager, Communications	• Coordinates media responses, marketing and advertising campaigns, the annual report and the development of Health Unit graphics • Internal communications training • Strategic and crisis communications planning	Programmatic and risk management functions
1.0 FTE/ Online Coordinator	• Development and oversight of website, social media and other online functions	Programmatic function
1.0 FTE/ Communication Assistant	• Administrative support to Manager, Communications and Online Coordinator	
1.0 FTE/ Manager, Privacy, Occupational Health and Safety	• Promotes compliance with privacy legislation • Develops and implements internal policies related to occupational health and safety • Processes access-to-information requests for members of the public.	Risk management function
0.5 FTE/ Administrative Assistants to Privacy, Occupational Health and Safety	• Adminstrative Support to Manager, Privacy and Occupational Health and Safety	
1.0 FTE/ Manager, Special Projects	• Manages accreditation and other quality assurance functions • Supports strategic planning, records management and other strategic initiatives	Partly programmatic functions
1.0 FTE/ Manager, Emergency Preparedness	• Prepares Health Unit to respond to emergencies, including those where public health is the lead as well as external emergencies • Develops Health Unit's Emergency Response Plan • Provides Health Unit education and training for emergency preparedness and response	Programmatic and risk management functions
0.5 FTE/ Administrative Assistant to Manager, Emergency Preparedness	• Administrative Support to the Manager, Emergency Preparedness	
0.3 FTE/ Staff Immunization Nurse	• Ensures staff are up to date with immunizations and TB skin tests	Risk management function
Total FTEs – 9.8		

MIDDLESEX-LONDON HEALTH UNIT

AGENCY ORGANIZATIONAL CHART

1.5 FTE + MOH



Board of Health	Medical Officer of Health	Office of the MOH	Service Areas	Programs

Implementation Date: November 1990	
Review Date(s)	**Revision Date(s)**
April 14, 2004, October 2008, March 2009	Feb. 20 1995, May 4 1995, Feb 5 1997, June 15 2000, June 17, 2004. April 2005, April 2006, October 2008, July 2010, May 2011, March 2012

Board Chair's Signature _____

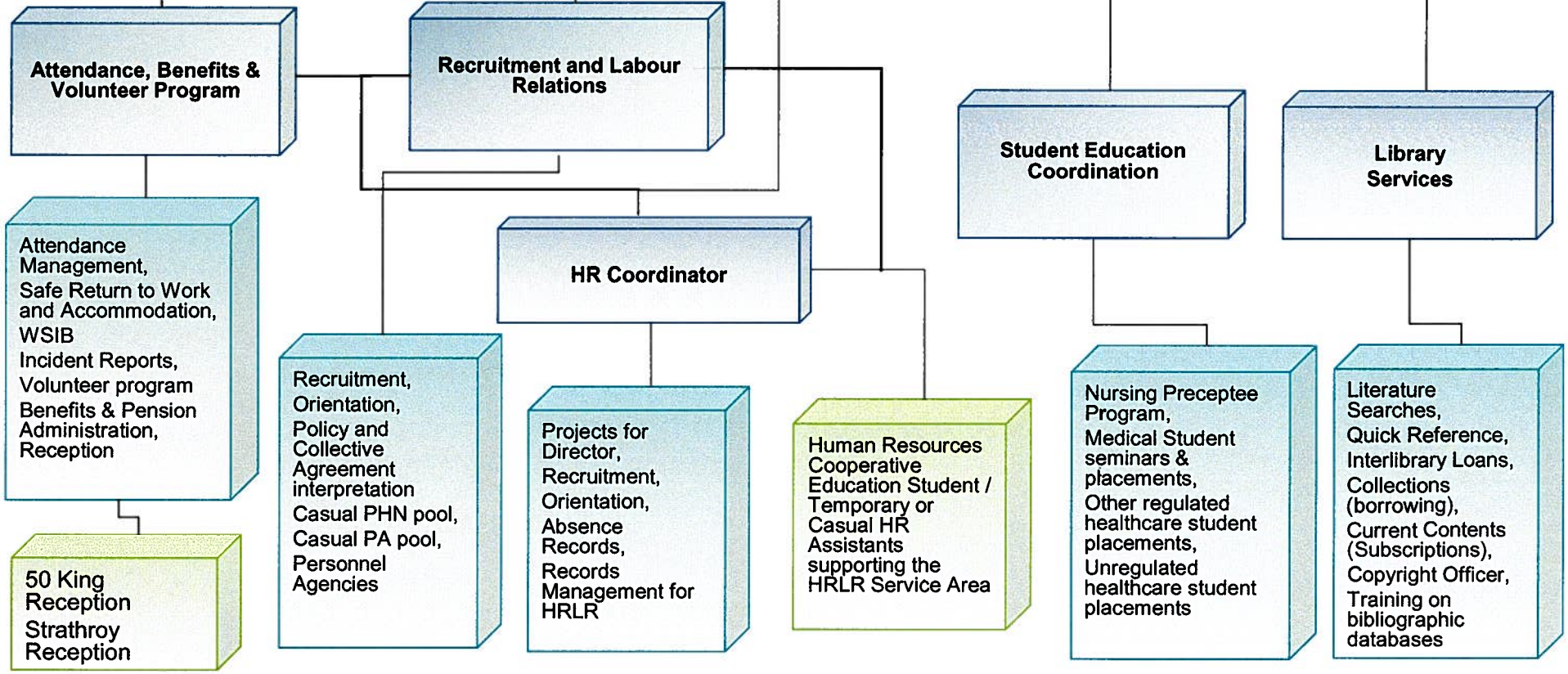
MIDDLESEX-LONDON HEALTH UNIT

HUMAN RESOURCES AND LABOUR RELATIONS

Director

Administrative Assistant to the Director

Organization and Job Design, Job Evaluation, Policy Development, Negotiations, Union-management Relations, Management & Staff Development, Performance Management, Employment Legislation

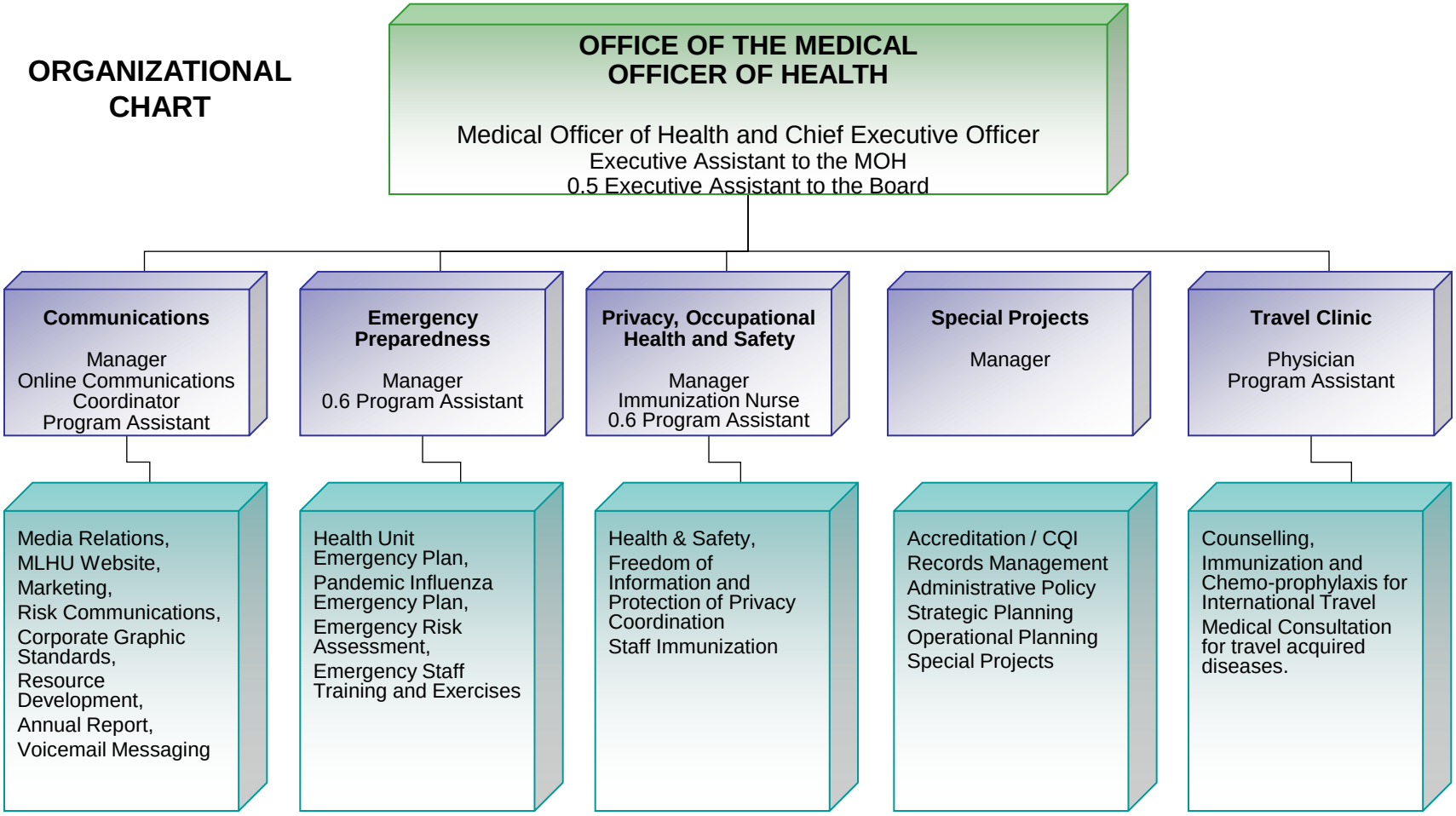


Service Area	Administrative Support	Programs & Services	Description of Services

Implementation Date: 2011 February 14	
Review Date(s)	**Revision Date(s)** **June 1, 2012**

Director's Signature Louise Tyler

ORGANIZATIONAL CHART



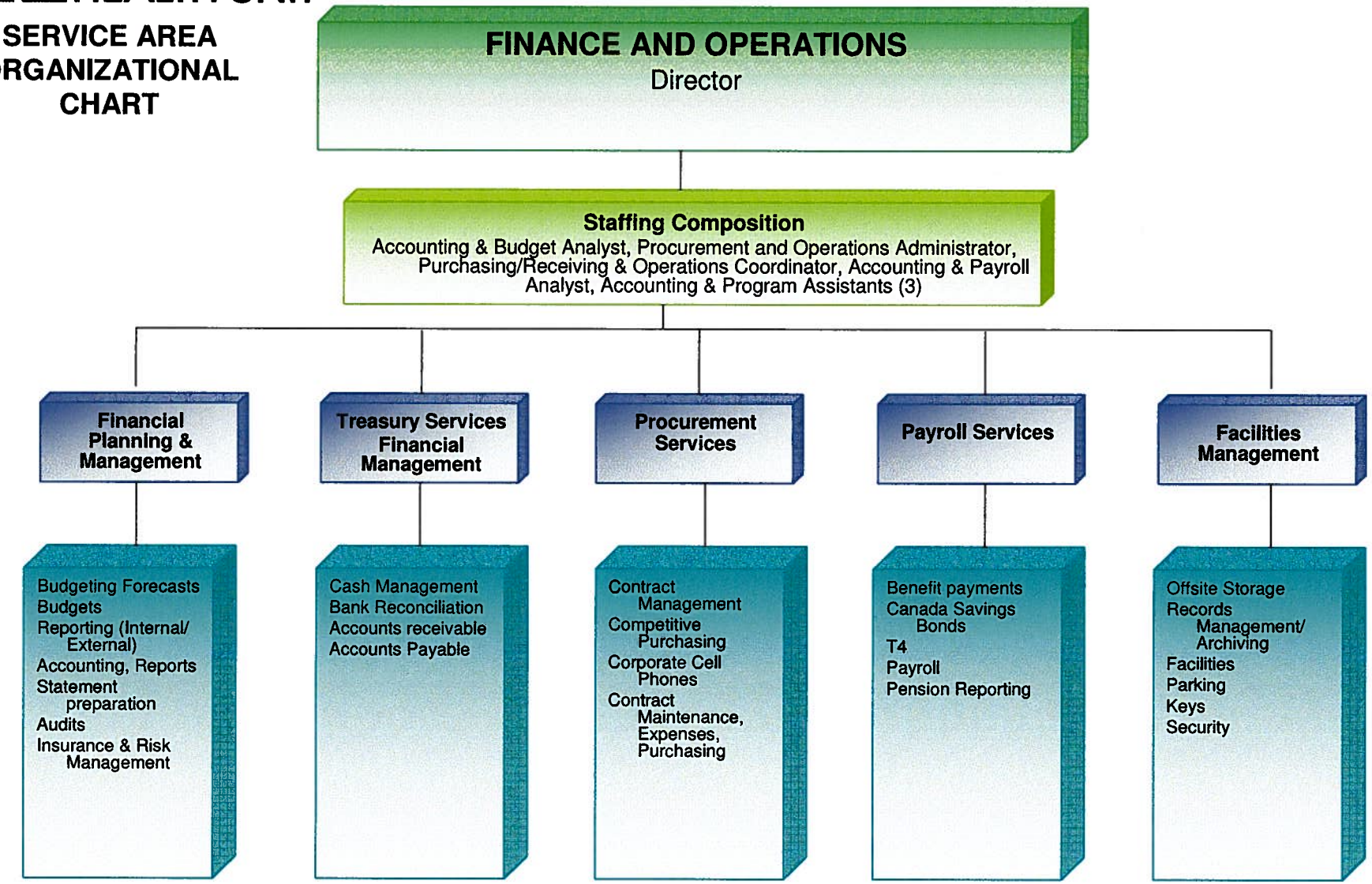
Service Area	Program & Team Composition	Program Description

Implementation Date: April 14, 2004	
Review Date(s)	**Revision Date(s)**
October 2008	April 2005, April 2006, October 2008, March 2009, July 2010, May 2011

Director's Signature _____

MIDDLESEX-LONDON HEALTH UNIT

SERVICE AREA ORGANIZATIONAL CHART



Service Area	Team Composition	Program	Program Description

Implementation Date: 2010 July 05	
Review Date(s)	**Revision Date(s)** 2011 February 18

Director's Signature

MIDDLESEX-LONDON HEALTH UNIT

SERVICE AREA ORGANIZATIONAL CHART

Information Technology

Director
Administrative Assistant to the Director

Staffing Composition

Business Analyst; Data Analyst; Server Infrastructure Analyst; Applications and Desktop Analyst; Network and Telecommunications Analyst; Corporate I.T. Trainer; Helpdesk Analyst

Applications

- Business Analysis, Project Management, application selection/implementation.
- Business process improvement.
- Data analysis.
- Core I.T. applications including e-mail, core desktop applications, web/intranet services, database services, telephone/voice applications, etc.
- Application standards.

Infrastructure

- Desktop/laptop/mobile devices & standards.
- Servers, storage, tape backup and uninterruptable power supply.
- Wired and wireless network devices and cable plant.
- Inter-site connectivity.
- Internet access.
- Telephony devices—handsets, servers, switches, etc.

Security Management

- Standards & policy development and documentation.
- Data security technologies and approaches including encryption.
- Password policies and procedures.
- Investigation and audit.
- Firewalls and remote access.

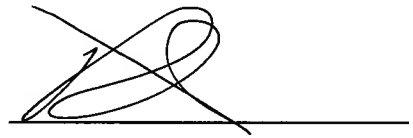
Support & Operations

- Helpdesk—client support.
- Client Training.
- Account management.
- Infrastructure monitoring.
- Device build and configuration.
- Device/application refresh and deployment.
- Patch deployment.
- E-mail support and troubleshooting.
- Asset tracking/management.
- Preventative maintenance.
- Data backup/restore.
- Trending, budgeting & planning.

Service Area	Team Composition	Program	Program Description

Implementation Date: 2010 July 05	
Review Date(s)	**Revision Date(s)** 2011 February 18

Director's Signature



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 008-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

ANNUAL PERFORMANCE REPORT ON THE STRATEGIC DIRECTIONS

Recommendation

It is recommended that Report No. 008-13 re "Annual Performance Report on the Strategic Directions" be received for information.

Key Points

- While the first year of a strategic plan is traditionally known as the 'planning year', 2012 saw some major accomplishments toward achieving the 2012-2014 Strategic Directions.
- Given the importance of the Strategic Directions, moving forward with these objectives will be a major focus for 2013.

Background & Timeline

Maintaining a strategic plan is required of all Boards of Health by the Ontario Public Health Organizational Standards (No. 3.2). Prior to strategic planning being a requirement, the Middlesex-London Board of Health undertook a rigorous community consultation and strategic planning process in 2011. This resulted in a new 10-year vision and three broad strategic directions for 2012-2014. Upon conclusion of the strategic planning process, staff established the necessary structures and plans, and began coordinating activities to achieve these directions, and operationalize the new vision. The Board of Health has received the following reports regarding the strategic directions and plan:

Date	June 2011	November 2011	February 2012	November 2012
Report #	063-11	110-11	025-12	136-12
Subject	Approval of 10-year vision and 3-year strategic directions	Identification of 3-year objectives	1st Progress Report: • Established Strategic Achievement Groups (SAGs) • Presented Visions/ Directions Document • Reported internal/ external communications plan	2nd Progress Report: • Reported SAGs progress • Reported external SAG members • Presented Strategic Plan Community Report

The Terms of Reference for the Strategic Achievement Groups (i.e., six internal committees, each tasked with a particular strategic direction) dictate quarterly reporting to the Health Unit's senior leadership, and annual performance reporting to the Board.

Major Achievements in 2012

While the first year of a strategic plan if often dubbed 'the planning year', the Strategic Achievement Groups quickly moved from planning to action. The Groups were first required to (a) identify existing activities and where appropriate, plan and ensure coordination of additional activities, and (b) identify measurable indicators and report performance. Once plans were approved by senior leadership, the Groups met approximately monthly to begin their work. Major achievements are presented below, according to their corresponding direction:

Strategic Direction (A): Improved Health Outcomes

Physical Activity and Healthy Eating Group (led by Ms. Mary Lou Albanese & Ms. Christine Preece)

- Established an organizational lead staff member for physical activity (Ms. Nadine Cruickshank) and healthy eating (Ms. Christine Callaghan) who support the Health Unit's health promotion, family and schools programs to integrate novel best-practices in order to reduce obesity rates and improve consumption of fruits and vegetables. The leads will be coordinating additional targeted activities in 2013-2014 that show promise of moving towards the identified health objectives.

Health Inequities Group (led by Ms. Nancy Summers & Ms. Melanie Elms)

- The Well-Baby Clinics are piloting the province's Health Equity Impact Assessment tool (which aims to orient service delivery toward 'those who need services the most'). This assessment tool will be rolled out for other Health Unit services in 2013-2014.

- Over 200 Health Unit staff received health literacy training to ensure the Health Unit's promotional messaging and health promotion materials (e.g., fact sheets) are written as clearly and simply as possible.

Strategic Direction (B): Organizational Health & Vitality (led by Dr. Bryna Warshawsky)

- The senior leadership team dedicated several meetings and two days for organizational- and self-assessment regarding the Health Unit's culture, decision-making processes, communication and teamwork. To support ongoing communication with staff members, there have been frequent email updates about evolving issues and several open town hall-style meetings in 2012 where staff could ask questions / discuss issues with the Health Unit Directors. Senior leadership has dedicated time in 2013 to explore other strategies to further align the organization's culture with the 10-year vision.

Strategic Direction (C): Infrastructure

Communications Group (led by Mr. Dan Flaherty)

- Significant progress has been made toward a new Health Unit website. Further information will be presented at an upcoming Board of Health meeting.

IT Group (led by Mr. Rick Shantz)

- Following an external scan and internal assessment, a draft strategy document is being developed to support the Health Unit to migrate toward Electronic Client Recordkeeping (ECR). This strategy will be presented to the Board in 2013 and will chart the course for ECR implementation.

Facilities Group (led by Mr. John Millson)

- The template and tools to develop a Facilities Plan have been drafted and are under review. This plan will support Board decision-making re: a long-term facilities strategy for the Health Unit.

Sustaining Momentum in 2013

In 2013, the Strategic Achievements Groups will continue working towards achieving the objectives in their operational plans. The Groups will continue to meet approximately monthly and report quarterly to senior leadership. Given the importance of the Strategic Directions, moving forward with these objectives will be a major focus for 2013.

This report was prepared by Mr. Ross Graham, Manager, Special Projects.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 009-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

MIDDLESEX-LONDON HEALTH UNIT MAINTAINS HIGHEST STANDARD OF ACCREDITATION

Recommendation

It is recommended that Report No. 009-13 re "Middlesex-London Health Unit Maintains Highest Standard of Accreditation" be received for information.

Key Points

- Following the annual site visit and review, the Ontario Council on Community Health Accreditation (OCCHA) awarded the Middlesex-London Health Unit (MLHU) the highest standard of Accreditation: Unconditional Accreditation Status for 2012-2013.

On December 11, 2012, the Ontario Council on Community Health Accreditation (OCCHA) board announced its decision to award the Health Unit the highest standard of Accreditation: "Unconditional Accreditation Status" for 2012-2013 (see Appendix A for OCCHA Accreditation Annual Review Summary).

As part of the three-year accreditation cycle, OCCHA surveyors visited the Health Unit on October 1, 2012 to conduct an annual site visit. This visit included a review of Health Unit programs and services operational plans, outcome reports, research activities and community collaboration. The surveyors also reviewed the Board's progress on its strategic plan, as well as Board member orientation, attendance, educational activities and compliance with Organizational Standards.

Featured Programs and Services

A number of Health Unit programs and activities were featured as examples during the 2012-2013 site visit:

- Adventures in Sex City Game Part 2
- Hepatitis C Health Care Provider Workshop
- Nicotine Replacement Therapy Pilot
- Methadone Maintenance Best Practices Workshop
- Food Handler Training Evaluation
- Building the Case for Smoke-Free Public Outdoor Spaces Technical Report
- Sex Workers Forum
- SafeGrad Workshop
- Child & Youth Network Involvement

- Environmental Land Use Planning program
- All-Ages Provincial Bicycle Helmet Legislation Petition
- Building a Healthy Workplace: Blueprint for Success Report
- Media Relations Summary
- Bed Bug Program Review
- Parkhill Vector-Borne Disease Management
- Healthy Smiles Ontario Marketing Campaign
- Engaging Youth to Build Healthy School Communities Conference

Extension Request

The year 2012 concluded the 3-year accreditation cycle. The first year of the next cycle requires intensive preparatory work for a new application. Prior to beginning this preparatory work, the Health Unit is consulting with the OCCHA Board regarding options for the upcoming year's accreditation. Given the current transitional leadership, the possibility of extending the current cycle with OCCHA for one additional year is being explored with the OCCHA Board.

This report was prepared by Mr. Ross Graham, Manager, Special Projects.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health

OCCHA Accreditation Annual Review Summary

Health Unit: Middlesex-London Health Unit	**Date of Review:** October 1, 2012	**Date of Original Survey:** September 29, 2010

Section I - Summary of Findings from Annual Questionnaire (2012)

The Health Unit completed the Annual Questionnaire and provided all required documentation. No new gaps were identified upon review of the questionnaire.

Section II – Outstanding Items from Accreditation Report (i.e., Requirements, Recommendations, Suggestions)

Standard #	Standard	Year 1 Findings – 2010	Year 2 Findings - 2011	Year 3 Findings – 2012
1A	The agency shall work with the governing body, staff and community partners to ensure the development, implementation and monitoring of a strategic plan.	There is an approved strategic plan, which includes the vision/mission statements, principles and values and governance and mandate of the Health Unit. The strategic plan also includes an area of focus for 2008/2009. A review of evidence indicates that there was also an area of focus for 2006/2007. There is a strategic planning policy, ADMIN 1-010, which states that, each year, the strategic plan will be formally reviewed by management and the Board of Health. Evidence indicates that, while informal review of the strategic plan has been conducted by the Directors Committee and updates provided to the Board of Health, formal review and approval of the areas of focus has occurred every two years. By OCCHA definition, the strategic plan is an action oriented document used by the organization to achieve stated long-term goals and objectives (quantifiable statements that establish realistic levels of future performance including timeframes and quantifiable levels of performance.	The Board of Health approved the Ten Year Vision and Three Year Strategic Directions of the Health Unit on June 16, 2011. The strategic planning process included input from staff, board members and community partners and clients. The health unit has begun work on operationalizing these directions through the development of indicators and goals and assigning roles and responsibilities. ***The health unit has addressed the recommendation in the establishment of a vision and strategic directions. In year 3, the survey team will review the work completed towards the implementation of these directions.***	The health unit has established six Strategic Achievement Groups (SAG's) to facilitate implementation of the strategic directions for 2012-2014. Terms of reference and operational plans for each of these groups have been developed. There was ample evidence of ongoing monitoring of progress towards implementation of strategic directions. ***No specific follow-up is required as monitoring of the strategic plan is included in the annual accreditation review process.***

		Evidence indicates that these objectives are identified within the service area operational plans. Evidence and interviews also identified the need to link the strategic plan with the operational plans in a more explicit way to inform program planning and implementation towards achievement of stated long term goals and objectives/areas of focus. The process for the development of a new three year strategic plan (based on a ten year vision) is underway; a working group has been established with Board of Health representation. The process also provides for consultation with community partners, key stakeholders and staff. The strategic plan is scheduled to be completed by the end of March, 2011. **RECOMMENDATION:** The Health Unit is encouraged to continue their efforts towards the development and implementation of a strategic plan that links with operational planning and is reviewed on a regular basis, in a manner consistent with identified timelines and agency policy.		
3C	The general administrative body shall establish processes/mechanisms to ensure that all programs, services and projects, including research, are coordinated, planned, implemented, monitored and evaluated. Where agency committees (e.g., program planning committee, program	The Directors Committee meets regularly, minutes are taken and pertinent information is communicated to staff. The agency has also established several standing committees of the Directors Committee to facilitate achievement of goals and objectives. There is a policy, ADMIN 1-031, re: Health Unit Committees that indicates that Terms of Reference for all standing committees shall be approved by the Directors Committee and that an annual report summary shall be completed and submitted to the Directors Committee.	Terms of reference were provided for all new planning/coordinating committees noted in the annual questionnaire and the Directors Committee has identified a schedule for review of standing committee terms of reference. In January of 2011, the Directors Committee supported the practice of verbal updates/presentations by standing committees in lieu of formal written annual reports. However, the policy on Health Committees (Admin 1-	There was evidence that the health unit has reviewed the inventory of internal committees and the process for reporting to the Director's Committee. Changes have been made to the policy in support of the internal review. ***No further follow-up is required.***

	advisory committee, program support committees, etc.) are established to facilitate achievement of this objective, terms of reference shall be developed, which include responsibilities and lines of communication/authority.	Evidence indicates that these committees have Terms of Reference and meet regularly. However, not all committees have had the terms of reference approved nor are annual summaries completed for all of these committees. **RECOMMENDATION:** That the Health Unit strengthen its efforts to ensure that terms of reference are formally approved and annual summaries completed for all applicable committees in a manner consistent with agency policy.	031) has not been revised to reflect this change of practice, although the need to update the policy has been identified. ***In year 3, the survey team will review the policy on Health Unit Committees to confirm that the policy has been updated to reflect approved practice.***	
5F	The governing body shall adopt practices consistent with government regulations related to the protection of human resources and the general public	There is a multi-site Joint Health and Safety Committee and approved terms of reference which include composition, function and meetings. The committee meets regularly and minutes of meetings are made available to all staff. The health and safety policy is posted and is reviewed regularly and first aid stations are identified. A review of evidence indicates that monthly workplace inspections have not been consistently conducted in all of the health unit offices in a manner consistent with legislation or agency policy. Interviews indicate that this was in large part due to a misinterpretation of the legislation as it relates to workplace inspections. Evidence however, does indicate that this was identified by the health unit, and improvements have been made in the past 12 months. **REQUIREMENT:** The health unit continue its ongoing efforts to ensure that monthly workplace inspections are conducted in a manner consistent with agency policy and legislation.	Evidence indicates that the health unit has strengthened efforts to ensure monthly workplace inspections are conducted in all offices. A review of inspection reports indicates that, in the past year, all but two monthly inspections were conducted across all offices. ***In year 3, the survey team will confirm that monthly inspections are conducted for all offices.*** Current WHMIS inventories (MSDS binders) have been developed specific to each service area, which will serve as the basis for WHMIS training. A general WHMIS orientation module was provided to new hires in May 2011. Service area re-training began in September 2011 and was completed in three service areas. Evidence and interviews indicate that the health unit will be conducting re-training, specific to each service area for all staff on an annual basis. Service areas will be	Inspections reports were reviewed for all office sites for the past 12months. Evidence indicates that monthly workplace inspections are being conducted in a consistent manner. ***No further follow-up is required.*** WHMIS inventories have been created for each service area. A review of evidence indicates that 94% of staff members have completed the re-training as of September 2012 and a plan is in place for the remaining 6% (casual and/new staff members). ***No further follow-up is required.***

		Evidence and interviews indicate that initial WHMIS training is generally conducted upon hire as part of the orientation process. However, while training is conducted annually in some program areas, evidence indicates that an annual assessment of training needs is not conducted for all staff members. In addition, a review of the MSDS binder indicates that it is out of date. Interviews indicate that an external review was conducted by the Health Unit related to WHMIS education, training and inventory updates and a plan is under development to implement the recommendations contained in the review. **REQUIREMENT:** That the Health Unit should continue its efforts to ensure that WHMIS needs are assessed annually and that it implement the recommendations contained in the WHMIS review. Further, the Health Unit shall ensure that the MSDS binder is updated.	required to provide documentation that re-training has been conducted. ***The health unit has demonstrated progress towards addressing this requirement. In year 3, the survey team will confirm that service WHMIS inventories are current and that re-training for all staff has been completed in a manner consistent with agency policy/practice.***	
7C	The general administrative body shall ensure that there are written position descriptions for all positions, which are reviewed on a regular basis, revised as appropriate and made available to each staff member. Position descriptions shall include a specific statement of duties/responsibilities, level/type of required education, training and	There are current written positions for all staff. Interviews indicate that staff members are aware of the existence of their position descriptions and their location. Health Unit policy notes that position descriptions are to be used in the performance evaluation process. However, interviews indicate that not all staff members are made aware of reviews and/or updates to their position description. Further, interviews also indicate that not all staff feel that there is a linkage between the position description and the performance evaluation process. It was noted that position descriptions are under review as a result of the recent	As noted in the 2010 accreditation review, the health unit has undergone organizational changes resulting in some delays in the implementation of internal strategies. At the time of the annual review, there was no specific evidence of enhanced communication strategies for informing staff of changes to position descriptions. However, it was noted that, while the policy on position descriptions (5-015) references the linkage between position descriptions and performance evaluation process, the policy on performance evaluations does not clearly identify the linkages between the two.	The local public school board has recently introduced new requirements for staff members working in schools and has requested the development of task-focused position descriptions for these staff members. This has further delayed the progress towards the development of competency based position descriptions. ***During the next accreditation review in 2013, the survey team will review the progress to-date towards review of the position descriptions and communication to staff members.***

	related work experience and should be considered during the performance evaluation process.	organizational changes to the agency. **SUGGESTION:** The Health Unit is encouraged to consider more formal mechanisms to update staff on changes to their position description and to establish a linkage between position descriptions and the performance evaluation process.	***In year 3, the survey team will review the development of strategies and/or tools to enhance the process of communicating changes to the position description.***	
9B	Performance evaluations shall be completed in a manner consistent with agency policy. Staff shall be provided the opportunity for input into the performance evaluation process. All performance evaluations shall be dated and signed by both the staff member being evaluated and the appropriate signing authority(ies). The original signed performance evaluation shall be kept in the personnel file.	There is a policy and procedure for performance evaluations, including a performance evaluation template. Evidence and interviews indicate that performance evaluations have not been conducted in a manner consistent with agency policy. **REQUIREMENT**: While the OCCHA Board of Directors recognizes that the re-organization and response to H1N1 have had some impact on activities over the past year, the Health Unit shall ensure that performance evaluations are completed in a manner consistent with agency policy.	Evidence indicates that the health unit has made significant progress toward ensuring that performance evaluations are being conducted in a manner consistent with policy. A new tool for has been developed and implemented for public health nurses. ***In year 3, the survey team will review the ongoing efforts of the health unit in ensuring that performance evaluations are being conducted in a manner consistent with agency policy.***	A review of evidence indicates that the health unit continues to make progress towards ensuring that performance evaluations are conducted in a manner consistent with agency policy. There were some outstanding evaluations due to changes in management staff, leaves of absence or illness, but there was documentation of follow-up. ***No specific follow-up is required.***
12B	Program/service policies and procedures shall be regularly reviewed, with staff consultation, and revised, as required. Dates of all review and revisions shall be recorded.	Policy and procedure manuals exist for all service areas and are available to staff. A review of program policies and procedures indicate that the policy for review varies across service areas, from annual to every three years. Further, review logs indicate there have been some minor inconsistencies in reviews being conducted in a manner consistent with service area policy. Interviews indicate that some of these service area manuals will be reviewed	The health unit policy on policy development and review (Admin 1-060) was revised in June 2010. This policy indicates that directors/designates are responsible for the development, distribution, maintenance and bi-annual review of policies and procedures that relate to the work of their Service Area. Interviews indicate that the health unit will be looking at strategies to streamline and ensure consistency	The health unit has reviewed its protocols for administrative and service area policy manual review. Program areas will continue to review their manuals using existing processes, but all manuals will be reviewed on a 2 year cycle. ***No further follow-up is required.***

		as part of the re-organization. **SUGGESTION:** The Health Unit is encouraged to consider options to facilitate a more consistent approach to review of service/program policy and procedures manuals.	between agency and service area policies and procedures. It was also noted that a leave of absence has resulted in the delay of some service area policies. ***In year 3, the survey team will review the efforts of the health unit to streamline policies and procedures and ensure a consistent approach to review across all program areas.***	
12G **12H**	There shall be an annual written operational plan for each program/service which identifies, at a minimum: activities (implementation and monitoring); time-lines; responsibilities, and expected outcomes. Operational plans shall be the basis of program/service implementation and shall be reviewed and revised, as required, to reflect changing priorities, financial and program developments.	Interviews indicate that program teams meet regularly and use these meetings to provide for coordination amongst programs. Staff input, community needs and health status information are used to inform program planning and coordination. Operational plans do exist for all programs and the Health Unit uses a planning template which includes activities; timelines, responsibility/resources; projected outcomes and a reference to the relevant Ontario Public Health Standard. The planning template also provides for the documentation of review and revisions dates on the cover page. Review of the operational plans noted that projected outcomes are, for the most part process indicators, rather than measurable short or long term program outcomes. In addition, the documentation of review and revision dates is not consistent across all programs; although interviews indicate that this is done regularly by program areas. **SUGGESTION:** The Health Unit is encouraged to consider a review of the planning template to identify short and long term program objectives, not just process	A review of evidence indicates that a revised planning tool is under development for use as an on-line planning module. The Agency Questionnaire indicated that operational plans for IT and Special Projects were in the process of developing operational plans to reflect changes in organizational structure and health unit priorities. ***In year 3, the survey team will review the implementation of the new planning template across all service areas.***	Operational plans for 2012 were developed for all service areas using the planning template. ***No further follow-up is required.***

		objectives and encourage programs to clearly document review and revision dates.		
15C **15F**	Programs/services shall regularly monitor activities as identified in the operational plans, and evaluate, document and disseminate program/service outcomes, both short-term and long-term. Programs/services shall ensure that all monitoring, surveillance, evaluation and results are considered in subsequent program planning and implementation.	There was evidence that monitoring and evaluation occurs across program/service areas and there was evidence of outcome reports, although most were process based. In addition, there was no consistent documentation used to demonstrate how monitoring and evaluation activities and results inform subsequent program planning and implementation. During the previous accreditation survey, it was noted that the planning template did include a component to demonstrate how activities impact on future operational planning; although this was consistently used by all program/service areas. **SUGGESTION:** As previously noted in Standard 12, the Health Unit is encouraged to review the planning template and revise to encourage a more consistent approach to documentation of how monitoring and evaluation activities inform subsequent program planning and implementation.	As noted above, the new operational planning template is still under development. (See 12G). ***In year 3, the survey team will review the use of the planning template, including documentation of actual achievements/outcomes.***	Given that the new planning template was implemented in 2012, the survey team was not able to review documentation of actual achievements/outcomes using this template. There was evidence that monitoring and evaluation is occurring across all programs areas. ***The survey team will review the use of the planning template to document service outcomes during the next accreditation review.***

Section III – Program Standards						
Std	**Component**	**Content**	**Applicable Programs**	**Year 1 - 2010**	**Year 2 - 2011**	**Year 3 - 2012**
10B	Collaboration	Programs/services shall share best available evidence with community partners, priority populations and target groups to increase community capacity	CDP, PISM, SH/STI	CDP – Middlesex County Advocacy Initiative 2009-2010 (Middlesex-London in motion) – re: Physical Activity	PISM – Healthy Communities Partnership – Middlesex-London Community Picture	SH/STI – Adventures in Sex City Game
10C	Collaboration	Programs/services shall collaborate with community	IDPC, TBPC, SH/STI	SH/STI – Youth Engagement	IDPC – Infection prevention and control workshop for hospitals,	TBPC – Hepatitis C Health Care Provider Workshop -

		partners, priority and target groups to develop, plan and implement programs/services and policies		Strategy and Sexual Health Campaign (Mind Your Mind)	long-term care homes and retirement homes providing training, fostering and implementation of disease prevention programs/services.	education of physicians and other health care providers
13A	Health Promotion	Programs/services shall provide opportunities for education and skills development to community partners and priority populations.	CDP, PISM, SH/STI, VPD, FS, SW.	CDP – CINOT Program Expansion SW – London-Middlesex Children's Water Festival	VPD - The HPV Vaccine Campaign - to female grade eight students, their parents/guardians and teachers. FS – Cook It Up! Cooking pilot program for at-risk youth	SH – Sex Workers Forum PISM – SafeGrad Workshop aimed at reducing harm due to drug/alcohol misuse
13B	Health Promotion	The agency shall work with community agencies, partners and organizations to identify and develop strategies to create and enhance support environments.	CDP, RH, CH, PISM, SH/STI	RH – Community Collaboration PISM – Golf Course Alcohol Liability and Risk Management Workshop	SH/STI – Hep C Conference for individuals who work with clients with HC – to foster an improved and supportive environment for clients PISM – Helmets on Kids Partnership	FH – Youth Create Healthy Communities Initiative CH – City of London Child and Youth Network to improve well-being of children and youth
13C	Health Promotion	The agency shall model and develop strategies to promote, support and/or implement healthy policy, both internally and within the community.	CDP, RH,CH, PISM, VPD, HH	PISM – BeCAUSE campaign – distracted driving module CH – Internal Breastfeeding Working Group Staff Education Plan	RH – Community Prenatal Health Services Provider Network CDP – Ontario Coalition for Smoke Free Movies	HH – The Environmental Land Use Planning program CDP – Child Safety – bike helmet advocacy.

Section IV – Areas of Follow-up in support of continuous quality improvement				
Standard	**Component**	**Year 1 Findings and Follow-up 2010**	**Year 2 Findings and Follow-up 2011**	**Year 3 Findings and Follow-up 2012**
4B	The general administrative body shall ensure that each program/service has an organizational structure that is outlined in an organizational chart which delineates the lines of authority and formal lines of communication within that program/service and which is made available to staff.	The Health Unit has recently made changes to its organizational structure, resulting in the need to update and approve existing organizational charts for several program/service areas. ***In year 2, the survey team will review the progress to-date towards completion and approval of revised organizational charts.***	Approved current organizational charts were provided for all service areas. ***No further follow-up is required.***	***N/A***
6B	The records of the agency and each program/service shall be maintained in a manner consistent with applicable legislation and agency policy.	There are policies for records management, which include creation, access, maintenance retention and disposal. There is a Records Management Project Group and the agency has developed an operational plan for Access/Privacy which includes strategies for assessment, priority privacy projects, consultation, education and awareness, reporting and incident response. While many of the components are ongoing, some activities have implementation/completion dates of December 2010. ***In year 2, the survey team will review the progress to-date towards the implementation of the***	In May 2011, the Directors Committee reviewed the status of the recommendations from the Privacy Risk Assessment as well as a comprehensive operational plan status report. The five core recommendations of the assessment have been fully implemented. Work continues on the implementation of activities/strategies as identified in the operational plan. ***As operational plans for all service areas are reviewed annually as part of OCCHA's process, no further follow-up related to this item is required.***	***N/A***

		components/strategies as indicated in the Access/Privacy Operational Plan.		
11A	The governing body shall approve a written policy on research/evaluation activities, including requirements for methodological and ethical review.	As previously noted, the Health Unit has recently undergone organizational changes, with the closure of REED Services. There were policies and procedures related to research and knowledge exchange, as well as coordination across program areas within REED Services policy manual. In addition, the inventory of research projects was maintained by this division. Interviews and evidence indicate that these policies and procedures are currently under review towards alignment with the current organizational structure. ***In year 2, the survey team will review the status of the realignment of policies and procedures and their incorporation into appropriate agency and/or service manuals.***	As part of the health unit's re-organization of service areas, REED functions have been decentralized, with an Epidemiologist(s) in each of the program service areas to support their planning, implementation, monitoring and evaluation. As part of the policy and procedure review process, REED policies wil be incorporated into the Administration Manual. The terms of reference for the Research Advisory Committee are under review. An inventory of research activities is maintained by the Special Projects Manager. ***No further follow-up is required.***	***N/A***

Section V – Summary of Annual Review Findings

A review of the Annual Questionnaire and all evidence indicates that the Health Unit has demonstrated significant progress towards addressing most of the requirements, recommendations and suggestions contained in the original accreditation report and has demonstrated ongoing compliance with the OCCHA accreditation standards.

As approved by the OCCHA Board of Directors on November 7, 2012	**The Middlesex-London Health Unit is encouraged to continue its efforts to address any outstanding items in support of compliance with the OCCHA accreditation standards.**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 010-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

MEDIA SUMMARY REPORT - JANUARY 2012 TO DECEMBER 2012

Recommendation

It is recommended that Report No. 010-13 re "Media Summary Report - January 2012 to December 2012" be received for information.

Over the course of 2012 there were 1,389 media reports noting the involvement and activities of the Health Unit in the community. This total is a decrease (9%) when compared to the 1,516 media stories in 2011, yet represents a significant increase (17%) over the 1,188 media reports recorded in all of 2010. Media coverage in 2012 equates to an average of just over 3.8 Health Unit media stories per day.

Health Unit media coverage in 2012 includes several major stories that received considerable attention from reporters and news editors across the Middlesex-London region. The top story of 2012 was influenza, with coverage that was split between the end of the mild 2011-2012 influenza season and the early start of the 2012-2013 influenza season, which is turning into one of the most active in years. The Health Unit's tobacco control program was also given significant media attention, including the effort to create a municipal by-law regulating smoking in outdoor public spaces, automatic prohibitions given to retailers who contravened the *Smoke-Free Ontario Act*, and the outdoor *Smoke-Free Movie Night* held on September 21st. The third most covered story of the year was related to mosquitoes, specifically the Vector-Borne Disease Program, including West Nile Virus surveillance, human cases of the disease and the mosquito situation in Parkhill. Other stories which garnered significant media attention were: matters related to the Health Unit's budget, extreme temperature alerts, *Adventures in Sex City II*, and the Health Unit's efforts to raise awareness about the dangers associated with home-based tattooing.

Radio reports were the main source of information about the Health Unit, noting its programs and services 887 times; followed by print media with 294 stories; television news reports featured the Health Unit 181 times, and talk shows had Health Unit guests on their programs 24 times.

In all, 39% of stories came after news releases were issued, while 34% were initiated by the media themselves; slightly more than 6% of media coverage came as a result of Board of Health reports, while program promotion accounted for about 21% of stories (e.g. advertising, regular television appearances, etc.). For a detailed overview, please refer to the attached Media Summary Report (Appendix A).

This report was prepared by Mr. Dan Flaherty, Manager, Communications.

Bryna Warshawsky, MDMC, CCFP, FRCPC
Acting Medical Officer of Health

This report addresses Policy #9-40 Media Relations, as outlined in the MLHU Administration Policy Manual.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

MEDIA SUMMARY REPORT
JANUARY – DEC 2012

1. MEDIA COVERAGE*				TOTAL: 1389
RADIO	TV	PRINT	INTERNET	TALK SHOW
887	180	294	4	24

* These figures reflect the number of times that each item was aired.

2. Origin Codes			
Media Release (MR)	195	Media Initiated (EXT)	171
Board Reports (BR)	28	MLHU Initiated (INT)	108

3. NEWS/CURRENT AFFAIRS COVERAGE

Date	Code	Outlet	Topic
04-Jan	INT	Middlesex Banner	Influenza Surveillance Report (Dec. 22/11)
05-Jan	INT	Parkhill Gazette	Healthy Smiles Ontario
10-Jan	EXT	CTV	New Year Resolutions
10-Jan	EXT	CTV	Risk of overeating - Health @ Home
16-Jan	INT	London Free Press	Norovirus circulating in community
16-Jan	MR	NewsTalk 1290 CJBK	National Non-Smoking Week
17-Jan	EXT	London Free Press	Immunization rates in health care workers
17-Jan	MR	London Free Press	National Non-Smoking Week
17-Jan	MR	Metro	Driven to Quit Challenge
18-Jan	EXT	XFM Fanshawe	Norovirus
18-Jan	MR	Fanshawe Broadcast	National Non-Smoking Week
18-Jan	INT	London Free Press	Internet streaming of January BofH meeting
18-Jan	MR	My-FM Strathroy	STOP on the Road
18-Jan	EXT	My-FM Strathroy	Norovirus
18-Jan	MR	NewsTalk 1290 CJBK	Weedless Wednesday
18-Jan	MR	Middlesex Banner	Health Unit Offers Support if You're Giving Up Smoking in 2012
19-Jan	EXT	Strathroy Age Dispatch	Well Baby/Child Breastfeeding Clinic at Kenwick Mall
19-Jan	EXT	Parkhill Gazette	Public meeting to update community on Parkhill mosquito problem
19-Jan	BR	London Free Press	Recommendation to MOHLTC to include bedbug funding in HU budgets
19-Jan	EXT	London Free Press	City budget - requested cuts to MLHU budget
19-Jan	MR	SRC - Windsor	Driven to Quit Challenge
20-Jan	EXT	Fanshawe Broadcast	Bed bug program
21-Jan	EXT	London Free Press	Adventures in Sex City II
21-Jan	EXT	London Free Press	Response to Jan 17 "flu shot flunkies" article
23-Jan	EXT	XFM Fanshawe	Radio doc on the dangers of tanning beds / regulations
23-Jan	EXT	Western Gazette	Adventures in Sex City II

Date	Code	Outlet	Topic
23-Jan	EXT	XFM Fanshawe	Radio doc on health care workers and vaccines
24-Jan	EXT	London Free Press	Practices at MLHU re: staff receiving flu shots
25-Jan	EXT	Middlesex Banner	Public meeting to update community on Parkhill mosquito problem
25-Jan	EXT	London Free Press	Public meeting re: fluoridation of City of London water
25-Jan	EXT	London Free Press	Response to Jan 24th article re: MLHU staff & flu shots
25-Jan	EXT	NewsTalk 1290 CJBK	Public meeting re: fluoridation of City of London water
26-Jan	EXT	NewsTalk 1290 CJBK	Breathable caffeine - effects of caffeine on the body
26-Jan	EXT	XFM Fanshawe	Influenza vaccination - what's it all about?
27-Jan	EXT	London Community News	Food Literacy and Youth Cooking Program
30-Jan	EXT	London Free Press	City of London Official Plan
30-Jan	EXT	Strathroy Age Dispatch	Eastern Equine Encephalitis
31-Jan	EXT	AM980	Heath Unit budget
31-Jan	MR	NewsTalk 1290 CJBK	Community Influenza Report
02-Feb	EXT	Rogers TV - Newsmakers	Community Water Fluoridation
02-Feb	EXT	Transcript & Free Press	Healthy Smiles Ontario
02-Feb	EXT	Transcript & Free Press	Case of whooping cough at Glencoe District High School
02-Feb	EXT	Parkhill Gazette	Public meeting to update community on Parkhill mosquito problem
02-Feb	EXT	London Community News	Public meeting re: fluoridation of City of London water
03-Feb	EXT	London Free Press	City budget - requested for further cuts to MLHU budget
10-Feb	EXT	XFM Fanshawe	"Let's Talk London" i-view on sexual health, birth control and STIs
10-Feb	EXT	London Free Press	City budget - council endorsed MLHU budget request, but asked for appointment of an assessor
10-Feb	BR	CTV	Proposed bylaw on banning smoking in outdoor spaces
10-Feb	EXT	CTV	Discussion of MLHU budget
13-Feb	BR	NewsTalk 1290 CJBK	City council to debate proposed smoking ban in public places
13-Feb	EXT	XFM Fanshawe	Radio doc on Travel Immunizations
13-Feb	BR	London Free Press	City council to debate proposed smoking ban in public places
14-Feb	BR	Western Gazette	Proposed bylaw on banning smoking in outdoor spaces
14-Feb	MR	CTV	Health Unit issues warning about home-based tattooing
14-Feb	MR	AM980	Health Unit issues warning about home-based tattooing
14-Feb	MR	XFM Fanshawe	Health Unit issues warning about home-based tattooing
14-Feb	EXT	Metro	Outcome of vote by City Council on proposed smoking ban in public places
14-Feb	EXT	London Free Press	Support for MLHU in aftermath of city budget meeting
14-Feb	EXT	London Free Press	Outcome of vote by City Council on proposed smoking ban in public places
15-Feb	MR	CJBK - London in the Morning	Health Unit issues warning about home-based tattooing
15-Feb	MR	UWO Gazette	Health Unit issues warning about home-based tattooing
15-Feb	INT	London Free Press	Internet streaming of February BofH meeting
15-Feb	MR	Middlesex Banner	Health Unit launches 2nd annual Nic-O-Time Challenge
15-Feb	MR	Metro	Health Unit issues warning about home-based tattooing
15-Feb	INT	Middlesex Banner	Driven to Quit Challenge
15-Feb	INT	Dorchester Signpost	Driven to Quit Challenge
16-Feb	EXT	AM980	Low influenza vaccination numbers
16-Feb	EXT	London Community News	City budget - council endorsed MLHU budget request, but asked for appointment of an assessor

Date	Code	Outlet	Topic
16-Feb	EXT	London Community News	Heather Thomas teaches youth at resource centres how to cook
16-Feb	EXT	London Community News	Outcome of vote by City Council on proposed smoking ban in public places
16-Feb	INT	Transcript & Free Press	Driven to Quit Challenge
16-Feb	INT	Parkhill Gazette	Driven to Quit Challenge
16-Feb	BR	XFM Fanshawe	Parenting Teens videos
16-Feb	BR	XFM Fanshawe	Toronto Charter
16-Feb	BR	XFM Fanshawe	Healthy Smiles Ontario
17-Feb	EXT	Business Wire Canada	HPV Vaccine for men
17-Feb	INT	Metro	Driven to Quit Challenge
22-Feb	INT	Middlesex Banner	Driven to Quit Challenge
22-Feb	EXT	London Free Press	Council approved report on banning smoking in public outdoor spaces
23-Feb	EXT	XFM Fanshawe	Proper condom use
23-Feb	MR	Transcript & Free Press	Health Unit issues warning about home-based tattooing
23-Feb	INT	Parkhill Gazette	Driven to Quit Challenge
23-Feb	INT	Transcript & Free Press	Driven to Quit Challenge
24-Feb	INT	Metro	Driven to Quit Challenge
27-Feb	INT	London Free Press	Internet streaming of March BofH meeting
27-Feb	EXT	NewsTalk 1290 CJBK	Update on flu situation and other viruses that are circulating
27-Feb	INT	Metro	Driven to Quit Challenge
28-Feb	EXT	Free FM	Bed bug program
29-Feb	INT	Dorchester Signpost	RFP - Website Redevelopment
01-Mar	INT	The Londoner	RFP - Website Redevelopment
01-Mar	INT	London Community News	RFP - Website Redevelopment
01-Mar	INT	Transcript & Free Press	RFP - Website Redevelopment
01-Mar	INT	Parkhill Gazette	RFP - Website Redevelopment
06-Mar	MR	Western Gazette	Signs and symptoms of meningococcal disease
06-Mar	MR	Western News	Risks associated with meningococcal disease
06-Mar	MR	XFM Fanshawe	Meningococcal disease
07-Mar	INT	Middlesex Banner	RFP - Website Redevelopment
07-Mar	EXT	XFM Fanshawe	Reasons why low numbers of influenza cases this season
06-Mar	MR	London Free Press	Health Unit advises how to reduce infections
08-Mar	EXT	XFM Fanshawe	Safe Tattooing - what people need to know
13-Mar	MR	AM980	Community Influenza Report
13-Mar	EXT	XFM Fanshawe	Sexual health and sexual education
13-Mar	MR	CTV	Community Influenza Report
14-Mar	EXT	XFM Fanshawe	Bed bug program
14-Mar	MR	Metro	Influenza Surveillance Report (Mar.13/12)
15-Mar	MR	Transcript & Free Press	HU advises how to reduce infections including meningococcal disease
16-Mar	EXT	Transcript & Free Press	Pregnancy and alcohol and substance misuse
16-Mar	MR	MYFM Radio	Community Influenza Report
20-Mar	MR	Free FM	London Life Nutrition Award - Gold Level
20-Mar	MR	Rogers TV - Newsmakers	London Life Nutrition Award - Gold Level

Date	Code	Outlet	Topic
20-Mar	MR	XFM Fanshawe	London Life Nutrition Award - Gold Level
21-Mar	INT	London Free Press	Internet streaming of April BofH meeting
21-Mar	INT	Middlesex Banner	Influenza Surveillance Report (Mar.13/12)
21-Mar	EXT	Middlesex Banner	Public health funding
22-Mar	EXT	XFM Fanshawe	Audio feature on Extreme Partying
22-Mar	EXT	NewsTalk 1290 CJBK	Trans fat reduction strategy
22-Mar	EXT	London Free Press	Ontario Injury Data Report - reaction
22-Mar	EXT	AM980	Advancer on West Nile Virus season for 2012
23-Mar	BR	London Free Press	Public Sector Salary Disclosure - 2011
23-Mar	EXT	London Free Press	MLHU Board of Health - seeking 75% funding from Ministry
26-Mar	MR	XFM Fanshawe	Unlicensed Tattoo Parlours
29-Mar	MR	Parkhill Gazette	Eat Smart Award for London Life
30-Mar	INT	Metro	Bed bug program
01-Apr	INT	Magazine Latino	Mosquito Larviciding
02-Apr	INT	London Free Press	Mosquito Larviciding
03-Apr	EXT	CTV	Ontario study on the 5 unhealthy habits
04-Apr	INT	My-FM Strathroy	Pre-natal Health Fair
04-Apr	INT	Middlesex Banner	Mosquito Larviciding
04-Apr	INT	Dorchester Signpost	Mosquito Larviciding
05-Apr	INT	The Londoner	Mosquito Larviciding
05-Apr	INT	Parkhill Gazette	Mosquito Larviciding
05-Apr	INT	Transcript & Free Press	Mosquito Larviciding
12-Apr	EXT	XFM Fanshawe	SafeGrad
13-Apr	EXT	CBC Radio - Ontario Morning	Late story on influenza activity
17-Apr	MR	NewsTalk 1290 CJBK	Community Influenza Report
17-Apr	MR	AM980	Community Influenza Report
20-Apr	BR	London Free Press	Bicycle helmets legislation
20-Apr	BR	NewsTalk 1290 CJBK	Bicycle helmets legislation
20-Apr	BR	AM980	Bicycle helmets legislation
22-Apr	EXT	CTV	Fluoride in City water
24-Apr	EXT	London Free Press	Fluoride in City water
24-Apr	EXT	London Free Press	MOH Retirement Announcement
25-Apr	EXT	London Free Press	Food Inspections
25-Apr	BR	SRC - Windsor	Bicycle helmets legislation
25-Apr	MR	AM980	Adventures in Sex City II
25-Apr	MR	Rogers TV - Newsmakers	Adventures in Sex City II
25-Apr	EXT	NewsTalk 1290 CJBK	Dr. Pollett's retirement
26-Apr	MR	Inspire-FM	Adventures in Sex City II
26-Apr	MR	London Free Press	Adventures in Sex City II
26-Apr	MR	Metro	Adventures in Sex City II
26-Apr	EXT	AM980	Private Members Bill to outlaw tanning beds for minors
26-Apr	EXT	Free FM	Private Members Bill to outlaw tanning beds for minors
27-Apr	Ext	Metro	Debate on Tanning beds

Date	Code	Outlet	Topic
01-May	Ext	London Free Press	Food Handler Certificate Tracking
03-May	MR	London Community News	Adventures in Sex City II
03-May	EXT	AM980	WNV - and MLHU larviciding plans or 2012
04-May	EXT	Free FM	Dr. Pollett's retirement
07-May	INT	Metro	The Health Connection is your direct line to PHNs in Middlesex-London
08-May	EXT	CTV	Private Members Bill on posting nutritional info at restaurants
08-May	EXT	NewsTalk 1290 CJBK	Private Members Bill on posting nutritional info at restaurants
10-May	INT	Metro	Influenza Surveillance Report (May 1/12)
14-May	EXT	CTV	Safe Grad video contest winners
15-May	EXT	Free FM	Health Canada warning about buying at yard sales
15-May	EXT	Canadian Press	Food Safety during picnics - how to prepare safely, etc…
16-May	INT	London Free Press	Internet streaming of May BofH meeting
16-May	EXT	Dorchester Signpost	Mental Wellness week at Northdale Central School
17-May	BR	Free FM	2013 City of London Budget Target
17-May	BR	London Free Press	2013 City of London Budget Target
18-May	BR	London Free Press	2013 City of London Budget Target
22-May	INT	London Free Press	The Health Connection is your direct line to PHNs in Middlesex-London
25-May	MR	NewsTalk 1290 CJBK	Health Unit issues warning about home-based tattooing
25-May	MR	London Free Press	Health Unit issues warning about home-based tattooing
25-May	MR	AM980	Health Unit issues warning about home-based tattooing
25-May	MR	Free FM	Health Unit issues warning about home-based tattooing
28-May	MR	NewsTalk 1290 CJBK	Heat alert issued for Middlesex-London (May 28/12)
28-May	MR	AM980	Heat alert issued for Middlesex-London (May 28/12)
28-May	MR	CBC Radio - London	Heat alert issued for Middlesex-London (May 28/12)
28-May	MR	XFM Fanshawe	Heat alert issued for Middlesex-London (May 28/12)
28-May	INT	London Free Press	The Health Connection is your direct line to PHNs in Middlesex-London
31-May	MR	Parkhill Gazette	Health Unit issues warning about home-based tattooing
31-May	MR	Parkhill Gazette	Heat alert issued for Middlesex-London (May 28/12)
04-Jun	EXT	XFM Fanshawe	Safe proms: alcohol, drugs, sexual health
04-Jun	EXT	Free FM	Drowning prevention
08-Jun	EXT	Free FM	Influenza season wrap up - what kind of year has it been
08-Jun	EXT	Metro	Sex worker conference
13-Jun	EXT	Dorchester Signpost	Car seat safety clinic in Dorchester
18-Jun	MR	XFM Fanshawe	Heat alert issued for Middlesex-London (June 18/12)
18-Jun	MR	CTV	Heat alert issued for Middlesex-London (June 18/12)
18-Jun	MR	NewsTalk 1290 CJBK	Heat alert issued for Middlesex-London (June 18/12)
18-Jun	MR	Free FM	Heat alert issued for Middlesex-London (June 18/12)
19-Jun	EXT	Metro	Report from Chief Coroner re: cycling deaths
20-Jun	MR	Metro	Heat alert issued for Middlesex-London (June 18/12)
20-Jun	MR	Middlesex Banner	Heat alert issued for Middlesex-London (June 18/12)
20-Jun	INT	London Free Press	Internet streaming of June BofH meeting
20-Jun	MR	London Free Press	Heat alert issued for Middlesex-London (June 18/12)

Date	Code	Outlet	Topic
21-Jun	EXT	NewsTalk 1290 CJBK	West Nile Virus update
21-Jun	EXT	Rogers TV - Newsmakers	Coping with the heat - precautions, dangers, vulnerable populations
21-Jun	BR	London Free Press	2013 Budget - In camera discussion at board of health meetings
22-Jun	BR	London Free Press	2013 Budget
22-Jun	MR	Free FM	Health Unit warns against home based tattoos
22-Jun	MR	NewsTalk 1290 CJBK	Health Unit warns against home based tattoos
23-Jun	MR	London Free Press	Health Unit warns against home based tattoos
23-Jun	EXT	London Free Press	Point of View: Protect Your Family by the Pool campaign
28-Jun	MR	Metro	Heat alert issued for Middlesex-London (June 27/12)
29-Jun	MR	AM980	West Nile Virus positive crow in Old South
29-Jun	INT	Metro	Do you know what your kids are watching?
29-Jun	MR	London Free Press	Heat alert issued for Middlesex-London (June 27/12)
29-Jun	MR	lfpress.com	Public advised not to play in water to consume fish from Pottersburg Creek
30-Jun	MR	London Free Press	Public advised not to play in water to consume fish from Pottersburg Creek
01-Jul	EXT	Today's Parent Magazine	What should my baby eat?
03-Jul	EXT	Windsor Star	Preparation of raw meat dishes in restaurants
03-Jul	INT	My-FM Strathroy	MLHU Website redevelopment project
04-Jul	MR	My-FM Strathroy	MLHU issues Heat Alert
04-Jul	INT	Dorchester Signpost	Website survey
04-Jul	INT	Middlesex Banner	Website survey
05-Jul	EXT	London Free Press	Efforts to curb mosquito situation in Parkhill successful
05-Jul	EXT	Parkhill Gazette	Mosquito numbers down in Parkhill
05-Jul	INT	Parkhill Gazette	Website survey
06-Jul	MR	CHRW	MLHU issues Heat Alert
07-Jul	EXT	XFM Fanshawe	West Nile Virus and Lyme Disease
10-Jul	EXT	London Free Press	Near drowning in Class B Pool
12-Jul	MR	Transcript & Free Press	Crow found in Old South tests positive for WNV
12-Jul	EXT	Parkhill Gazette	Efforts to curb mosquito situation in Parkhill successful
16-Jul	MR	Free FM	Heat alert issued for Middlesex-London (July 16/12)
16-Jul	MR	XFM Fanshawe	Heat alert issued for Middlesex-London (July 16/12)
17-Jul	MR	London Free Press	Heat alert issued for Middlesex-London (July 16/12)
19-Jul	MR	My-FM Strathroy	Summer heat and health risks
19-Jul	EXT	London Free Press	Heat may be to blame for outbreak of virus at nursing home
23-Jul	MR	AM980	Heat alert issued for Middlesex-London (July 23/12)
23-Jul	MR	Metro	Heat alert issued for Middlesex-London (July 23/12)
24-Jul	MR	CHRW	West Nile Virus Found in Local Mosquito Pool and Three Dead Birds
24-Jul	MR	MYFM Radio	West Nile Virus Found in Local Mosquito Pool and Three Dead Birds
25-Jul	MR	Middlesex Banner	Heat alert issued for Middlesex-London (July 23/12)
25-Jul	MR	CJBK - London in the Morning	West Nile Virus Found in Local Mosquito Pool and Three Dead Birds
24-Jul	EXT	London Free Press	Seniors and sex
01-Aug	MR	London Community News	Automatic Prohibition notices sent to five local tobacco retailers

Date	Code	Outlet	Topic
01-Aug	MR	MYFM Radio	Automatic Prohibition notices sent to five local tobacco retailers
01-Aug	MR	CTV News	Automatic Prohibition notices sent to five local tobacco retailers
02-Aug	MR	CJBK - London in the Morning	Automatic Prohibition notices sent to five local tobacco retailers
02-Aug	EXT	CJBK	Fewer mosquitoes than previous years
01-Aug	MR	London Free Press	Automatic Prohibition notices sent to five local tobacco retailers
02-Aug	MR	Free FM	How to prevent the spread Legionella bacteria
02-Aug	EXT	London Free Press	Fewer mosquitoes than previous years
02-Aug	INT	Strathroy Age Dispatch	MLHU recruiting CERV volunteers
03-Aug	MR	AM980	Heat alert issued for Middlesex-London (August 4)
03-Aug	MR	CJBK	Heat alert issued for Middlesex-London (August 4)
03-Aug	MR	London Free Press	Heat alert issued for Middlesex-London (August 4)
08-Aug	MR	Middlesex Banner	Five tobacco retailers penalized for repeated tobacco sales to youth
10-Aug	MR	Metro	MLHU reports increase in number of invasive Group A Strep infections
10-Aug	MR	XFM Fanshawe	Healthy City / Active London position statement
10-Aug	MR	AM980	Healthy City / Active London position statement
11-Aug	MR	London Free Press	Healthy City / Active London position statement
13-Aug	MR	Metro	Healthy City / Active London position statement
13-Aug	MR	XFM Fanshawe	More WNV-positive mosquitoes found in London & Middlesex County
13-Aug	MR	CTV	More WNV-positive mosquitoes found in London & Middlesex County
13-Aug	MR	NewsTalk 1290 CJBK	More WNV-positive mosquitoes found in London & Middlesex County
14-Aug	MR	NewsTalk 1290 CJBK	More WNV-positive mosquitoes found in London & Middlesex County
14-Aug	MR	Metro	More WNV-positive mosquitoes found in London & Middlesex County
15-Aug	MR	Middlesex Banner	More WNV-positive mosquitoes found in London & Middlesex County
15-Aug	MR	Dorchester Signpost	More WNV-positive mosquitoes found in London & Middlesex County
16-Aug	MR	CJBK	First probable human case of West Nile Virus
16-Aug	MR	AM980	First probable human case of West Nile Virus
16-Aug	MR	MYFM Radio	First probable human case of West Nile Virus
16-Aug	MR	London Community News	Healthy City / Active London position statement
16-Aug	MR	London Free Press	First probable human case of West Nile Virus
16-Aug	MR	CTV News	First probable human case of West Nile Virus
16-Aug	MR	Parkhill Gazette	More WNV-positive mosquitoes found in London & Middlesex County
16-Aug	MR	Transcript & Free Press	More WNV-positive mosquitoes found in London & Middlesex County
17-Aug	MR	Metro	First probable human case of West Nile Virus
17-Aug	INT	Metro	The Health Connection is your direct line to PHNs in Middlesex-London
17-Aug	EXT	CTV News	City of London Community Services Committee (Aug 21) - Smoke-free Outdoor Spaces Bylaw Options
18-Aug	EXT	London Free Press	City of London Community Services Committee (Aug 21) - Smoke-free Outdoor Spaces Bylaw Options
20-Aug	EXT	London Free Press	Oakville becomes the first municipality in Ontario to prevent teens from using tanning beds

Date	Code	Outlet	Topic
20-Aug	EXT	CJBK	City of London Community Services Committee (Aug 21) - Smoke-free Outdoor Spaces Bylaw Options
21-Aug	Ext	CJBK	City of London Community Services Committee (Aug 21) - Smoke-free Outdoor Spaces Bylaw Options
21-Aug	EXT	Free FM	Road safety for cyclists and pedestrians
22-Aug	EXT	Metro	City of London Community Services Committee (Aug 21) - Smoke-free Outdoor Spaces Bylaw Options
23-Aug	MR	Middlesex Banner	MLHU reports increase in number of invasive Group A Strep infections
23-Aug	MR	Transcript & Free Press	MLHU reports increase in number of invasive Group A Strep infections
23-Aug	MR	Transcript & Free Press	MLHU advises how to prevent the spread of Legionella Bacteria
23-Aug	MR	Transcript & Free Press	More WNV-positive mosquitoes found in London & Middlesex County
23-Aug	MR	London Community News	First probable human case of West Nile Virus
24-Aug	EXT	CJBK	West Nile Virus
27-Aug	INT	Metro	Do you know what your kids are watching?
29-Aug	EXT	London Free Press	Ontario cities moving to ban kids from tanning salons
30-Aug	MR	CTV	Second probable human case of West Nile Virus
30-Aug	MR	AM980	Second probable human case of West Nile Virus
30-Aug	EXT	The Londoner	Public participation meeting on Oct 1 re: smoking in municipal outdoor spaces
31-Aug	MR	London Free Press	Second probable human case of West Nile Virus
04-Sep	EXT	Toronto Star	Naloxone - any plans to distribute in Middlesex-London
05-Sep	MR	Middlesex Banner	Second probable human case of West Nile Virus
06-Sep	MR	CBC Radio London	Number of local pertussis cases on the rise
06-Sep	MR	Free FM	Number of local pertussis cases on the rise
06-Sep	MR	CTV	Number of local pertussis cases on the rise
06-Sep	MR	London Community News	One Life One You join call for federal ban on flavoured tobacco products
10-Sep	EXT	XFM Fanshawe	BC Centre for Disease Control report on "Canadian Problem" with flu shot
10-Sep	EXT	London Community News	Disciplining children - ideas/ what to do, what not to do.
11-Sep	EXT	Western Gazette	Student alcohol abuse and addiction
11-Sep	EXT	London Free Press	County council - creating administrative efficiency
11-Sep	INT	Metro	The Clinic
12-Sep	EXT	London Free Press	Third party review of MLHU budget
12-Sep	INT	London Free Press	Internet streaming of the September 2012 Board of Health meeting
12-Sep	MR	Middlesex Banner	Number of local pertussis cases on the rise
12-Sep	EXT	XFM Fanshawe	Tobacco-Free Sport and Recreation / tobacco control
12-Sep	EXT	AM980	Increase in WNV cases - worst year since 2002
13-Sep	EXT	XFM Fanshawe	Safe sex and condom use
13-Sep	EXT	XFM Fanshawe	Bed bugs - how to avoid them, how to get rid of them?
13-Sep	MR	Transcript & Free Press	One Life One You join call for federal ban on flavoured tobacco products
13-Sep	MR	Transcript & Free Press	Second probable human case of West Nile Virus
14-Sep	BR	London Free Press	MLHU budget - administrative costs
15-Sep	INT	London Free Press	Smoke-Free Movie Night

Date	Code	Outlet	Topic
17-Sep	INT	Metro	Smoke-Free Movie Night
17-Sep	MR	NewsTalk 1290 CJBK	Smoke-Free Movie Night
18-Sep	EXT	XFM Fanshawe	HPV vaccine - TPH offering vaccine to those eligible who didn't get it
19-Sep	EXT	XFM Fanshawe	Prenatal and other programs aimed at teens
19-Sep	BR	XFM Fanshawe	Public participation meeting on outdoor smoking ban in public places
19-Sep	EXT	London Community News	WNV larviciding on public property - what can MLHU do?
20-Sep	Ext	London Community News	HIV Statistics for Middlesex-London
20-Sep	MR	NewsTalk 1290 CJBK	Smoke-Free Movie Night
20-Sep	INT	The Londoner	Smoke-Free Movie Night
20-Sep	INT	London Community News	Smoke-Free Movie Night
20-Sep	EXT	The Londoner	Potential by-law change to allow kids to cycle on sidewalks
20-Sep	EXT	London Community News	What would 0% tax increase look like in 2013
21-Sep	MR	Free FM	Smoke-Free Movie Night
21-Sep	MR	NewsTalk 1290 CJBK	Smoke-Free Movie Night
24-Sep	EXT	XFM Fanshawe	Public participation meeting on smoking in outdoor public places
25-Sep	EXT	London Free Press	Variant Influenza Viruses
25-Sep	MR	XFM Fanshawe	Active Transportation Plan
26-Sep	EXT	Middlesex Banner	County council - creating administrative efficiency
26-Sep	EXT	Middlesex Banner	Health Unit board reviews ways to cut MLHU costs
28-Sep	MR	NewsTalk 1290 CJBK	Adventures in Sex City Heroes Bring Safe Sex Messages to Local Bars
28-Sep	MR	XFM Fanshawe	Adventures in Sex City Heroes Bring Safe Sex Messages to Local Bars
28-Sep	MR	CTV	Adventures in Sex City Heroes Bring Safe Sex Messages to Local Bars
28-Sep	MR	XFM Fanshawe	Adventures in Sex City Heroes Bring Safe Sex Messages to Local Bars
01-Oct	EXT	Fanshawe TV	West Nile Virus - how prominent has it been this summer?
01-Oct	EXT	CTV	Smoking in outdoor public places tee-up story
02-Oct	EXT	Metro	New bylaw pending on banning smoking in municipal outdoor spaces
02-Oct	EXT	The McLeod Report	Blog on Oct 1st meeting re: banning smoking in municipal outdoor spaces
02-Oct	MR	CBC Ontario Morning	Adventures in Sex City Heroes Bring Safe Sex Messages to Local Bars
02-Oct	MR	London Free Press	Cleardale Public School neighbourhood walk
03-Oct	MR	Middlesex Banner	Adventures in Sex City Heroes Bring Safe Sex Messages to Local Bars
03-Oct	MR	The Londoner	Cleardale Public School neighbourhood walk
03-Oct	MR	Rogers TV - Newsmakers	Cleardale Public School neighbourhood walk
03-Oct	MR	CTV	Cleardale Public School neighbourhood walk
03-Oct	MR	XFM Fanshawe	Cleardale Public School neighbourhood walk
04-Oct	EXT	London Community News	Councillors comments following public mtg re: smoking in outdoor spaces
04-Oct	EXT	London Free Press	Be Safe Be Seen contest
04-Oct	MR	Rogers TV - Daytime	Cleardale Public School neighbourhood walk
04-Oct	EXT	The Londoner	Benefit of getting the flu shot
05-Oct	EXT	London Free Press	Proposed bylaw on banning smoking in outdoor spaces

Date	Code	Outlet	Topic
05-Oct	EXT	London Free Press	PHO calling for influenza vaccination be a condition of employment for health care workers
05-Oct	EXT	AM980	Best practices for cooking a turkey
05-Oct	EXT	London Free Press	Comment re: Supreme Court of Canada decision on HIV disclosure
05-Oct	EXT	XFM Fanshawe	Comment re: Supreme Court of Canada decision on HIV disclosure
09-Oct	MR	XFM Fanshawe	Launch of community health stats website
09-Oct	MR	Rogers TV - Newsmakers	Launch of community health stats website
09-Oct	MR	NewsTalk 1290 CJBK	Launch of community health stats website
09-Oct	MR	CTV	Launch of community health stats website
09-Oct	EXT	XFM Fanshawe	Guidelines around breast cancer screening
09-Oct	EXT	AM980	Mandatory flu shots being suggested by PHO
09-Oct	EXT	London Free Press	Smoking law need to be standardized
09-Oct	EXT	London Free Press	Opinion column on mandatory flu shots for health care workers
10-Oct	EXT	XFM Fanshawe	Radio Doc: How "The Pill" has changed over the years (dosage, etc…)
10-Oct	EXT	London Free Press	London council directing city staff to craft bylaw re: banning smoking within 9 meters of playgrounds, sports fields, municipal building doorways
10-Oct	MR	London Free Press	Launch of community health stats website
10-Oct	EXT	London Free Press	Recruitment of new MOH
10-Oct	EXT	Middlesex Banner	London council directing city staff to craft bylaw re: banning smoking within 9 meters of playgrounds, sports fields, municipal building doorways
10-Oct	MR	London Free Press	Stats on flu vaccination of health care workers from 2004-2012
10-Oct	MR	Metro	Launch of community health stats website
10-Oct	EXT	CTV	Smoking ban within 9 meters of playgrounds, sports fields, municipal building doorways
11-Oct	EXT	XFM Fanshawe	Reaction to Health Canada comment on energy drinks and alcohol
11-Oct	MR	The Londoner	Identifying risk key to encouraging kids to walk and bike to school
11-Oct	EXT	CHRW	Smoking ban within 9 meters of playgrounds, sports fields, municipal building doorways
11-Oct	MR	Western Gazette	Launch of community health stats website
12-Oct	MR	Free FM	Launch of community health stats website
15-Oct	BR	London Free Press	MLHU administration budget
15-Oct	EXT	XFM Fanshawe	Birth Control - how it is provided at The Clinic
17-Oct	EXT	XFM Fanshawe	HPV shots - value; why they're a good thing
17-Oct			
17-Oct	INT	London Free Press	Internet streaming of October BOH meeting
17-Oct	BR	London Free Press	Establishing reserve fund
18-Oct	INT	The Londoner	Influenza Vaccination Clinics
19-Oct	INT	Metro	Influenza Vaccination Clinics
19-Oct	BR	London Free Press	Vote to maintain status quo re: budget
21-Oct	EXT	London Free Press	Health Unit urging all Londoners over six months get flu shot
22-Oct	INT	Metro	Influenza Vaccination Clinics
22-Oct	INT	London Free Press	Influenza Vaccination Clinics
23-Oct	MR	Free FM	Influenza Vaccination Clinics
23-Oct	MR	AM980	Influenza Vaccination Clinics

Date	Code	Outlet	Topic
23-Oct	MR	Rogers - Inside London	Influenza Vaccination Clinics
23-Oct	MR	XFM Fanshawe	Influenza Vaccination Clinics
24-Oct	INT	Metro	Parent Symposium - Raising Emotionally Healthy Children
24-Oct	MR	Metro	Community Flu Clinic kicks off annual flu clinic campaign
24-Oct	MR	Western Gazette	Influenza Vaccination Clinics
24-Oct	INT	Middlesex Banner	Influenza Vaccination Clinics
24-Oct	INT	Dorchester Signpost	Influenza Vaccination Clinics
24-Oct	MR	CTV	Influenza Vaccination Clinics
24-Oct	MR	XFM Fanshawe	Information about the influenza vaccine
25-Oct	MR	London Free Press	Not By Accident Conference
25-Oct	INT	Transcript & Free Press	Influenza Vaccination Clinics
25-Oct	INT	Parkhill Gazette	Influenza Vaccination Clinics
26-Oct	INT	Metro	Parent Symposium - Raising Emotionally Healthy Children
27-Oct	INT	London Free Press	Influenza Vaccination Clinics
29-Oct	INT	Metro	Parent Symposium - Raising Emotionally Healthy Children
31-Oct	INT	Metro	Parent Symposium - Raising Emotionally Healthy Children
31-Oct	EXT	London Free Press	MLHU urging Ontarians to have an emergency kit
01-Nov	EXT	XFM Fanshawe	Candy and the damages it causes to teeth
01-Nov	EXT	XFM Fanshawe	OMA recommendations on junk food labels
03-Nov	INT	London Free Press	Influenza Vaccination Clinics
05-Nov	EXT	XFM Fanshawe	Health concerns related to breakfast sandwiches
07-Nov	INT	Middlesex Banner	Influenza Vaccination Clinics
07-Nov	INT	Dorchester Signpost	Influenza Vaccination Clinics
07-Nov	EXT	Dorchester Signpost	St. David Catholic School Healthy Hearts Committee
07-Nov	EXT	XFM Fanshawe	Nursing students needing flu shots for their program
08-Nov	INT	Parkhill Gazette	Influenza Vaccination Clinics
08-Nov	INT	Transcript & Free Press	Influenza Vaccination Clinics
08-Nov	EXT	XFM Fanshawe	Radio doc on the effectiveness of tobacco warning labels
08-Nov	INT	Strathroy Age Dispatch	Influenza Vaccination Clinics
09-Nov	EXT	London Free Press	Terms of Reference for review of administrative functions
10-Nov	INT	London Free Press	Influenza Vaccination Clinics
13-Nov	EXT	XFM Fanshawe	Predrinking and the associated health risks
13-Nov	EXT	Rogers TV - Fanshawe Learns	Healthy eating over the winter months
13-Nov	MR	Rogers TV - Daytime	Parent Symposium - Raising Emotionally Healthy Children
14-Nov	INT	London Free Press	Internet streaming of November BOH meeting
14-Nov	MR	NewsTalk 1290 CJBK	Influenza update
14-Nov	MR	XFM Fanshawe	Influenza update
14-Nov	MR	Free FM	Influenza update
14-Nov	MR	CTV	Influenza update
14-Nov	MR	CBC Radio London	Influenza update
14-Nov	MR	Western Gazette	Influenza update
15-Nov	MR	CBC Ontario Morning	Parent Symposium - Raising Emotionally Healthy Children
15-Nov	MR	London Free Press	First confirmed cases of Influenza in Middlesex-London

Date	Code	Outlet	Topic
15-Nov	BR	London Free Press	Terms of Reference for review of administrative functions
15-Nov	MR	Metro	First confirmed cases of Influenza in Middlesex-London
16-Nov	BR	London Free Press	Efficiencies & administrative review
16-Nov	MR	Free FM	New parenting videos
16-Nov	MR	XFM Fanshawe	New parenting videos
18-Nov	EXT	London Free Press	Mayor calling for greater city council presence on BofH
19-Nov	MR	Metro	New parenting videos
20-Nov	MR	XFM Fanshawe	Influenza Surveillance Report (Nov 19/12)
21-Nov	INT	Middlesex Banner	Influenza Vaccination Clinics
21-Nov	MR	Metro	Influenza Surveillance Report (Nov 19/12)
21-Nov	INT	Dorchester Signpost	Influenza Vaccination Clinics
22-Nov	INT	Parkhill Gazette	Influenza Vaccination Clinics
22-Nov	MR	Transcript & Free Press	New parenting videos
22-Nov	MR	London Community News	First confirmed cases of Influenza in Middlesex-London
22-Nov	MR	London Community News	New parenting videos
23-Nov	EXT	London Community News	Third city councillor to join MLHU board of health
23-Nov	EXT	Free FM	Attendance at community flu clinics
24-Nov	INT	London Free Press	Article on Health Unit funding and shared services review
27-Nov	MR	CTV	Influenza Surveillance Report (Nov 27/12)
27-Nov	MR	The Londoner	Influenza Surveillance Report (Nov 27/12)
27-Nov	MR	AM980	Influenza Surveillance Report (Nov 27/12)
28-Nov	MR	XFM Fanshawe	Influenza Surveillance Report (Nov 27/12)
28-Nov	EXT	CTV	Travel vaccines and others things you need to bring when you travel
28-Nov	MR	Metro	Influenza Surveillance Report (Nov 27/12)
28-Nov	MR	London Free Press	Influenza Surveillance Report (Nov 27/12)
28-Nov	MR	UWO Journalism	Influenza Surveillance Report (Nov 27/12)
29-Nov	MR	Transcript & Free Press	Influenza Surveillance Report (Nov 27/12)
06-Dec	MR	London Community News	Influenza Surveillance Report (Nov 27/12)
06-Dec	MR	Transcript & Free Press	Influenza Surveillance Report (Nov 27/12)
06-Dec	EXT	Metro	Influenza A outbreak at Victoria Hospital resolved
06-Dec	MR	The Londoner	Influenza Surveillance Report (Nov 27/12)
07-Dec	MR	London Free Press	Influenza Surveillance Report (Dec 6/12)
07-Dec	MR	Metro	Influenza Surveillance Report (Dec 6/12)
12-Dec	INT	London Free Press	Notice re: Internet streaming of December Board of Health meeting
12-Dec	INT	Middlesex Banner	Make my first test an eye test
12-Dec	INT	Dorchester Signpost	Make my first test an eye test
12-Dec	MR	CTV	Influenza Surveillance Report (Dec 6/12)
12-Dec	MR	Free FM	Influenza Surveillance Report (Dec 6/12)
12-Dec	INT	Dorchester Signpost	Healthy Baby Healthy Brain
12-Dec	INT	Metro	The Health Connection is your direct line to PHNs in Middlesex-London
13-Dec	MR	My-FM Strathroy	Uninspected kitchens and holiday baking
13-Dec	MR	NewsTalk 1290 CJBK	Uninspected kitchens and holiday baking

Date	Code	Outlet	Topic
13-Dec	INT	Strathroy Age Dispatch	Make my first test an eye test
13-Dec	INT	Parkhill Gazette	Make my first test an eye test
13-Dec	INT	Transcript & Free Press	Make my first test an eye test
13-Dec	INT	Metro	Influenza Surveillance Report (Dec 12/12)
13-Dec	BR	London Free Press	Draft BofH Code of Conduct
13-Dec	INT	Strathroy Age Dispatch	Healthy Baby Healthy Brain
13-Dec	INT	The Londoner	The Health Connection is your direct line to PHNs in Middlesex-London
14-Dec	EXT	London Community News	Influenza update - what kind of season has it been so far?
14-Dec	INT	Parkhill Gazette	Healthy Baby Healthy Brain
15-Dec	INT	Transcript & Free Press	Healthy Baby Healthy Brain
15-Dec	BR	London Free Press	Draft BofH Code of Conduct
17-Dec	INT	Metro	The Health Connection is your direct line to PHNs in Middlesex-London
19-Dec	INT	Dorchester Signpost	The Health Connection is your direct line to PHNs in Middlesex-London
19-Dec	INT	Middlesex Banner	Healthy Baby Healthy Brain
19-Dec	INT	Middlesex Banner	Influenza Surveillance Report (Dec 12/12)
19-Dec	INT	Metro	It is illegal to smoke in enclosed workplaces, including workplace vehicles
19-Dec	BR	London Community News	Draft BofH Code of Conduct
20-Dec	INT	Strathroy Age Dispatch	Notice re: Strathroy Immunization Clinic schedule
20-Dec	INT	Strathroy Age Dispatch	The Health Connection is your direct line to PHNs in Middlesex-London
20-Dec	INT	The Londoner	It is illegal to smoke in enclosed workplaces, including workplace vehicles
20-Dec	INT	Metro	Influenza Surveillance Report (Dec 18/12)
20-Dec	INT	Transcript & Free Press	The Health Connection is your direct line to PHNs in Middlesex-London
21-Dec	INT	Parkhill Gazette	The Health Connection is your direct line to PHNs in Middlesex-London
20-Dec	INT	Transcript & Free Press	Influenza Surveillance Report (Dec 12/12)
20-Dec	INT	Parkhill Gazette	Notice re: Strathroy Immunization Clinic schedule
26-Dec	INT	Middlesex Banner	Notice re: Strathroy Immunization Clinic schedule
27-Dec	INT	Strathroy Age Dispatch	Notice re: Strathroy Immunization Clinic schedule
27-Dec	INT	The Londoner	The Health Connection is your direct line to PHNs in Middlesex-London
28-Dec	EXT	Mom & Caregiver	Breastfeeding: more than just nutrition

* The Communications Department issues Public Service Announcements (PSA's) to all local radio, tv & newspaper outlets on a regular basis. However, because it is very difficult to track if or when PSA's are aired we have not included this information.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 011-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

ONA PAY EQUITY MAINTENANCE

Recommendation

It is recommended that Report No. 011-13 re "ONA Pay Equity Maintenance" be received for information

Key Points

- Representatives from the Ontario Nurses Association (ONA) recently requested a meeting to discuss the development of Terms of Reference to conduct job evaluations and negotiate a new pay equity plan for all nursing positions.
- Pay Equity was initially negotiated with ONA in the mid-1990s and pay equity adjustments were made at that time.
- Steps have been taken to start the process of hiring a consultant with expertise in pay equity to assist management to negotiate and settle the pay equity issues between ONA and the Health Unit.

Background about Pay Equity

Pay equity is the concept whereby equal pay is granted for work of equal value. Pay equity programs are designed to ensure that work that is traditionally done by women is paid equally to work of equal value that is traditionally done by men. The parties are required by law to assess job content in a gender neutral way. The process involves applying the four factors of skill, responsibility, working conditions and physical and mental demands, to compare each female job with male jobs and determine their relative value. Adjustments to wages are then made to ensure that female jobs are paid the same wage as a male job of equal value.

Pay Equity and the Ontario Nurses Association

Ontario Nurses Association (ONA) members comprise the largest job class (approximately 100 full-time and part-time employees) at the Health Unit. The Health Unit negotiated pay equity with ONA in the 1990s. At that time, pay equity adjustments were made in order for the job rate for Public Health Nurses (PHN) to be 84% of the job rate of the chosen male comparator, the position of Health Unit Epidemiologist (a non-union position). There is little documentation available as to how this result was negotiated, but it is clear that this is what was agreed to.

Once pay equity is achieved, if all employees within an organization receive the same percentage increases to their salaries annually and no other changes are made to the salary structure that would affect

the job rates, pay equity is maintained. At the Health Unit, several events took place which may have affected pay equity maintenance. For example, the position of Epidemiologist changed and is no longer a male comparator, as all Epidemiologists hired since the male incumbent resigned have been females. Several other positions occupied by males, that may have been used as male comparators in the mid-1990s, no longer exist at the Health Unit due to organizational restructuring.

A new male comparator or male wage line needs to be established in order to demonstrate that pay equity has been maintained. A proposal was made to ONA in 2009 to adopt the Canadian Union of Public Employee (CUPE) job evaluation plan and use the results of CUPE job evaluation for male jobs as a starting point for negotiating pay equity maintenance; however, this has not been pursued by ONA. The Health Unit was advised that ONA Central was developing a provincial strategy for pay equity, and had identified a need to develop expertise within their own staff before proceeding. ONA has also taken the position in subsequent collective bargaining sessions that negotiation of pay equity must be separate from the negotiation of renewals or changes to the collective agreement.

Pay Equity Negotiations with ONA

Representatives from ONA recently requested a meeting with the Director of Human Resources & Labour Relations to discuss the development of Terms of Reference to conduct job evaluations and negotiate a new pay equity plan for all nursing positions at the Health Unit. Obtaining the advice of an external consultant for the Health Unit is necessary as legislation provides little guidance regarding the processes for maintaining pay equity. As well, since there is no documentation that explains the comparison of Public Health Nurses to the Epidemiologist in the 1990s, it appears that the way to maintain pay equity is to start the job evaluation and pay equity process again from the beginning.

There are multiple decision points in the process of negotiating pay equity, such as the selection of a job evaluation plan, assigning weights to sub-factors to create a point-factor system, identifying male comparators to be evaluated, and selecting the method for creating a male wage line, if there is no agreement on a direct job-to-job comparison. The use of external expertise will protect the interests of the Board during pay equity negotiations with ONA. Even a small adjustment in wages, if retroactive, would create a significant unfunded liability for the Board of Health. The Board may wish to consider setting up a reserve fund in order to mitigate any potential future obligations.

As stipulated under the Health Unit's Procurement Policy, the Health Unit will be undertaking a Request for Proposal process for an external consultant to assist in its pay equity negotiations with ONA. The funding for the external consultant will come from the general consulting budget line. In the 2013 budget, this line was reduced by $145,000 to achieve a 0% municipal tax increase, leaving $108,356 remaining as a source of funds for this project.

This report was prepared by Ms. Louise Tyler, Director, Human Resources & Labour Relations, and Mr. John Millson, Director, Finance & Operations. Ms. Tyler will be present at the meeting to speak to this report and answer questions from the Board of Health regarding job evaluation and pay equity maintenance.

Bryna Warshawsky, MDCM, FRCPC
Acting Medical Officer of Health

This report addresses the requirement(s) of the Pay Equity Act, R.S.O. 1990, c. P7 and Policy # 4 – 025, Procurement, as outlined in the MLHU Administration Policy Manual.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 012-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

SIGNIFICANT INFLUENZA ACTIVITY TO-DATE IN THE 2012-2013 SEASON

Recommendation

It is recommended that Report No. 012-13 re "Significant Influenza Activity To-date in the 2012-2013 Season" be received for information.

Key Points

- There has been significant influenza activity to-date in the 2012-2013 influenza season, almost to the extent of the activity seen during the 2009 H1N1 pandemic.
- It is not too late to receive the influenza vaccine, which is the most important way to prevent influenza.
- Other strategies to prevent spreading illness include frequent hand washing or use of alcohol-based hand sanitizers and staying home if you are ill.
- Thirty influenza outbreaks in facilities such as hospitals, nursing homes, retirement homes and assisted living facilities have been identified as of January 7, 2013. Health Unit staff members assist the facilities in limiting further spread to residents, who are at risk of complications from the infection.

Significant Influenza Season

The first laboratory-confirmed case of influenza A was reported to the Health Unit on November 6, 2012 and a community-wide influenza outbreak was declared on November 27, 2012. Since that time there has been increasing influenza activity in the community.

The Health Unit issues regular reports regarding the level of influenza activity in the community. These are distributed widely to health care providers, community organizations and the media, and posted on the Health Unit's website. The most recent report was issued on January 9, 2013. It indicates that there is a lot of influenza activity in the community. High rates of influenza activity are also being noted elsewhere in Canada and in the United States.

Comparison with Other Influenza Seasons

Table 1 provides a comparison with influenza seasons since 2009. It indicates that the 2012-2013 influenza season to-date, based on most indicators, is almost as severe as the pandemic H1N1 influenza season. It should be noted that the 2012-2013 influenza season is still in progress and so data is not complete for this season.

Table 1: Influenza Statistics, Middlesex-London Health Unit
2009-2010, 2010-2011, 2011-2012, 2012-2013 to January 7, 2013

Characteristics	2009-2010	2010-2011	2011-2012	2012-2013 (to January 07, 2013)
Laboratory-Confirmed Cases	391	276	106	327
Hospitalizations	92	161	34	162*
Deaths	8	17	3	12*
Outbreaks	2	28	6	30

* As not all laboratory-confirmed cases have been followed-up by the Health Unit, it is possible that there are additional hospitalizations and/or deaths that are not included in these statistics.

Prevention of Influenza

The Health Unit continues to provide advice to the community via the media, information to schools and the influenza reports on steps to reduce the chance of illness. Most notably, it is not too late to get the influenza vaccine, which is the most important way to prevent influenza. Frequent hand washing or use of alcohol-based hand sanitizers is recommended to reduce the chance of getting influenza and other viruses. As well, the public is advised to stay home and away from others if they are feeling unwell.

Management of Influenza Outbreaks

As of January 7, 2013, 30 influenza A outbreaks have been identified in facilities including hospitals, nursing homes, retirement homes and assisted living facilities. Influenza in these group settings can be significant, as the virus can spread easily from one resident to another. As well, the residents are often elderly with underlying medical conditions, the groups most at risk for complications of influenza which can result in hospitalizations, and occasionally deaths.

When the Health Unit becomes aware of influenza outbreaks in facilities, Health Unit staff members assist the facility in controlling further spread. This is done by supporting the facility to implement measures which may include isolating the ill residents; keeping residents from mixing between one floor or unit and another; frequent hand washing or use of alcohol-based hand sanitizer; personal protective equipment (such as masks, eye protection and gloves) for staff members; and enhanced environmental cleaning. As well, the antiviral drug, oseltamivir, is recommended for all residents and for unvaccinated staff members.

The large number of influenza outbreaks and laboratory-confirmed cases have resulted in a significant increase in work for the Infectious Disease Control Team and the Epidemiologist in the Oral Health, Communicable Disease and Sexual Health Services Team. They are to be commended for their hard work and dedication during this busy time.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health

This report addresses the requirement(s) of the Ontario Public Health Standards: Infectious Disease Prevention and Control, and Vaccine Preventable Diseases.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 013-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 January 17

ACTING MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – DECEMBER 6, 2012 – JANUARY 9, 2013

Recommendation

It is recommended that Report No. 013-13 re "Acting Medical Officer of Health Activity Report - December 6, 2012 – January 9, 2013" be received for information.

The following report highlights activities of the Acting Medical Officer of Health from December 6, 2012 to January 9, 2013. It is divided into activities related to the role of Acting Medical Officer of Health and Chief Executive Officer, and activities related to the role of the Associate Medical Officer of Health / Director, Oral Health, Communicable Disease and Sexual Health Services.

Acting Medical Officer of Health and Chief Executive Officer

As directed at the December 13 Board of Health meeting, a Vox Pop from the Board Chair was submitted to the London Free Press but was not accepted for publication. A meeting with the Editors of the London Free Press is being organized to discuss the relationship with this important media outlet.

Work continues on the Shared Services Review in collaboration with Mr. John Millson, Director, Finance and Operations; Mr. Rick Shantz, Director, Information Technology; and Ms. Louise Tyler, Director Human Resources and Labour Relations. A meeting was held on December 10 with PricewaterhouseCoopers staff members from London and Toronto to review the first draft of the project plan. Subsequent revisions have been made to the plan which is being presented for approval by the Board of Health at this meeting (see Report No. 002-13). Meetings have also been held with representatives from the City of London and Middlesex County to inform them of the project plan.

Other activities related to this role have included:

- **Community and Health Unit Events / Meetings:**
  - **Warden's Inaugural Meeting:** Attended with Mr. John Millson, Director, Finance and Operations (December 6);
  - **Retirement party for Ms. Bonnie Wooten, Manager in Family Health Services:** Ms. Wooten retired after 12 years of service to the Health Unit (December 13);
  - **Meeting regarding community development demonstration initiative to support children's mental health:** Participated in this meeting with researchers from Western University along with Ms. Diane Bewick, Director, Family Health Services and Ms. Christine Preece, Manager, Young Adult Team (January 8);
  - **Organizational Health and Vitality Strategic Achievement Group:** Chaired a session of this committee, which consists of Health Unit Directors, to continue work on this element of the Strategic Plan (January 9).

Associate Medical Officer of Health / Director, Oral Health, Communicable Disease and Sexual Health

Considerable time over the past month has been spent providing support to the Infectious Disease Control Team as they respond to the large amount of influenza in the community (see Report No. 012-13). From the start of the influenza season to January 7, 2013, the Infectious Disease Control Team has assisted in the management of 30 outbreaks in hospitals, nursing homes, retirement homes and assisted living facilities. There has been intense activity over the holiday season, on some occasions requiring two staff members to provide on call coverage. The Associate Medical Officer of Health has also been on call over the holiday season.

The Associate Medical Officer of Health has also spent a significant amount of time working with Ms. Marlene Price, Manager, Vaccine Preventable Disease, to update the medical directives pertaining to immunizations. Medical Directives are written documents that provide authorization for the Public Health Nurses to provide immunizations. As significant changes to the Canadian Immunization Guide were released in early December 2012, revision of the Health Unit's medical directives was required to reflect these changes.

Other activities of the Associate Medical Officer of Health include:

- **Infection Control Meetings** were attended as follows:
  - **City-wide Infection Control Committee –** For London Health Sciences Centre and St. Joseph's Health Care London (December 14);
  - **Middlesex Hospital Alliance –**For Strathroy Middlesex General Hospital and Four Counties Health Services (December 18 – via teleconference)
  -
- **Presentations:**
  - **Vaccine Preventable Disease Team** – Changes to the Canadian Immunization Guide (December 18);
  - **Community Medicine Seminar –** Presentation to third year medical students on the role of the Medical Officer of Health (January 9).

- **HIV Medications for Post-Exposure Management:** Held a second meeting of a community group to develop a plan to provide appropriate medication to prevent HIV in a timely manner after a blood-borne exposure (December 14).

On call coverage for Sarnia- Lambton Community Health Services Department:

The Acting Medical Officer of Health and Dr. David Colby, Medical Officer of Health for the Chatham Kent Public Health Unit (who also provides on call coverage at the Middlesex-London Health Unit), have been asked to provide on call coverage for the Sarnia-Lambton Community Health Services Department from February 6 to 26, 2013 while Sarnia-Lambton's Medical Officer of Health is away.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health