A G E N D A

MIDDLESEX-LONDON BOARD OF HEALTH

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

THURSDAY, 7:00 p.m.
2011 June 16

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

Ms. Patricia Coderre (Chair)	Ms. Viola Poletes Montgomery (Vice-Chair)
Ms. Denise Brown	Ms. Nancy Poole
Mr. Al Edmondson	Mr. Don Shipway
Dr. Francine Lortie-Monette	Mr. Mark Studenny
Ms. Doreen McLinchey	Mr. Joe Swan
Mr. Marcel Meyer	Dr. Graham Pollett (Secretary-Treasurer)

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

7:10 - 7:20 p.m.	Mr. David Arnold, Senior Manager, KPGM LLP, and Mr. John Millson, Director, Finance and Operations, re Item #1
7:20 – 7:30 p.m.	Ms. Maria Sánchez-Keane, Principal Consultant, Centre for Organizational Effectiveness, re Item #2
7:30 – 7:40 p.m.	Ms. Margaret MacPherson, Workplace Program Developer, Neighbours, Families & Friends Program, and Ms. Christine Preece, Manager, Young Adult Team, Family Health Services, re Item #4
8:00 – 8:10 p.m.	Mr. Fred Blake, National Representative, Canadian Union of Public Employees (CUPE) re Collective Bargaining
8:30 – 8:45 p.m.	Mr. John Judson, Health Unit Solicitor, Lerners LLP, and Ms. Louise Tyler, Director, Human Resources and Labour Relations, re Item #18

ACTION REQUIRED

1) Report No. 062-11 re 2010 Auditor's Reports and Financial Statements

2) Report No. 063-11 re Strategic Plan – Ten Year Vision and Three Year Strategic Directions

3) Report No. 064-11 re 2011 Healthy Babies Healthy Children Program Budget

4) Report No. 065-11 re Moving Forward to Address Violence Against Women

5) Report No. 066-11 re 50 King Street Air Quality – HVAC Upgrades/Repairs

FOR INFORMATION

6) Report No. 067-11 re Medical Officer of Health Activity Report – June

7) Report No. 068-11 re Volunteer Resources

8) Report No. 069-11 re Cell Phone Use and Cancer

9) Report No. 070-11 re E. Coli Outbreak in Europe

10) Report No. 071-11 re Teen Panel: A Pregnancy Prevention Program

11) Report No. 072-11 re Being Positive About Young Mothers

12) Report No. 073-11 re Click for Babies

13) Report No. 074-11 re Expansion of Publicly Funded Immunization Program

14) Report No. 075-11 re Continuing Education for Board of Health Members

15) Report No. 076-11 re Elevator Repair at 50 King Street – Final Costs

16) Report No. 077-11 re Board of Health Performance Assessment

CONFIDENTIAL

17) The Board of Health will move in camera for the purpose of considering personal matters about an identifiable individual, including Board employees.

18) The Board of Health will remain in camera for the purpose of considering matters concerning labour relations or employee negotiations.

OTHER BUSINESS

Next scheduled Board of Health Meeting – Thursday, September 15, 2011 7:00 p.m.

CORRESPONDENCE RECEIVED

a) Dated 2011 May 5 (received 2011 May 25) A copy of correspondence from Ms. Amanda Rayburn, Chair, Board of Health Wellington Dufferin Guelph, to The Honourable Deb Matthews, Minister of Health and Long-Term Care, urging the Minister to support Bill 31, an Act to prevent skin cancer.

b) Dated 2011 May 26 (received 2011 June 7) Correspondence from The Honourable Chris Bentley, Attorney General and MPP for London West, acknowledging receipt of Board of Health Report No. 036-11 re Call for Action Against Smoking in Movies.

c) Dated 2011 May 30 (received 2011 June 2) A copy of correspondence from Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit, to Ms. Lorraine Fry and Ms. Andrea Kita, Co-chairs, Ontario Coalition for Smoke-Free Movies, advising that the Board of Health of the Grey Bruce Health Unit passed the following motion:

That, the Board of Health support the recommendations from the Ontario Coalition for Smoke-free Movies' aimed at reducing exposure of youth to smoking in movies as referenced by Middlesex London Health Unit and Peterborough County-City Health Unit.

d) Dated 2011 May 30 (received 2011 June 6) A copy of correspondence from Mr. Andy Sharpe, Chair, Board of Health, Peterborough County-City Health Unit, to The Right Honourable Stephen Harper, Prime Minister of Canada, requesting action be taken to remove an infant formula advertisement (Nestle Good Start Laughing Baby television commercial) that is in direct violation of the International Code of Marketing of Breast Milk Substitutes.

e) Dated 2011 May 30 (received 2011 June 6) A copy of correspondence from Mr. Andy Sharpe, Chair, Board of Health, Peterborough County-City Health Unit, to The Honourable Dalton McGuinty, Premier of Ontario, advising of that Board's support of Bill 90, Healthy Decisions for Healthy Eating Act, 2010, which requires food premises owners to display the number of calories for food and drink items sold and served through menu labeling.

f) Dated 2011 May 30 (received 2011 June 6) A copy of correspondence from Mr. Andy Sharpe, Chair, Board of Health, Peterborough County-City Health Unit, to The Honourable Deb Matthews, Minister of Health and Long-Term Care, requesting increasing the eligibility for the human papillomavirus vaccines to include males and females up to age 18 years.

g) Dated 2011 May 30 (received 2011 June 6) A copy of correspondence from Mr. Andy Sharpe, Chair, Board of Health, Peterborough County-City Health Unit, to Mr. Gary Bettman and the Board of Governors, National Hockey League (NHL), endorsing the request by the Middlesex-London Board of Health to effectively eliminate fighting and checks to the head in the NHL.

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

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 062-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

2010 Auditor's Reports and Financial Statements

Recommendation
It is recommended that the Board of Health accept the audited 2010 Financial Statements for the Middlesex-London Health Unit, December 31st (2010) Consolidated Programs as appended to Report No. 062-11.

Attached as Appendix A are draft Consolidated Financial Statements for Health Unit programs with an operating year from January 1, 2010, to December 31, 2010.

The Health Unit auditors KPMG did not require any items to be noted on an Auditor's Management Recommendation Letter for these programs.

A common practice in presenting an Audit Report is for the Auditors to meet in private with a Board of Directors excluding the Chief Executive Officer, Chief Financial Officer and all other staff. While this option has not been exercised in the recent past, Board members should be aware of its existence should they so wish to avail themselves.

Mr. John Millson, Director, Finance and Operations, and Mr. David Arnold from KPMG will be in attendance at the June 16th Board meeting to address any questions regarding this report.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses By-law #2 Banking & Finance, part 7 (d) re annual audit

DRAFT Financial Statements of

MIDDLESEX-LONDON HEALTH UNIT

Year ended December 31, 2010

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Financial Statements
DRAFT
Year ended December 31, 2010

Consolidated Financial Statements

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Financial Statements
DRAFT
Year ended December 31, 2010

Management's Responsibility for the Consolidated Financial Statements

The accompanying consolidated financial statements of the Middlesex-London Health Unit are the responsibility of the Health Unit's management and have been prepared in compliance with legislation, and in accordance with generally accepted accounting principles for local governments established by the Public Sector Accounting Board of The Canadian Institute of Chartered Accountants. A summary of the significant accounting policies are described in Note 1 to the consolidated financial statements. The preparation of financial statements necessarily involves the use of estimates based on management's judgment, particularly when transactions affecting the current accounting period cannot be finalized with certainty until future periods.

The Health Unit's management maintains a system of internal controls designed to provide reasonable assurance that assets are safeguarded, transactions are properly authorized and recorded in compliance with legislative and regulatory requirements, and reliable financial information is available on a timely basis for preparation of the consolidated financial statements. These systems are monitored and evaluated by management.

The Board of Health meets with management and the external auditors to review the consolidated financial statements and discuss any significant financial reporting or internal control matters prior to their approval of the consolidated financial statements.

The consolidated financial statements have been audited by KPMG LLP, independent external auditors appointed by the City of London. The accompanying Auditor's Report outlines their responsibilities, the scope of their examination and their opinion on the Health Unit's consolidated financial statements.

Dr. Graham Pollett, MD,
Medical Officer of Health &
Chief Executive Officer

John Millson, BA, CGA
Director, Finance & Operations

Ms. Patricia L. Coderre, Chair
Board of Health

AUDITORS' REPORT

To the Chair and Members, Middlesex-London Health Unit

We have audited the Statement of Financial Position of Middlesex-London Health Unit as at December 31, 2010 and the statements of operations, change in net debt and cash flows for the year then ended. These financial statements are the responsibility of Management. Our responsibility is to express an opinion on these financial statements based on our audit.

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

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Middlesex-London Health Unit as at December 31, 2010 and the results of its operations for the year then ended in accordance with generally accepted accounting principles.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements of the Middlesex-London Health Unit taken as a whole. The 2010 budget information included in the statement of operations is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such supplementary information has not been subjected to the auditing in the audit of the basic financial statements.

Chartered Accountants, Licensed Public Accountants

London, Canada

March, 2010

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Financial Position
DRAFT
December 31, 2010, with comparative figures for 2009

	2010	2009
Financial Assets		
Cash	$ 4,691,586	$ 3,797,782
Accounts receivable	412,781	236,012
Grants receivable	393,357	2,051,936
	$ 5,497,724	$ 6,085,730
Financial Liabilities		
Province of Ontario	$ 1,293,704	$ 1,501,418
Government of Canada	29,496	0
The City of London	347,255	988,282
The County of Middlesex	65,397	140,625
Accounts payable and accrued liabilities	1,744,978	1,621,199
Accrued wages and benefits	984,055	1,120,472
Vested sick leave liability (note 4)	407,903	448,916
Vested post-employment benefits liability (note 4)	1,656,300	1,643,300
	6,529,088	7,464,212
Net debt	(1,031,364)	(1,378,482)
Non-Financial Assets		
Tangible capital assets (note 8)	3,788,917	3,822,066
Prepaid expenses	36,528	173,352
	3,825,445	3,995,418
Commitments (note 3)		
Contingencies (note 10)		
Accumulated Surplus	$ 2,794,081	$ 2,616,936

The accompanying notes are an integral part of these consolidated financial statements.

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Operations

DRAFT

Year ended December 31, 2010, with comparative figures for 2009

	Budget	2010	2009
	(unaudited)		
Revenue:			
Grants:			
Ministry of Health and Long-Term Care	$ 9,689,537	$ 10,116,926	$ 12,156,217
Ministry of Health Promotion	7,740,702	7,938,859	7,769,817
Ministry of Children & Youth Services	5,520,898	5,217,325	4,815,414
Federal Government	152,430	134,715	184,014
The City of London	6,195,059	5,851,722	5,582,214
The County of Middlesex	1,180,011	1,114,614	1,063,279
	30,478,637	30,374,161	31,570,955
Other:			
Property search fees	3,750	2,865	3,182
Family planning	285,000	348,539	307,667
Dental service fees	296,823	240,692	256,143
Investment income	5,000	8,120	4,676
Prenatal class income	35,000	31,585	38,022
Other income	581,709	659,676	575,396
	1,207,282	1,291,477	1,185,086
Total Revenue	31,685,919	31,665,638	32,756,041
Expenditures:			
Salaries:			
Medical Officers of Health	548,940	541,984	509,715
Public Health Nurses	8,512,372	8,244,698	8,515,902
Public Health Inspectors	2,267,869	2,117,743	2,075,232
Administrative staff	3,001,510	2,978,005	2,699,664
Dental staff	805,200	766,783	747,648
Other salaries	3,853,280	3,655,027	4,461,343
	18,989,171	18,304,240	19,009,504
Other Operating:			
Benefits (note 4)	4,270,286	4,220,660	4,374,750
Travel	524,178	419,494	458,309
Materials & supplies	1,070,724	1,299,847	1,125,725
Professional services	3,079,595	3,200,370	3,676,711
Rent & maintenance	1,498,628	1,543,214	1,552,625
Amortization expense	406,258	745,053	728,782
Other expenses (Note 6)	1,847,079	1,809,078	1,759,121
	12,696,748	13,237,716	13,676,023
Total Expenditures	31,685,919	31,541,956	32,685,527
Annual surplus		123,682	70,514
Accumulated surplus, beginning of year		2,616,936	2,546,422
Accumulated surplus, end of year		$ 2,740,618	$ 2,616,936

The accompanying notes are an integral part of these consolidated financial statements.

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Change in Net Debt

DRAFT

Year ended December 31, 2010, with comparative figures for 2009

	2010	2009
Annual surplus	$ 123,682	$ 70,514
Acquisition of tangible capital assets	(711,905)	(861,683)
Amortization of tangible capital assets	745,053	728,782
	210,293	(62,387)
Acquisition of prepaid expenses	(36,528)	(173,352)
Use of prepaid expenses	173,352	176,317
Change in net debt	347,117	(59,422)
Net debt, beginning of year	(1,378,482)	(1,319,060)
Net debt, end of year	$ (1,031,365)	$ (1,378,482)

The accompanying notes are an integral part of these consolidated financial statements.

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Cash Flows

DRAFT

December 31, 2010, with comparative figures for 2009

	2010	2009
Cash provided by (used in):		
Operating activities:		
Annual surplus	$ 123,682	$ 70,514
Items not involving cash:		
Amortization	745,053	728,782
Change in employee benefits and other liabilities	(28,013)	22,989
Change in non-cash assets and liabilities:		
Accounts receivable	(176,769)	33,622
Grants receivable	1,658,579	(1,773,667)
Prepaid expenses	136,824	2,965
Due to Province of Ontario	(207,714)	351,722
Due to Government of Canada	29,496	
Due to The City of London	(641,027)	612,845
Due to The County of Middlesex	(75,228)	116,732
Accounts payable and accrued liabilities	123,779	(771,776)
Accrued wages and benefits	(136,417)	386,363
Net change in cash from operating activities	1,605,708	(218,909)
Capital activities:		
Cash used to acquire tangible capital assets	(711,905)	(861,683)
Net change in cash from capital activities	(711,905)	(861,683)
Net change in cash	893,803	(1,080,592)
Cash, beginning of year	3,797,782	4,878,374
Cash, end of year	$ 4,691,585	$ 3,797,782

The accompanying notes are an integral part of these consolidated financial statements.

The Middlesex-London Health Unit is a joint local board of the municipalities of The City of London and the County of Middlesex that was created on January 1, 1972. The Middlesex-London Health Unit provides programs which promote healthy and active living throughout the participating municipalities.

1. Significant accounting policies:

The consolidated financial statements of the Middlesex-London Health Unit are prepared by management in accordance with Canadian generally accepted accounting principles for governments as recommended by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants. Significant accounting policies adopted by the Middlesex-London Health Unit are as follows:

(a) Basis of consolidation:

The consolidated financial statements reflect the assets, liabilities, revenue and expenditures of the reporting entity. The reporting entity is comprised of all programs funded by the Province of Ontario, the City of London, and the County of Middlesex. It also includes other programs that the Board of Health may offer from time to time with special grants and/or donations from other sources

Inter-departmental and inter-organizational transactions and balances between entities and organizations have been eliminated.

(b) Basis of accounting:

Sources of financing and expenditures are reported on the accrual basis of accounting with the exception of donations, which are included in the statement of operations as received.

The accrual basis of accounting recognizes revenues as they become available and measurable; expenditures are recognized as they are incurred and measurable as a result of receipt of services and the creation of a legal obligation to pay.

The operations of the Middlesex-London Health Unit are funded by the Province of Ontario, The City of London and the County of Middlesex. Funding amounts not received at year end are recorded as receivable. Funding amounts in excess of actual expenditures incurred, during the year, are repayable and are reflected as liabilities.

1. Significant accounting policies (continued):

(c) Employee future benefits:

(i) The Middlesex-London Health Unit provides certain employee benefits which will require funding in future periods. These benefits include sick leave, life insurance, extended health and dental benefits for early retirees.

The cost of sick leave, life insurance, extended health and dental benefits are actuarially determined using management's best estimate of salary escalation, accumulated sick days at retirement, insurance and health care cost trends, long term inflation rates and discount rates.

(ii) The cost of multi-employer defined contribution pension plan benefits, namely the Ontario Municipal Employees Retirement System (OMERS) pensions, are the employer's contributions due to the plan in the period. As this is a multi-employer plan, no liability is recorded on the Middlesex-London Health Unit's general ledger.

(d) Non-financial assets:

Non financial assets are not available to discharge existing liabilities and are held for use in the provision of services. They have useful lives extended beyond the current year and are not intended for sale in the ordinary course of operations.

(i) Tangible Capital Assets

Tangible capital assets are recorded at cost which includes amounts that are directly attributed to acquisition, construction, development or betterment of the asset. The cost, less residual value, of the tangible capital assets, excluding land, are amortized on a straight line basis over the estimated useful lives as follows:

Asset	**Useful Life - Years**
Leasehold Improvements	5 -15
Computer Systems	4
Motor Vehicles	5
Furniture	7

1. Significant accounting policies (continued):

Assets under construction are not amortized until the asset is available for productive use.

(ii) Contributions of tangible capital assets

Tangible capital assets received as contributions are recorded at their fair market value at the date of receipt and also are recorded as revenue.

(iii)Leased tangible capital assets

Leases which transfer substantially all of the benefits and risks incidental to ownership of property are accounted for as leased tangible capital assets. All other leases are accounted for as operating leases and the related payment are charged to expense as incurred.

(e) Use of estimates:

The preparation of the Middlesex-London Health Unit's financial statements requires management to make estimates and assumptions that affect the reporting amounts of assets and liabilities, and disclosures of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the period. Significant estimates include assumptions used in estimating provisions for accrued liabilities, and in performing actuarial valuations of employee future benefits.

In addition, the Middlesex-London Health Unit’s implementation of the Public Sector Accounting Handbook PS3150 has required management to make estimates of the useful lives of tangible capital assets.

Actual results could differ from these estimates.

2. Commitments:

The Middlesex-London Health Unit is committed under operating leases for rental property.

Future minimum payments to expiry are as follows:

2011	$ 1,276,570
2012	1,302,102
2013	1,328,144
2014	1,354,707
2015	1,381,801

3. Employee future benefits liability:

The Middlesex-London Health Unit provides certain employee benefits which will require funding in future periods. They are:

(i) Vested post-retirement benefits liability:

The Middlesex-London Health Unit pays certain life insurance benefits on behalf of the retired employees as well as extended health and dental benefits for early retirees to age sixty-five. The Middlesex-London Health Unit recognizes these post-retirement costs in the period in which the employees rendered the services. The most recent actuarial valuation was performed as at December 31, 2008.

	2010	2009
Accrued employee future benefit obligations	$ 1,656,300	$ 1,643,300
Employee future benefits liability as of December 31	$ 1,656,300	$ 1,643,300

Retirement and other employee future benefit expenses included in total expenditures consist of the following:

	2010	2009
Current year benefit cost	$ 91,400	$ 82,900
Interest on accrued benefit obligation	79,300	75,000
Total benefit cost	$ 170,700	$ 157,900

Benefits paid during the year were $ 152,500 (2009 - $136,500).

3. Employee future benefits liability (continued):

The main actuarial assumptions employed for the valuations are as follows:

(a) Interest (discount rate):

The obligation as at December 31, 2010, of the present value of future liabilities and the expense for the year ended December 31, 2010, were determined using a discount rate of 5%.

(b) Medical costs:

Medical costs were assumed to increase at the rate of 11% per year reducing by 1% a year until an ultimate rate of 5% per year in 2014.

(c) Dental costs:

Dental costs were assumed to increase at the rate of 4% per year.

(ii) Vested sick leave liability:

Under the sick leave benefit plan, unused sick leave can accumulate and employees may become entitled to a cash payment when they leave the Middlesex-London Health Unit's employment. This plan applies to employees hired prior to January 1, 1982.

The liability for these accumulated days, to the extent that they have vested and could be taken in cash by an employee on termination, amounted to approximately $ 407,903 (2009 - $448,916) at the end of the year.

A reserve of $ 548,361 has been established to meet future commitments for this liability.

4. Pension agreement:

The Middlesex-London Health Unit contributes to the Ontario Municipal Employees Retirement Fund (OMERS) which is a multi-employer plan, on behalf of approximately 280 members of its staff. The plan is a defined benefit plan which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay.

For 2010, the plan required employers to contribute 6.4% of employee earnings below the year's maximum pensionable earnings and 9.7% thereafter. The Health Unit contributed $1,169,296 (2009 - $1,136,745) to the OMERS pension plan on behalf of its employees during the year ended December 31, 2010.

5. Other expenses:

The following are sub-categories for other expenses. They are consolidated for presentation purposes.

	2010 Budget	2010 Actual	2009 Actual
	(unaudited)		
Communications	$ 209,358	$ 193,713	$ 201,050
Health promotion/advertising	376,301	521,186	561,391
Miscellaneous expenses	716,162	649,673	521,477
Postage and courier	73,900	81,971	79,036
Printing	276,462	219,370	287,410
Staff development	194,896	143,165	108,757
	$ 1,847,079	$1,809,078	$ 1,759,121

6. Prepaid leave trust funds:

The Prepaid Leave Plan is a self-funded program for participating employees. A portion of the employees' salary is held in trust to be paid in the year of leave. The employees are credited with interest income from the trust funds annually, prior to the year end. The balance of the Prepaid Leave Plan at December 31, 2010 is $92,811, (2009 - $92,811). These amounts have not been included in the Consolidated Statement of Financial position nor have their operations been included in the Consolidated Statement of Operations.

7. Tangible Capital Assets:

Cost	Balance at December 31, 2009 (note 2)	Additions	Disposals	Balance at December 31, 2010
Leasehold Improvements – 15 yrs	$ 2,125,222	$ 70,820	$ -	$ 2,196,042
Leasehold Improvements – 5 yrs	101,802	49,625	-	151,427
Computer Systems	2,025,450	218,470	(677,971)	1,565,949
Motor Vehicles	35,014	-	-	35,014
Furniture & Equipment	2,512,138	372,990	(699,282)	2,185,846
Total	$ 6,799,626	$ 711,905	$ (1,377,253)	$ 6,134,278

Accumulated amortization	Balance at December 31, 2009 (note 2)	Disposals	Amortization expense	Balance at December 31, 2010
Leasehold Improvements – 15 yrs	$ 250,661	$ -	$ 144,042	$ 394,703
Leasehold Improvements – 5 yrs	16,524	-	25,323	41,847
Computer Systems	1,272,088	(677,971)	288,307	882,424
Motor Vehicles	24,510	-	7,003	31,513
Furniture & Equipment	1,413,777	(699,282)	280,378	994,873
Total	$ 2,977,560	$ (1,377,253)	$ 745,053	$ 2,345,360

	Net book value December 31, 2009	Net book value December 31, 2010
Leasehold Improvements – 15 yrs	$ 1,874,561	$ 1,801,339
Leasehold Improvements – 5 yrs	85,278	109,580
Computer Systems	753,362	683,525
Motor Vehicles	10,504	3,501
Furniture & Equipment	1,098,361	1,190,973
Total	$ 3,822,066	$ 3,788,918

7. Tangible Capital Assets (continued):

Cost	Balance at December 31, 2008 (note 2)	Additions	Disposals	Balance at December 31, 2009
Leasehold Improvements – 15 yrs	$ 2,017,260	$ 107,962	$ -	$ 2,125,222
Leasehold Improvements – 5 yrs	31,715	70,087	-	101,802
Computer Systems	1,573,965	451,485	-	2,025,450
Motor Vehicles	35,014	-	-	35,014
Furniture & Equipment	2,279,989	232,149	-	2,512,138
Total	$ 5,937,943	$ 861,683	$ -	$ 6,799,626

Accumulated amortization	Balance at December 31, 2008 (note 2)	Disposals	Amortization expense	Balance at December 31, 2009
Leasehold Improvements – 15 yrs	$ 112,578	$ -	$ 138,083	$ 250,661
Leasehold Improvements – 5 yrs	3,172	-	13,352	16,524
Computer Systems	968,074	-	304,014	1,272,088
Motor Vehicles	17,507	-	7,003	24,510
Furniture & Equipment	1,147,447	-	266,330	1,413,777
Total	$ 2,371,920	$ -	$ 728,782	$ 2,977,560

	Net book value December 31, 2008	Net book value December 31, 2009
Leasehold Improvements – 15 yrs	$ 1,904,682	$ 1,874,561
Leasehold Improvements – 5 yrs	28,543	85,278
Computer Systems	605,891	753,362
Motor Vehicles	17,507	10,504
Furniture & Equipment	1,132,542	1,098,361
Total	$ 3,689,165	$ 3,822,066

8. Accumulated Surplus:

Accumulated surplus consists of individual fund surplus and reserves as follows:

	2010	2009
Surpluses:		
Invested in tangible capital assets	$ 3,788,918	$ 3,822,066
Unfunded:		
Sick leave benefits	(407,903)	(448,916)
Post-employment benefits	(1,656,300)	(1,643,300)
Total Surplus	1,724,714	1,729,850
Reserves set aside by the Board:		
Accumulated sick leave	548,361	597,059
Funding stabilization	317,410	67,410
Environmental – septic tank	6,044	6,044
Dental Treatment reserve	197,552	216,573
Total reserves	1,069,367	887,086
Accumulated surplus	$ 2,794,081	$ 2,616,936

9. Contingent liabilities:

From time to time, the Health Unit is subject to claims and other lawsuits that arise in the ordinary course of business, some of which may seek damages in substantial amounts. These claims may be covered by the Health Unit's insurance. Liability for these claims and lawsuits are recorded to the extent that the probability of a loss is likely and it is estimable.

10. Budget data:

The unaudited budget data presented in these consolidated financial statements is based upon the 2010 operating budgets approved by the Board of Health on **October 16, 2008**. Amortization was not contemplated on development of the budget and, as such, has not been included. The chart below reconciles the approved budget to the budget figures reported in these consolidated financial statements

Revenues:		
Operating budget	$	31,650,801
Expenses:		
Operating budget		31,146,007
Capital budget		504,794
Total Expenses		31,650,801
Annual surplus, as budgeted		-
Amortization		728,782
Capital Expenditures		(861,683)
Annual surplus		132,901

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 063-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Strategic Plan - Ten Year Vision and Three Year Strategic Directions

Recommendation
It is recommended that the Board of Health approve the Strategic Plan – Ten Year Vision and Three Year Strategic Directions attached as Appendix A to Report No. 063-11.

For over a year, the Board of Health and staff have been involved in a comprehensive strategic planning process. This has included extensive consultation with clients, staff and members of the Board of Health. It has been facilitated throughout by Ms. Maria Sánchez-Keane, Principal Consultant, Centre for Organizational Effectiveness. Regular updates have been provided through reports and presentations at previous Board meetings.

Attached as Appendix A is the outcome of these many activities – a Ten Year Vision and Three Year Strategic Directions statement. This document will provide the focus for the Board of Health and staff in the provision of public heath programs and services for the time periods specified. It incorporates the input of the many participants and is consistent with the Board of Health mandate as defined by the Health Protection and Promotion Act and its Ontario Public Health Standards.

Ms. Sánchez-Keane will be in attendance at the June 16th Board of Health meeting to summarize the strategic planning process to date and highlight next steps for the implementation of the Ten Year Vision and Three Year Strategic Directions.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

Middlesex London Health Unit
Strategic Planning
Ten Year Vision & Three Year Strategic Directions

Ten Year Vision

We are Public Health - we focus on preventing illness and injury, promoting and protecting health and improving quality of life.

We serve our diverse and ever changing community, ensuring accessibility to all. We reach out to our Middlesex-London community both physically and virtually. We provide our services where people live, learn, work and play.

Together with our partners, we are a vital part of the community, trusted to provide credible and reliable public health information, programs and services.

We are an integrated public health team committed to providing service excellence through client-centred, & evidence-informed practice; innovation; and collaboration.

Our workplace culture is marked by effective leadership, mutual trust, respect, transparency, professionalism and personal well being.

We have ample human, physical, technological and financial resources; and are accountable for effective use of these resources.

We share a common vision, each of us contributing our expertise toward enabling the people of Middlesex-London to reach optimal health!

Three Year Strategic Directions

Your Health is Your Wealth

Improved Health Outcomes:

The Public Health Standards will continue to be met and monitored within the context of the accountability framework. In addition to this work, special emphasis will be placed on the following:

- Improve health outcomes by enhancing service delivery through collaborative comprehensive, integrated strategies in Middlesex-London in the areas of:
    - Healthy eating, and physical activity for all
    - Reducing health inequities

[Strategies must: be integrated, expand what we do, have a virtual component, serve Middlesex-London, provide excellent health information to staff and partners, contain an outcomes and evaluation plan,

Organizational Health and Vitality

- Continually enhance internal collaboration
- Foster effective internal communication and decision-making processes and practices
- Enhance Health Unit leadership at all levels

Infrastructure

To support the work of better health outcomes:

- Enhance the capacity of the Health Unit to inform and respond to its communities through the application of communications strategies (enhanced online presence, marketing)
- Enable the delivery of the Health Unit's services through the use of current and emerging technologies

- Develop a Facilities Plan to address the needs of the HU and the growing, ever changing community it serves

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 064-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

2011 Healthy Babies Healthy Children Program Budget

Recommendation

It is recommended that the Board of Health approve the 2011 Healthy Babies Healthy Children Program Budget in the amount of $2,776,356 as attached as Appendix A to Report No. 064-11.

Background

The Healthy Babies Healthy Children (HBHC) Program focuses on children from birth to age six (6) years with the intent of providing children the best start in life. Initially, the responsibility of the Ministry of Health and Long-Term Care, the program was transferred to the Ministry of Children and Youth Services (MCYS) upon creation of the latter Ministry. Each year in Middlesex-London, approximately 5,000 babies are born. About 90% of those families receive a phone call and/or a home visit from a public health nurse (PHN) who provides assessment, information, counseling and referral to appropriate community resources. Twenty five percent of families receive in-depth assessment as hospital screening prior to discharge indicates the families are at risk. A proportion of these vulnerable families are offered ongoing nursing and mentoring services.

The HBHC Program is often referred to as being 100% funded by the MCYS. However, the province does not allow any of its funding to be applied to administrative costs including rent, administration, human resource support, financial support, communication support, etc. The funding for the HBHC Program has been further frustrated from a Board of Health perspective in that past funding increases on the part of the province have failed to keep pace with those program costs for which the funding can be applied (e.g., staffing costs). Consequently, the budget for the HBHC Program has been substantially supported by the cost shared program budget even though there is no specific allocation in the latter budget for this purpose.

2011 Budget

As in past practice, the MYCS requests Health Units across the province to submit a Request for Funding Schedule for the HBHC Program based on a “preliminary” allocation. The completed Request Form is attached as Appendix A. The accompanying Service Planning Schedule which looks at last year’s service indicators, projected service level outcomes for 2011 and actual service level indicators for 2010 is attached as Appendix B.

The Health Unit’s preliminary allocation has been reduced by $50,000 from 2010, which represents only 6 months of direct funding for the pilot project for social work services. The remaining six (6) months will come from the base funding. The 2011 grant also includes $343,043 in one-time funding to assist the province in the implementation of the NCAST program (parenting resources). Health Unit staff members have taken a leadership role in this training and development of HBHC staff across the province.

Meeting the Preliminary Budget

In order to meet the grant allocation, a number of budget readjustments have been made. The complement of Family Home Visitor (FHV) positions has been decreased by 1 full time equivalent (FTE) to accommodate for the full year cost of the social worker position. These changes were approved by the Board of Health at the May meeting. The remaining staff complement is as follows: 11.5 PHNs, 11.5 FHVs, 3 program assistants, 1 social worker and 2.5 program managers. Benefit cost increases, primarily pension costs, have been accommodated as a result of budget savings due to the Restraint Act.

Operating costs were not significantly impacted as these resources had been greatly decreased in previous years. In the past, one-time funding was received to offset pressures in other operating costs, however, at present, no additional funding is anticipated for this operating year.

Summary

The HBHC budget allocation for 2011 takes into account staffing changes to accommodate a full-time social worker position and pension cost increases. The remainder of the program costs remain relatively unchanged due to the impact of the Restraint Act on salary and wage costs.

This report was prepared by Ms. Diane Bewick, Director, Family Health Services and Mr. John Millson, Director, Finance and Operations.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses Policy No. 4-10, (Budget Preparation and Approval) as outlined in the MLHU Administration Policy Manual.

Healthy Babies Healthy Children
Early Learning and Child Development Branch
Strategic Policy and Planning Division
Ministry of Children and Youth Services
2011 Request for Funding Schedule
January 1, 2011 - December 31, 2011

Public Health Unit: Middlesex-London Health Unit

	Previous Year Approved FTE	Previous Year Approved Budget	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
Salaries & Wages: Staff	29.0	1,849,513	29.0	1,814,067	28.5	1,794,250	-
Employee Benefits		423,261		412,810		437,816	-
Employee Benefits as % of S&W Staff		22.9%		22.8%		24.4%	0.0%
Contracted Services	1.0	65,478	1.0	58,461	0.5	38,903	-
Operating Costs		145,061		145,066		162,344	-
TOTAL REQUEST	30.0	2,483,313	30.0	2,430,404	29.0	2,433,313	-
One-Time Grant Request	-	-	-	-	-	343,043	
GRAND TOTAL	30.0	2,483,313	30.0	2,430,404	29.0	2,776,356	-

Public Health Unit: Middlesex-London Health Unit

	Previous Year Approved FTE	Previous Year Approved Request	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
1. Salaries & Wages							
Management	2.5	233,343	2.5	234,241	2.5	233,343	
Public Health Nurses	11.5	882,828	11.5	871,268	11.5	843,703	
Lay Home Visitors	12.5	620,119	12.5	598,792	11.5	558,147	
Social Workers					0.5	48,325	
Administration: Program Support	1.5	67,934	1.5	65,304	1.5	66,439	
Administration: ISCIS Data Entry Support	1.0	45,289	1.0	44,463	1.0	44,293	
Administration: ISCIS Release Support							
Other Professional (specify)							
Other Non-Professional (specify)							
Total Salaries & Wages	29.0	1,849,513	29.0	1,814,067	28.5	1,794,250	-
Employee Benefits		423,261		412,810		437,816	
2. Contract Services							
Other Professional - Social Worker	1.0	53,623	1.0	45,454	0.5	26,812	
Other Non-Professional - Translation		11,855		13,007		12,091	
Lay Home Visitors							
Administration: ISCIS Release Support							
Total Contract Services	1.0	65,478	1.0	58,461	0.5	38,903	-
3. Operating Costs							
Office Supplies		17,936		22,861		17,700	
Office Equipment		425		2,529		425	
Professional Development &Training		9,700		7,235		22,724	
Travel		70,000		58,186		70,000	
Public Awareness/Promotion		2,000		1,533		2,000	
Program Resources		9,300		14,396		13,795	
Computer costs for ISCIS		30,000		30,000		30,000	
Audit		3,700		3,362		3,700	
Other - Client Travel		2,000		4,966		2,000	
Total Operating Costs		145,061		145,066		162,344	-
Total Request from MCYS (1+2+3+EB)	30.0	2,483,313	30.0	2,430,403	29.0	2,433,313	-
4. One-Time Grant Request							
Validation Exercise						12,500	
NCAST training materials						80,000	
Support of province-wide training						250,543	
Total	30.0	2,483,313	30.0	2,430,403	29.0	2,776,356	-

Authorized by Chair Board of Health, CEO or Medical Officer of Health

Signature: _____

Name: _____

Date: _____

Healthy Babies Healthy Children
Early Learning and Child Development Branch
Strategic Policy and Planning Division
Ministry of Children and Youth Services
Service Planning Schedule, January 1 - December 31, 2011

Public Health Unit: Middlesex-London Health Unit

			Previous Year Projection and Achievement (January 2010 - December 2010)				
	Indicator	**IRSS Monitoring Report Indicator (Item #)**	**Public Health Unit Projected Achievement**		**Public Health Unit Actual Achievement**		**Explanation of Variance***
			Number	**Percent**	**Number**	**Percent**	
A. Screening and Assessment							
Prenatal Screening	25% of women screened using a Larson	Number: **Item #2** Percent: **Item #2** divided by **Item # 6**	2,727	59.0%	1,852	40.0%	
Screening at Birth	100% of births are screened with a Parkyn	Number: **Item #9** Percent: **Item #9** divided by **Item # 4 + #5**	3,893	82.5%	3,457	72.5%	Hospitals are not completing screen for every new birth due to workload challenges (specifically the merge of 2 hospitals)
Postpartum Contact	100% of families will be contacted within 48 hours of hospital discharge	Number: **Item #21.1** Percent: **Item #21.1** divided by **Item #20**	3,123	81.0%	3,224	94.0%	
Brief Assessment	Number of Families who had a Brief Assessment	Number: **Item #15**	3,350		2,801		
Postpartum Home Visit	75% of families will receive a postpartum home visit	Number: **Item #25** Percent: **Item #25** divided by **Item #20**	1,859	48.0%	1,287	38.0%	Reduction in PPHV related to reduced Parkyns. Low risk new moms are offered a visit by a PHN in the community site and so decline if it is felt to not be necessary
In-Depth Assessment	12% of families will have a completed In-depth Assessment	Number: **Item #18** Percent: **Item #18** divided by **Item #6**	497	11.0%	435	9.0%	
Home Visiting	100% of families in home visiting have a high risk rating on the In Depth Assessment	Number: **Item #28** Percent: **Item #28** divided by **Item #18.1**	410	93.0%	375	96.0%	
	Number of family visits performed by a LHV	Number: **Item #33.1**	3,135		3,207		
	Number of family visits performed by a PHN	Number: **Item #33.2**	2,006		2,125		
	Number of family visits performed jointly by a PHN and LHV	Number: **Item #33.3**	749		796		

* If the actual achievement varies by more than ±10% of what was projected an explanation must be provided to the Ministry.

Public Health Unit: Middlesex-London Health Unit

Actual Live Births (estimated)		
# of Direct Service Hours per FTE	PHN	1,258
# of Direct Service Hours per FTE	LHV	1,252
# of Direct Service Hours per FTE	SW	1,350

***The hours are calculated from the template provided below on page 3**

	Indicator	IRSS Monitoring Report Indicator (Item #)	2011 Projections						
			Public Health Unit Projected Achievement		FTE Requirements				
			Number	Percent	PHN	LHV	SW	Other Professional	Total FTE
A. Screening and Assessment									
Prenatal Screening	25% of women screened using a Larson	Number: **Item #2** Percent: **Item #2** divided by **Item # 6**	2727	59.0%	1.1				1.1
Screening at Birth	100% of births are screened with a Parkyn	Number: **Item #9** Percent: **Item #9** divided by **Item # 4 + #5**	4765	100.0%					-
Postpartum Contact	100% of families will be contacted within 48 hours of hospital discharge	Number: **Item #21.1** Percent: **Item #21.1** divided by **Item #20**	3424	100.0%	1.2				1.2
Brief Assessment	Number of Families who had a Brief Assessment	Number: **Item #15**	2801						-
Postpartum Home Visit	75% of families will receive a postpartum home visit	Number: **Item #25** Percent: **Item #25** divided by **Item #20**	1287	37.6%	3.7				3.7
In-Depth Assessment	12% of families will have a completed In-depth Assessment	Number: **Item #18** Percent: **Item #18** divided by **Item #6**	435	9.0%	1.4				1.4
Home Visiting	100% of families in home visiting have a high risk rating on the In Depth Assessment	Number: **Item #28** Percent: **Item #28** divided by **Item #18.1**	375	96.0%					-
	100% of families receiving High Risk Home Visiting have completed Family Service Plans in ISCIS	Number: **Item #47** Percent: **Item #47** divided by **Items #46 + #47**	375	100.0%					-
	Number of family visits performed by a LHV	Number: **Item #33.1**	3207			7.8			7.8
	Number of family visits performed by a PHN	Number: **Item #33.2**	2125		5.6				5.6
	Number of family visits performed jointly by a PHN and LHV	Number: **Item #33.3**	796						-
	Number of family visits performed by a SW	Number: **Item #33.5**	300						-
Total FTE Requirements					13.0	7.8	-	-	20.8

Public Health Unit: _____

	Indicator	Public Health Unit Projected Achievement Yes/No
Electronic Documentation in ISCIS	Do you do remote entry of ISCIS data?	no
	Does your Health Unit complete all documentation electronically? (electronic charting)	yes

Template used to calculate the number of Direct Service Hours per Public Health Nurses (PHN), Lay Home Visitors (LHV) and Social workers (SW).

Public Health Nurse (PHN) Full time hours available = 52 weeks * 35 hours = 1,820 hours	
Less:	Hours
Vacation	140
Stat/Region Holidays	84
Estimated illness/down time	35
Mentoring time	35
Team meetings	72
Supervisory meetings	12
Training	70
Other (breaks, etc.)	114
Subtotal	562
Total Direct Service Hours	1,258

Activity	Benchmark (hours)
Prenatal Screening	0.5
Postpartum Phone Call	0.5
Postpartum Home Visit	2.5
In-Depth Assessment	3.5
Home Visiting	
PHNs	3.5
LHVs and SWs	2.5

Lay Home Visitor (LHV) Full time hours available = 52 weeks * 35 hours = 1,820 hours	
Less:	Hours
Vacation	140
Stat/Region Holidays	84
Estimated illness/down time	84
Mentoring time	27
Team meetings	72
Supervisory meetings	12
Training	35
Other (breaks, etc.)	114
Subtotal	568
Total Direct Service Hours	1,252

Social Worker (SW) Full time hours available = 52 weeks * 35 hours = 1,820 hours	
Less:	Hours
Vacation	140
Stat/Region Holidays	83
Estimated illness/down time	28
Mentoring time	-
Team meetings	72
Supervisory meetings	12
Training	21
Other (breaks, etc.)	114
Subtotal	470
Total Direct Service Hours	1,350

Public Health Unit: Middlesex-London Health U

Achievements for 2010

Births - Items #4 plus #5				
Total FTE Hours	**Benchmark (provided by HU)**	**Total # of FTE from 2010 Actual Expenditures**	**Total Actual Hours Available for Service**	**Total FTE required**
PHN	1,258		-	
LHVs	1,252		-	
Schedule B	**Benchmark Hours**	**Service Units from Schedule B**	**Total Hours Required for Service Units**	**Total FTE required**
Prenatal Screening (Item #2)	0.5	2,727	1,363.5	1.1
Postpartum Contact (Item #21.1)	0.5	3,123	1,561.5	1.2
Postpartum Home Visits (Item #25)	2.5	1,859	4,647.5	3.7
In Depth Assessments (Item #18)	3.5	497	1,739.5	1.4
Home Visiting				
PHN (Item #33.2)	3.5	2,006	7,021.0	5.6
LHV* (Item #33.1 + Item #33.3)	2.5	3,884	9,710.0	7.8
Total Hours				
PHN			16,333.0	-
LHV*			9,710.0	-
Total FTE				
PHN			13.0	
LHV			7.8	

* LHV includes joint visits.

Projections for 2011

Births - Items #4 plus #5	-			
Total FTE Hours	**Benchmark (provided by HU)**	**Total # of FTE from 2011 Request for Funding Schedule**	**Total Actual Hours Available for Service**	**Total FTE required**
PHN	1,258	11.5	14,467	
LHVs	1,252	11.5	14,398	
SWs	1,350	1.0	1,350	
Schedule B	**Benchmark Hours**	**Service Units from Schedule B**	**Total Hours Required for Service Units**	**Total FTE required**
Prenatal Screening (Item #2)	0.5	2,727	1,363.5	1.1
Postpartum Contact (Item #21.1)	0.5	3,424	1,712.0	1.4
Postpartum Home Visits (Item #25)	2.5	1,287	3,217.5	2.6
In Depth Assessments (Item #18)	3.5	435	1,522.5	1.2
Home Visiting			-	
PHN (Item #33.2)	3.5	2,125	7,437.5	5.9
LHV* (Item #33.1 + Item #33.3)	2.5	4,003	10,007.5	8.0
SW (Item #33.5)	2.5	300	750.0	0.6
Total Hours				
PHN			15,253.0	-
LHV*			10,007.5	-
SW			750.0	-
Total FTE				
PHN			12.1	
LHV			8.0	
SW			0.6	

* LHV includes joint visits.

Public Health Unit: Middlesex-London Health U

Achievements for 2010

Births - Items #4 plus #5				
Total FTE Hours	**Benchmark (provided by HU)**	**Total # of FTE from 2010 Actual Expenditures**	**Total Actual Hours Available for Service**	**Total FTE required**
PHN	1,258		-	
LHVs	1,252		-	
Schedule B	**Benchmark Hours**	**Service Units from Schedule B**	**Total Hours Required for Service Units**	**Total FTE required**
Prenatal Screening (Item #2)	0.5	2,727	1,363.5	1.1
Postpartum Contact (Item #21.1)	0.5	3,123	1,561.5	1.2
Postpartum Home Visits (Item #25)	2.5	1,859	4,647.5	3.7
In Depth Assessments (Item #18)	3.5	497	1,739.5	1.4
Home Visiting				
PHN (Item #33.2)	3.5	2,006	7,021.0	5.6
LHV* (Item #33.1 + Item #33.3)	2.5	3,884	9,710.0	7.8
Total Hours				
PHN			16,333.0	-
LHV*			9,710.0	-
Total FTE				
PHN			13.0	
LHV			7.8	

* LHV includes joint visits.

Projections for 2011

Births - Items #4 plus #5	-			
Total FTE Hours	**Benchmark (provided by HU)**	**Total # of FTE from 2011 Request for Funding Schedule**	**Total Actual Hours Available for Service**	**Total FTE required**
PHN	1,258	11.5	14,467	
LHVs	1,252	11.5	14,398	
SWs	1,350	1.0	1,350	
Schedule B	**Benchmark Hours**	**Service Units from Schedule B**	**Total Hours Required for Service Units**	**Total FTE required**
Prenatal Screening (Item #2)	0.5	2,727	1,363.5	1.1
Postpartum Contact (Item #21.1)	0.5	3,424	1,712.0	1.4
Postpartum Home Visits (Item #25)	2.5	1,287	3,217.5	2.6
In Depth Assessments (Item #18)	3.5	435	1,522.5	1.2
Home Visiting			-	
PHN (Item #33.2)	3.5	2,125	7,437.5	5.9
LHV* (Item #33.1 + Item #33.3)	2.5	4,003	10,007.5	8.0
SW (Item #33.5)	2.5	300	750.0	0.6
Total Hours				
PHN			15,253.0	-
LHV*			10,007.5	-
SW			750.0	-
Total FTE				
PHN			12.1	
LHV			8.0	
SW			0.6	

* LHV includes joint visits.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 065-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Moving Forward to Address Violence Against Women

Recommendation
It is recommended that the Board of Health endorse the plan presented in Appendix A to Report No. 065-11 to address violence against women prevention strategies with Health Unit staff.

Introduction
The Health Unit has been actively involved over the past several years with addressing the issue of violence against women. Staff members have been leaders in addressing the issue of violence against women in Middlesex-London and across the province. Examples of staff activities include: participating on the London Coordinating Committee to End Woman Abuse and Phase One of the Neighbours, Friends & Families Program; co-hosting the annual Father's Day Breakfast; holding a Violence in Hockey Symposium; producing the Final Report: Task Force on the Health Effects of Women Abuse; creating the Routine Universal Screening (RUCS) tool; working with clients in shelters and frequently speaking out against violence. Recently, an internal Work Group has been formed to move forward with a plan that will build on past initiatives and revitalize strategies to address violence against women to be utilized by staff when performing daily work activities.

Supporting Literature
Health Canada defines violence against women as acts that result, or are likely to result, in physical, sexual and psychological harm or suffering to a woman, including threats of such an act, coercion or arbitrary deprivation of liberty whether occurring in public or private life. It is a major factor in women's health and well-being that occurs in all religious, ethnic, social and economic classes across Canada. Some women have been identified as more vulnerable, including those with precarious immigration status, women with disabilities and Aboriginal women. In addition, women living in rural communities are at a higher risk of violence than their urban counterparts.

Violence against females can occur at young ages. In 2005, girls under age 18 years experienced rates of sexual assault almost four times higher than their male counterparts. Rates of physical and sexual assault perpetrated by a family member are higher for girls than for boys. Female exposure to violence at young ages often leads to involvement with the justice system and living in abusive situations during adult years.

Related to violence against women is the issue of childhood bullying. Bullying behaviour during childhood is closely related with future antisocial behaviour and criminal activity in adolescence and adulthood, as well as adult bullying behaviours such as sexual harassment, dating aggression, workplace harassment and domestic violence.

Proposed Plan
The work of Health Unit staff is very diverse. The Work Group is proposing a three year plan (Appendix A) that includes a range of activities to address the complexities of violence against women relevant to the diversity of Health Unit programs. Staff members currently utilize the following three strategies to mitigate the effects of violence against women:

1. Primary prevention interventions are universal strategies to prevent the onset of violence. Primary prevention includes health promotion activities and actions that address the determinants of health. Activities may include: implementation of girl power groups, social norms communication about violence against females, small group work, and a comprehensive approach to bullying at all ages.
2. Secondary prevention strategies are intended to identify those who are being abused but are not exhibiting any outward or obvious physical or emotional signs; those who have experienced past abuse as well as selective implementation for those at increased risk for violence. Secondary prevention includes screening to detect abuse (RUCS) and appropriate follow-up, such as access to supports and treatment. Activities may include: revisions to RUCS protocol and continued education and training for staff.
3. Tertiary prevention strategies are focused on women who are outwardly experiencing abuse and aim to reduce the impact of the abuse and promote quality of life through active rehabilitation

(e.g., supports and follow-up for abused women in shelters; counseling for abused women regarding exit plans).

The first step will be to provide a refresher presentation to the Board of Health and all staff on the foundational details pertaining to violence against women. Staff members will be queried about the supports they need to address the issue while performing their daily activities. The Working Group will then develop resources to support staff members in addressing the issue of violence at a community level. Maintaining awareness about the link between violence against women and bullying will also be part of the overall plan.

Conclusion

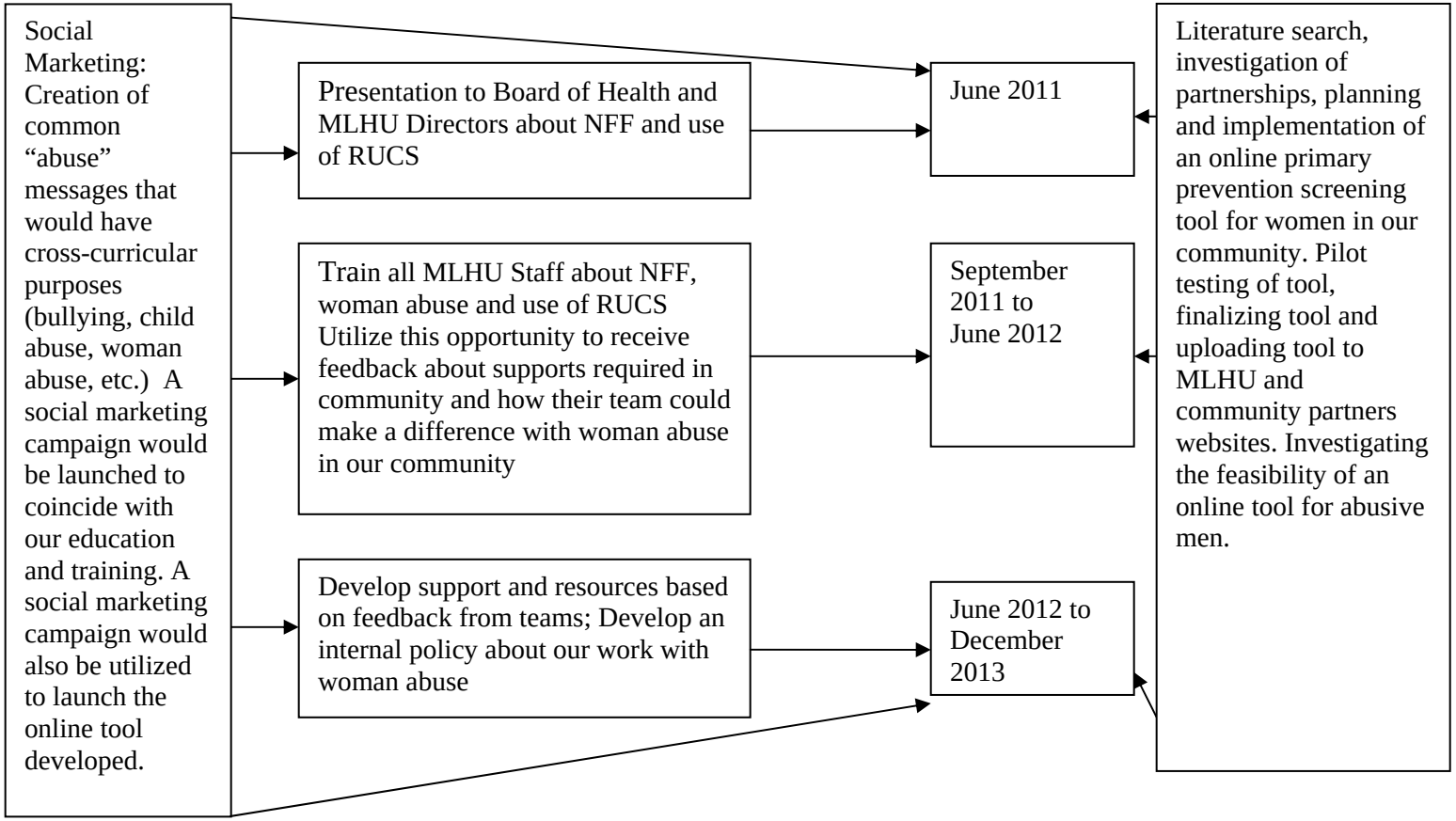
With the endorsement of the Board of Health, the intent is to move forward with a comprehensive approach to address the issue of violence against women. This important public health issue requires concentrated and collaborative efforts by all staff.

This report was prepared by Ms. Muriel Abbott, Public Health Nurse, and Ms. Christine Preece, Manager, Young Adult Team, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health 1,4,5,6,7,8.

MLHU Woman Abuse Taskforce Plan
May 2011



Appendix A

Appendix A

Opening Remarks (Day 1) by Dr. Graham Pollett

Conference on Pornography: It's Impact on Feminism, Men, Women and Children

June 6, 2011
Best Western Lamplighter Inn
Wellington Road, London, Ontario

Good morning and welcome to Pornography: It's Impact on Feminism, Men, Women and Children – a conference that has been organized by London Abused Women's Centre in partnership with Fanshawe College, the Middlesex-London Health Unit and St. Joseph's Health Care London. I'm Graham Pollett, the Medical Officer of Health for London and Middlesex County, and I'm pleased to be with you today to hear from leading academics and activists about the implications, dangers and costs associated with today's pornography industry and its overall impact on our society.

I'd like to begin by taking a look at the pervasiveness of porn in today's world. The figures are staggering but I hope that they provide you, as they did me, with a sense of how pervasive the industry is and how all too common and available its offerings have become.

Today there are an estimated 4 million pornography websites worldwide that account for 420 million pornographic web pages. Each day, there are 68 million Internet search requests for pornography and the number of worldwide visitors to porn websites totals 72 million on a monthly basis. Nearly 43% of all Internet users view porn.

Pornography has become big business. It's multi-billion dollar industry worth an established $97 billion worldwide. Advances in technology have made it possible for porn to be available to consumers in multiple electronic platforms and interfaces 24 hours a day, seven days a week.

As Dr. Robert Jensen, who is renowned for his research on pornography and who is a guest speaker at this conference notes in an interview: Changes in law, technology and social norms over the past four decades "have produced a pornography-saturated culture for which there is no historical precedent."

But today's porn is not that of previous generations. It's hard core. It's about visiting the maximum amount of humiliation and degradation upon women, men and children.

Dr. Gail Dines has studied the subject extensively and we're very pleased that she is able to be here with us over the next two days. She is an internationally acclaimed speaker, author and feminist activist. The jacket cover of her new book **Pornland** states:

"Although we are surrounded by pornographic images, many people are not aware of just how cruel and violent the industry is today. *Pornland* shows how today's porn is strikingly different from yesterday's Playboy and Penthouse Magazines – how

competition in the industry and consume desensitization have pushed porn toward hard core extremes."

I will be formally introducing Dr. Jensen and Dr. Dines shortly.

This turn to hard core happens at a time when young girls are bombarded with over-sexualized images of what it is to be female and where the average boy sees his first porn at the age of 11. All this takes place as the porn industry moves at an ever-accelerated rate with no end in sight. With each upload, download or DVD that is sold, we lose further ground on the progress we have made in redefining our relationships, understanding our humanity and addressing gender inequities.

To quote Maggie Hays, the creator of the website Against Pornography: "Contemporary pornography is not a form of art but of exploitation." In essence, our society has become "pornified" and its time to change.

But where and how do we begin to fight against a multi-billion dollar money-making machine that shows no signs of slowing?

How do we mount a challenge to a worldwide entity that continues to push the boundaries of cruelty, oppression and domination while hiding behind the veil of choice and freedom of speech?

How do we reinstate the value of humanness above all else, or at the very least above pornography?

How do we remember that no young girl or young boy comes into the world wanting to work in porn – that somewhere along the way they likely became entangled as a result of life circumstances, experiences and exposures?

How do we reclaim what has been lost? How do we make the distinction between sexuality and pornography?

How do we counter the misinformation and distortions of the pornography machine? And what do we do to stop the harm?

That's what we will focus on over the next couple of days. I would now like to introduce our two key-note speakers.

Dr. Gail Dines is a Professor of Sociology and Women's Studies and Chair of the American Studies Department at Wheelock College in Boston. A feminist activist, for over 20 years she has been researching and writing about the Porn Industry and Pop Culture and has published many articles on such varied topics as the image of women in Hollywood, racism in porn, the hypersexualization of our culture, and the ways images shape our sexuality and our relationships. A frequent guest on radio and television, Dr. Dines is a founding member of Stop Porn Culture – an educational and activist group made up of academics, anti-violence experts, community organizers and anyone who is concerned about the increasing pornification of the culture. Her new book Pornland: How Porn has Hijacked our Sexuality, examines how men and women's lives, sexuality and relationships are shaped by the porn culture.

Dr. Robert Jensen is a Professor in the School of Journalism at the University of Texas at Austin, where he teaches courses in media law, ethics, and politics. In his research, Dr. Jensen draws on a variety of critical approaches to media and power. Much of his work has focused on pornography and the radical feminist critique of sexuality and men's violence. He is the author of Getting Off: Pornography and the End of Masculinity, and is co-author with Gail Dines and Ann Russo of Pornography: The Production and Consumption of Inequality. Dr. Jensen is also the co-writer/producer of an educational slide show about pornography entitled, "Who Wants to be a Porn Star? Sex and Violence in Today's Pornography Industry." He was a consultant to the directors of the documentary called "The Price of Pleasure: Pornography, Sexuality, and Relationships".

Dr. Dines and Dr. Jensen will be participating in our conference in a variety of ways – as individual speakers, as co-presenters and as panel members.

Their books are available for sale at the registration desk and both Dr. Dines and Dr. Jensen will be available to sign them at the end of each day and during lunch hours.

I've been asked to advise you that some of the material you will hear over the next two days may be offensive and upsetting. We have some counselors from LAWC who are available to provide assistance for anyone who requests it. Would the counselors please stand.

I would now like to call upon Dr. Dines to speak to us on the subject of Pornography and the High-Jacking of Feminism: the relationship of pornography and feminism.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 066-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

50 King Street Air Quality – HVAC Upgrades/Repairs

Recommendation

It is recommended:

1) That the Board of Health award the contract for the assessment at 50 King Street of the current Heating/Ventilating/Air Conditioning (HVAC) and Engineering Services to Johnson Controls L.P. at a total cost of $47,368, noting this is a single source purchase; and further;
2) That the Medical Officer of Health be given prior approval to enter into a contract with the lowest cost bidder who meets all required terms, conditions and specifications to an upset limit of $200,000 for the installation of the required equipment.

Background

Despite the alterations during the 2007/2008 renovations, specific areas of the 50 King Street facility still experience issues with air quality and temperature control. In January of 2011, Integrated Engineering was hired at a cost of $4,500 to complete an assessment of the building and provide recommendations for improvement. The recommendations proposed were not stand alone solutions as they have an impact on the ongoing maintenance of the current system which is maintained by Johnson Controls L.P., the negotiated long term contractor of Middlesex County (The Landlord).

The recommendations can be summarized as enhancing the current HVAC system by adding the ability to provide air conditioning in certain areas of the facility during the heating season. The current design is incapable of doing this.

Johnson Controls L.P. collaborated with Integrated Engineering to review the recommendations, and propose a plan of action to address the issues surrounding air quality and temperature control. It is being recommended that a complete assessment of the current mechanical systems be completed prior to finalizing the plan and before preparing tender documents.

As per the Procurement Policy, 4-25, section 3.4 (v) - Direct Negotiations - staff can enter into direct negotiations “where the required goods and services are to be supplied by a particular vendor or supplier having special knowledge, skills, expertise or experience.”

The extensive knowledge that Johnson Controls L.P. has of the equipment and the building and its limitations, make it essential to have them provide the project development, engineering solution, tender documentation and project management. It is expected that these services can be performed at a cost of $47,368 plus HST.

Johnson Controls L.P., in partnership with Integrated Engineering, would provide the following services:

- Provide a detailed assessment of the current mechanical systems associated with indoor air quality and environmental issues addressing capabilities and any deficiencies
- Propose a detailed engineered solution to address issues found during the assessment.
- Prepare all drawings, specifications and tender documentation. The award will be based on the lowest bid received that meets all terms, conditions and specifications.
- Provide project management throughout all phases of the work

Pre-approval of the installation work is necessary to properly address these issues and have the work completed prior to the next heating season as this is the period in which the air quality and temperature are at their worst.

As per the Procurement Policy, a competitive bid process (tender) will be completed and awarded by Johnson Controls L.P. on behalf of the Health Unit. The cost estimates provided by Johnson Controls L.P. are approximately $200,000. A detailed report will be provided to the Board of Health with the award information and exact expenditures at the September 2011 Board of Health meeting.

Source of Funding

The approximate $250,000 funding for this one-time expenditure can be accommodated in the Board of Health approved 2011 operating budget. In March 2011, the Board of Health approved an increase in the operating budget of $215,580 (which represented a 3% provincial grant increase rather than a 1.5% increase). Prior to this project these additional funds have not been earmarked for 2011. The remainder of the funding will come from realized savings due to the Restraint Act of 2010.

Conclusion

The 50 King Street Office continues to experience issues with air quality and temperature control. It is recommended that work be completed by Johnson Controls to review the current HVAC system and manage the project to correct the issues prior to the next heating season. By managing the project, Johnson Controls will be performing the work required to obtain competitive bids for the installation of new equipment. The Board of Health is being requested to pre-approve this work to an upset of $200,000 so that the work can begin without waiting until late September.

This report was prepared by Ms. Melody Couvillon, Manager, Purchasing and Operations, and by Mr. John Millson, Director, Finance and Operations.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Procurement Policy 4-25 as outlined in the MLHU Administration Policy Manual.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 067-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Medical Officer of Health Activity Report – June

Recommendation
It is recommended that Report No. 067-11 re Medical Officer of Health Activity Report – June be received for information.

The following report highlights activities of the Medical Officer of Health since the last Board of Health meeting.

Work continued on the development of the Strategic Plan with a meeting held of Directors on May 20th followed by a meeting of members of the Board of Health and Directors on May 26th. These meetings built upon the work of the Discovery Report and the Staff Session which occurred on May 11th and the Non –Union Management Session held May 20th. The result is a Ten Year Vision and Three Year Strategic Directions document which is the subject of Board of Health Report No. 063-11, this agenda.

The Medical Officer of Health participated in a number of activities related to the prevention of violence in society, particularly violence against women and children. The Health Unit was a co-host of the 5th Annual Father's Day Breakfast. This event is focused on high school boys, their teachers and coaches. It featured three speakers who addressed the importance of treating girls and women with respect and the importance of healthy relationships. The Health Unit was a partner together with Fanshawe College and St. Joseph's Health Care London in a conference on pornography organized by the London Abused Women's Centre. This event which was entitled Pornography: Its Impact on Feminism, Men, Women and Children was held at the Lamplighter Conference Centre June 6 and 7. The Medical Officer of Health provided opening remarks on both days of the conference. The key note speakers were Dr. Gail Dines, Professor of Sociology and Women's Studies at Wheelock College in Boston and Dr. Robert Jensen, Professor in the School of Journalism at the University of Texas at Austin, both of whom have written extensively on the subject. The magnitude of the problem posed by pornography is highlighted in the opening remarks provided by the Medical Officer of Health on the first day of the conference (Appendix A). The conference agenda is attached as Appendix B. The Medical Officer of Health also participated in a teleconference meeting of the Ontario Public School Boards Association Committee on Violence in the Media.

The Medical Officer of Health, together with Board Chair Ms. Pat Coderre and Board Members, Ms. Doreen McLinchey and Mr. Al Edmondson, attended the Association of Local Public Health Agencies (alPHa) Annual meeting. The Board of Health sponsored resolutions concerning alcohol were considered as part of the resolutions section of the conference. The outcome of the voting will be provided at the June 16th Board of Health meeting.

Collective Bargaining resumed with the Canadian Union of Public Employees Local 101. An update on these proceedings will be provided at the June 16th Board of Health meeting.

Other meetings involving the Medical Officer of Health since the last Board of Health meeting included: attendance at and provision of welcoming remarks to attendees at the inaugural meeting of the Bed Bug Advisory Group; several teleconferences with Dr. Henry Kurban, Acting Medical Officer of Health, Thunder Bay District Health Unit, for whom the MOH is providing College of Physicians and Surgeons of Ontario supervision; remarks for Ms. Charlene Beynon's retirement reception; participation in a Health Unit emergency planning exercise conducted June 2nd; appointment to and attendance at the initial meeting of a Ministry of Health and Long-Term Care Working Group on the implementation of the Chief Nursing Officer role in all provincial health units; and a meeting with Dr. Jason Gilliland, Director, Urban Development Program, University of Western Ontario.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

Appendix A

Opening Remarks (Day 1) by Dr. Graham Pollett

Conference on Pornography: It's Impact on Feminism, Men, Women and Children

June 6, 2011
Best Western Lamplighter Inn
Wellington Road, London, Ontario

Good morning and welcome to Pornography: It's Impact on Feminism, Men, Women and Children – a conference that has been organized by London Abused Women's Centre in partnership with Fanshawe College, the Middlesex-London Health Unit and St. Joseph's Health Care London. I'm Graham Pollett, the Medical Officer of Health for London and Middlesex County, and I'm pleased to be with you today to hear from leading academics and activists about the implications, dangers and costs associated with today's pornography industry and its overall impact on our society.

I'd like to begin by taking a look at the pervasiveness of porn in today's world. The figures are staggering but I hope that they provide you, as they did me, with a sense of how pervasive the industry is and how all too common and available its offerings have become.

Today there are an estimated 4 million pornography websites worldwide that account for 420 million pornographic web pages. Each day, there are 68 million Internet search requests for pornography and the number of worldwide visitors to porn websites totals 72 million on a monthly basis. Nearly 43% of all Internet users view porn.

Pornography has become big business. It's multi-billion dollar industry worth an established $97 billion worldwide. Advances in technology have made it possible for porn to be available to consumers in multiple electronic platforms and interfaces 24 hours a day, seven days a week.

As Dr. Robert Jensen, who is renowned for his research on pornography and who is a guest speaker at this conference notes in an interview: Changes in law, technology and social norms over the past four decades "have produced a pornography-saturated culture for which there is no historical precedent."

But today's porn is not that of previous generations. It's hard core. It's about visiting the maximum amount of humiliation and degradation upon women, men and children.

Dr. Gail Dines has studied the subject extensively and we're very pleased that she is able to be here with us over the next two days. She is an internationally acclaimed speaker, author and feminist activist. The jacket cover of her new book **Pornland** states:

> "Although we are surrounded by pornographic images, many people are not aware of just how cruel and violent the industry is today. *Pornland* shows how today's porn is strikingly different from yesterday's Playboy and Penthouse Magazines – how competition in the industry and consume desensitization have pushed porn toward hard core extremes."

I will be formally introducing Dr. Jensen and Dr. Dines shortly.

This turn to hard core happens at a time when young girls are bombarded with over-sexualized images of what it is to be female and where the average boy sees his first porn at the age of 11. All this takes place as the porn industry moves at an ever-accelerated rate with no end in sight. With each upload, download or DVD that is sold, we lose further ground on the progress we have made in redefining our relationships, understanding our humanity and addressing gender inequities.

To quote Maggie Hays, the creator of the website Against Pornography: "Contemporary pornography is not a form of art but of exploitation." In essence, our society has become "pornified" and its time to change.

But where and how do we begin to fight against a multi-billion dollar money-making machine that shows no signs of slowing?

How do we mount a challenge to a worldwide entity that continues to push the boundaries of cruelty, oppression and domination while hiding behind the veil of choice and freedom of speech?

How do we reinstate the value of humanness above all else, or at the very least above pornography?

How do we remember that no young girl or young boy comes into the world wanting to work in porn – that somewhere along the way they likely became entangled as a result of life circumstances, experiences and exposures?

How do we reclaim what has been lost? How do we make the distinction between sexuality and pornography?

How do we counter the misinformation and distortions of the pornography machine? And what do we do to stop the harm?

That's what we will focus on over the next couple of days. I would now like to introduce our two key-note speakers.

Dr. Gail Dines is a Professor of Sociology and Women's Studies and Chair of the American Studies Department at Wheelock College in Boston. A feminist activist, for over 20 years she has been researching and writing about the Porn Industry and Pop Culture and has published many articles on such varied topics as the image of women in Hollywood, racism in porn, the hypersexualization of our culture, and the ways images shape our sexuality and our relationships. A frequent guest on radio and television, Dr. Dines is a founding member of Stop Porn Culture – an educational and activist group made up of academics, anti-violence experts, community organizers and anyone who is concerned about the increasing pornification of the culture. Her new book Pornland: How Porn has Hijacked our Sexuality, examines how men and women's lives, sexuality and relationships are shaped by the porn culture.

Dr. Robert Jensen is a Professor in the School of Journalism at the University of Texas at Austin, where he teaches courses in media law, ethics, and politics. In his research,

Dr. Jensen draws on a variety of critical approaches to media and power. Much of his work has focused on pornography and the radical feminist critique of sexuality and men's violence. He is the author of Getting Off: Pornography and the End of Masculinity, and is co-author with Gail Dines and Ann Russo of Pornography: The Production and Consumption of Inequality. Dr. Jensen is also the co-writer/producer of an educational slide show about pornography entitled, "Who Wants to be a Porn Star? Sex and Violence in Today's Pornography Industry." He was a consultant to the directors of the documentary called "The Price of Pleasure: Pornography, Sexuality, and Relationships".

Dr. Dines and Dr. Jensen will be participating in our conference in a variety of ways – as individual speakers, as co-presenters and as panel members.

Their books are available for sale at the registration desk and both Dr. Dines and Dr. Jensen will be available to sign them at the end of each day and during lunch hours.

I've been asked to advise you that some of the material you will hear over the next two days may be offensive and upsetting. We have some counselors from LAWC who are available to provide assistance for anyone who requests it. Would the counselors please stand.

I would now like to call upon Dr. Dines to speak to us on the subject of Pornography and the High-Jacking of Feminism: the relationship of pornography and feminism.

Agenda

Monday June 6, 2011

Morning

9:00 – 9:15	Opening and Welcome **Dr.Graham Pollett**
9:15 – 10:15	Pornography and the High-Jacking of Feminism: the relationship of pornography and feminism **Dr. Gail Dines**
10:15 – 10:30	BREAK
10:30 – 11:30	Video: Dreamworlds 3 – Desire, Sex and Power in Music Video
11:30 – 12:00	Sexism, Porn and Abuse of Women – panel discussion with: **Candice Lawrence, Megan Walker, Dr. Robert Jensen and Dr. Gail Dines**
12:00 – 1:00	LUNCH

Afternoon

1:00 – 2:00	Pro-Porn Culture on Pornography and Pop Culture; in corporate media, imagery, theory and capitalism **Dr. Gail Dines**
2:00 – 2:15	BREAK
2:15 – 3:15	Video: Price of Pleasure
3:15 – 4:15	Discussion about Video: Price of Pleasure **Dr. Robert Jensen and Dr. Gail Dines**
4:15 – 4:30	Closing Remarks

Evening

7:00 – 9:00	Free Evening Presentation for the Public (by registration only) – Pornography – Its Impact on Feminism, Men, Women and Children: free public forum – **CANCELLED**

Tuesday June 7, 2011

Morning

9:00 – 9:15	Opening and Welcome **Dr.Graham Pollett**
9:15 – 10:30	Masculinity and Pornography **Dr. Robert Jensen**
10:30 – 10:45	BREAK
10:45 – 12:00	Normalizing and Mainstreaming Pornography: Impact of Pornography on Our Culture and Our Lives **Dr. Robert Jensen and Dr. Gail Dines**
12:00 – 1:00	LUNCH

Afternoon

1:00 – 2:00	Dealing with Backlash/Hostility: Mock Questions and Answers **Dr. Robert Jensen and Dr. Gail Dines**
2:00 – 2:15	BREAK
2:15 – 3:45	Change Making: Organizing Against Pornography – panel discussion with: **Candice Lawerence, Megan Walker, Dr. Robert Jensen and Dr. Gail Dines**
3:45 – 4:00	Closing Remarks

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 068-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Volunteer Resources

Recommendation
It is recommended that Report No. 068-11 re Volunteer Resources be received for information.

Background
The volunteer spirit is alive and well within the Health Unit. Volunteers enhance Health Unit staff's ability to carry out the mission of promoting wellness, preventing disease and injury, and protecting the public's health through the delivery of public health programs and services. The volunteers are hard-working, community-minded individuals who have made the decision to do more for their community.

Year-End Summary
The Volunteer Development Committee met four times during the past year. Members of the Committee are: Ms. Mary Bambrick, Volunteer; Ms. Lucy Corsaut, Volunteer; Ms. Marlene Harris, Volunteer; Ms. Marie Lawson, Volunteer; Mr. Reg Thibault, Volunteer; Ms. Janet Connolly, Public Health Nurse; Ms. Jane Tyers, Public Health Nurse; Ms. Gayle Riedl, Human Resources and Volunteer Coordinator. Ms. Mary Lou McRae, Public Health Nurse, was a long-standing member of this committee who retired in the fall of 2010.

From September 2010 until June 2011, Health Unit volunteers logged over 5,000 hours of service. They worked with the following Teams: Vaccine Preventable Disease, Child Health, Young Families, Health Promotion, Sexual Health Promotion, Let's Grow, Chronic Disease and Injury Prevention, Emergency Preparedness, Environmental Health and Office of the Medical Officer of Health. Two outside agencies, St. Leonard's House and the Optimist Club of Stoney Ridge – London, offered their assistance as a way of community partnering. A new Community Emergency Response Volunteer (CERV) team Delta with 15 members was brought on in September 2010. This new team brings the total number of CERV teams four. Volunteers were an important part of the Strategic Planning process by distributing and collecting surveys to Health Unit clients coming to the 50 King Street building.

After many years of offering a vision screening program in schools, the program was put on hold for the 2010/2011 school year while the Child Health Team reviewed current Health Unit practices related to children's eye health. As a result of the review, it was agreed that the Health Unit would discontinue the school vision screening program and replace it with comprehensive strategies that aim to increase the proportion of children having eye examinations prior to school entry and to ensure that families in financial need have access to eyeglasses (please refer to Report No. 013-11 re Promoting Eye Health in Children, February 2011). This decision had an impact on 28 volunteers as volunteers would no longer be needed to provide vision screening. The Board of Health sent a letter to each vision screening volunteer to show its appreciation for his/her dedicated service.

In recognition and in honour of volunteer support, the Health Unit hosted a volunteer reception on May 19, 2011, at which Board Chair, Ms. Patricia Coderre, expressed words of appreciation on behalf of the Board.

Ms. Riedl continues to be an active member of the London and Area Association of Volunteer Administration (LAVA) and the Ontario Public Health Volunteer Resource Management Network. She continues to work closely with Ms. Patricia Simone, Manager, Emergency Preparedness, in managing the CERV program with its ongoing training, recruitment, and evaluation processes.

This report was prepared by Ms. Gayle Riedl, Human Resources and Volunteer Coordinator.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 069-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Cell Phone Use and Cancer

Recommendation
It is recommended that Report No. 069-11 re Cell Phone Use and Cancer be received for information.

Background
On May 31, 2011, The World Health Organization (WHO)/International Agency for Research on Cancer (IARC) issued a press release (attached as Appendix A) classifying radiofrequency electromagnetic fields as 'possibly carcinogenic to humans' (Group 2B) based on an increased risk for glioma, a malignant type of brain cancer associated with wireless phone use. The IARC Carcinogenic Risk to Humans categories are explained in Appendix B. With the current number of global cell phone subscriptions estimated at 5 billion and usage increasing, especially among children and young adults, these findings have obvious public health relevance.

An IARC Working Group of international experts met in May 2011 to assess and evaluate the available research on various exposures to radiofrequency electromagnetic fields, including personal exposures associated with the use of wireless telephones. They reviewed exposure data, studies of cancer in humans, studies of cancer in experimental animals, and other relevant data to arrive at their conclusions. The assessments will be released at a later date and a summary of the main conclusions and the evaluations will be published in the July 1, 2011, edition of the journal, *The Lancet Oncology*.

Results
Among users of wireless telephones, the Working Group found "limited evidence of carcinogenicity" for two forms of cancer, glioma and acoustic neuroma, and "inadequate evidence of carcinogenicity" for other types of cancers. Although the Working Group did not quantitate the risk for these two types of cancer, they recognized that there is a possible risk and that the link between cell phones and cancer should be monitored closely. As a result, IARC Director, Dr. Christopher Wild, stresses the need for additional research and recommends taking pragmatic measures, such as using hands-free devices and texting, to reduce exposures.

Conclusion
Given the public health significance of the possibility that cell phone use may be linked to an increased risk of certain types of cancer, Environmental Health staff will review the results of the IARC Working Group when they are published and will monitor this issue closely in order to provide accurate information and appropriate recommendations to the residents of Middlesex-London. Staff will also provide the Board with an update on this issue at a future meeting.

This report was prepared by Mr. Iqbal Kalsi, Manager, Environmental Health, Health Hazard & Prevention Management, and Mr. Wally Adams, Acting Director, Environmental Health and Chronic Disease Prevention Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses Requirement 2(a)(i) of the Identification, Investigation, and Management of Health Hazards Protocol under the Health Hazard Prevention and Management Standard of the Ontario Public Health Standards, requiring Boards of Health to Identify and review relevant evidence-based information on environmental exposures and their relationship with potential adverse health outcomes.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 070-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

E. Coli Outbreak in Europe

Recommendation
It is recommended that Report No. 070-11 re be received for information.

There has been a great deal of concern and media attention paid over the past number of weeks concerning the outbreak of E. Coli 0104:H4 in Europe. This strain differs slightly from E. Coli 0157:H7 which Board members will be more familiar with as it was the causative agent in the Walkerton drinking water outbreak. Both strains however produce a toxin (shiga-toxin) which can result in potential complications including Haemolytic Uraemic Syndrome (HUS), a serious form of kidney disease.

As of the writing of this report, the food source of the European outbreak has not been confirmed. To date there is one probable travel-related case in Ontario. Laboratory confirmation of the 0104:H4 designation is pending.

Attached as Appendices A and B are a news release from Dr. Arlene King, Chief Medical Officer of Health, dated June 6, 2011, and a question and answer document prepared by the Ontario Ministry of Health and Long-Term Care containing relevant information as of the writing of this report. Should additional information become available it will be verbally provided at the June 16th Board of Health meeting.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

News Release Communiqué

E. Coli Outbreak In Europe

STATEMENT FROM DR. ARLENE KING, CHIEF MEDICAL OFFICER OF HEALTH

NEWS

June 6, 2011

Ontario has one suspect case of E. coli linked to the outbreak in Europe. This is the first suspect case in Canada. This case has a travel history to Germany and consumed local products while in that country. While confirmatory lab results will take a few more days, initial testing has confirmed the presence of toxin compatible with the current E. coli outbreak in Europe.

I would like to assure Ontarians that we are following the E.coli outbreak in Europe very closely. Alerts have been issued to all health units advising them to immediately report to the Ministry of Health and Long-Term Care any cases of E. coli with a travel history to Germany.

The risk to Ontarians from this outbreak is very low. However, people should always follow standard measures to prevent any type of E. coli infection. This means carefully washing all fruits and vegetables to reduce contamination, and thoroughly cooking meats, such as ground beef, which will kill any bacteria.

People should always practice good hand hygiene, particularly after using the washroom, after handling animals, and before preparing foods or eating.

If people have recently travelled to Germany and are experiencing diarrhea or severe tiredness, paleness and reduced urinary output following diarrhea, they should visit a health care practitioner and inform them of their recent travel to the country.

People who are planning a trip to Germany should visit the Public Health Agency of Canada travel advisory website before traveling (http://www.phac-aspc.gc.ca/tmp-pmv/thn-csv/ecoli-eng.php) and keep up to date on information from local health authorities during their trip.

Media Contact:
Andrew Morrison, Ministry of Health and Long-Term Care: 416-314-6197

E. coli O104:H4 – European Outbreak Qs&As

1. How many E. coli cases have been reported in Ontario?

1A: Year to date?

37 cases have E. coli O157:H7 have been reported to the Ministry as of June 6 for 2011. This strain of E. coli differs from the strain reported in Germany. The reported case numbers of E. coli O157:H7 in Ontario are well below the expected total for this time period. Approximately 200 cases have been reported per year for the past three years.

1B: Any cases linked to the European outbreak?

There has been one suspect case of E. coli O104:H4 reported in Ontario linked to the outbreak in Europe – it's the first suspect case in Canada.

The MOHLTC has relayed this information to the Public Health Agency of Canada which will, in turn, disclose it to European health authorities.

2. What can you say about the Ontario case related to the E. coli outbreak in Europe?

Ontario has its first suspect case of E. coli O104:H4 in a resident of Peel who returned from Germany at the end of May.

The individual went to a hospital Emergency Room late last week with diarrhea.

Initial testing has confirmed the presence of shigatoxin type 2, compatible with the current E. coli outbreak in Europe.

The individual was discharged from hospital but is now undergoing further evaluation.

We will not disclose further details to protect patient confidentiality.

3. Do you know what caused the E. coli infection in the Ontario case?

An investigation is underway. The Ontario case has a travel history to Germany and consumed local products while in that country.

4. How long will it take to confirm this case?

Confirmatory lab testing will take several more days.

5. Is there a risk to Ontarians from this case?

E. coli is not spread by coughing, kissing, or through normal, everyday interactions with friends or neighbours. However, once someone has consumed contaminated food, the infection can be passed from person to person by hand following poor hygiene after using the washroom. Proper hand hygiene is vital to preventing the spread of this illness.

6. Is it possible that we'll see more cases?

It's possible. Several Public Health Alerts have been issued to all health units in Ontario advising them to immediately report to the Ontario Ministry of Health and Long-Term Care any cases of E. coli with a travel history to Germany.

7. What is the treatment?

Generally, an E. coli infection must run its course. Antibiotics and antimotility medications are not recommended and may increase the risk of complications. Maintaining adequate fluid intake is very important.

8. Should Ontarians be concerned about the E. coli situation because we now have a case in this province?

The Ontario case has a travel history to Germany and consumed local products while in that country.

Imports of fresh produce from European countries account for less than 1% of total imports of produce from all countries.

The risk to Ontarians from this outbreak is very low. However, people should always follow the standard measure to prevent E. coli infections. These measures include carefully washing all fruits and vegetables to reduce contamination. Thorough cooking of meats, such as ground beef, will kill the bacteria.

Practicing good hand hygiene is advised, particularly after using the washroom, after handling animals, and before preparing foods or eating.

If you are ill with diarrhea, avoid preparing or handling food that others will be eating.

People should seek medical attention early for diarrhoeal illness.

9. What actions are local health units taking?

Public health units in Ontario routinely investigate all cases of E. coli reported. Several Public Health Alerts have been issued to all health units in Ontario advising them to immediately report to the Ontario Ministry of Health and Long-Term Care any cases of E. coli with a travel history to Germany.
Please note that a clinician would not know that a patient has E coli O104 or other non O157 E. coli infection unless the testing was specifically requested from the Ontario Agency for Health Protection and Promotion.

10. Is the ministry working with the CFIA to ensure that the food imports from Europe are being monitored for E. coli?

The ministry is in contact with the CFIA. The CFIA has enhanced border and surveillance controls for imported foods coming into Canada.

11. Does Canada import fresh produce (foods that could carry E. coli) from Europe? If so, what are they? Is there a plan to take those off the shelves?

Imports of fresh produce from European countries account for less than 1% of total imports of produce from all countries. The CFIA has enhanced border and surveillance controls for imported foods coming into Canada.

12. How is Ontario monitoring to prevent or mitigate the possible spread of this E. coli strain in the province?

Physicians are being advised to collect and submit specimens for any suspect case of E. coli to the Ontario Agency for Health Protection and Prevention Public Health Laboratory for testing. Once a case is identified, local public health units, in conjunction with the ministry, will follow up to ensure that appropriate precautions and prevention measures are implemented.

13. Are there any groups of people who may be specifically at high risk of this E. coli strain? Or of E. coli in general?

Based on the cases reported in Germany, adult women are the most affected by the outbreak caused by E coli O104. This is not typical for E. coli O157:H7 infections. Individuals who are at the greatest risk for the more severe forms of the disease or for complications such as Haemolytic Uremic Syndrome (HUS), a

kidney complication, generally involve the very young, the elderly or individuals who are immuno-compromised.

14. Is special direction provided to MDs on identification/testing of this organism? Should all suspect case samples, for instance, go to the OAHPP for assessment?

Physicians are being advised to heighten their suspicion of the possibility of this organism for all travellers returning from Germany who present with diarrhea.

They are also being advised that routine stool culture will not identify this organism. Hence, they should submit stool specimens for testing to the OAHPP PHL Toronto, and specifically request E coli O104 or shiga toxin producing E coli (STEC). They are asked to contact the OAHPP PHL helpline prior to submission at 416 235-6556 or 1-800-640-7221 in order to expedite testing.

15. What are we saying to people going to Germany, or who have returned, with or without symptoms?

We recommend that Ontarians travelling to Germany practice safe food and water precautions. We recommend that they visit the Public Health Agency of Canada travel advisory website before traveling.

Ontarians returning from Germany who are experiencing diarrhea should visit their health care practitioners and inform them of their recent travel to the country. PHAC's travel advisory website:
http://www.phac-aspc.gc.ca/tmp-pmv/thn-csv/ecoli-eng.php

16. Has the federal government made any statements or issued any travel advice?

A travel health notice pertaining to the E. coli outbreak has been posted on the Public Health Agency of Canada website. A Level 2 travel advisory to Canadians travelling to Germany has also been issued. At this level, travellers to Germany are advised to practice safe food and water precautions and to follow the advice of German authorities.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 071-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Teen Panel: A Pregnancy Prevention Program

Recommendation
It is recommended that Report No. 071-11 re Teen Panel: A Pregnancy Prevention Program be received for information.

Background
The Teen Panel Program was initiated in 1989 in response to a high teen pregnancy rate in Middlesex-London. A partnership was established with the Health Unit, Children's Aid Society, Thames Valley District School Board (TVDSB), London District Catholic School Board (LDCSB), and Merrymount Children's Centre. The ultimate goal was to provide an effective peer sexual health promotion program in order to prevent teen pregnancy. It was developed and delivered based on research which indicated strategies which reflect the realistic issues of being a teen parent are more effective when used in a pregnancy prevention program. Today, research still states that countries which include open, frank discussions about sexuality at an early age show lower incidence of teen pregnancies.

Program Description
Currently an Advisory Committee, consisting of members from the aforementioned organizations and Childreach, guides the development, implementation, evaluation, and analysis of the program. Teen parents are recruited and trained to visit secondary school classes and talk to their peers about the consequences of pregnancy and the challenges of being a parent. These challenges specifically address health, finances, school work and relationships. Panel presenters talk openly about what their lives were like before they became pregnant, during their pregnancy and after. At the conclusion of the presentation, feedback forms for both students and teachers are distributed. Before and after the presentation, a Teacher's Resource Kit is used to engage the students in activities that will both prepare them for the presentation and follow-up with key themes highlighted in the presentation for the purpose of reflecting on their learning.

Program Update
The Teen Panel Program did not operate during the 2009/10 school year due to funding set backs; however, it was reintroduced in 2010/11 due to a grant received by the TVDSB. Four female presenters were recruited and trained for the program as there was difficulty in recruiting male presenters. The presenters were trained by staff from Merrymount and the Health Unit.

From February to May 2011, 43 presentations took place in 12 TVDSB secondary schools and 4 LDCSB secondary schools. These presentations reached approximately 1100 students, mainly in grades 9 and 10. Students ranged from ages 13 to 19, with a slightly higher female than male representation. Using a scale from "strongly disagree" to "strongly agree," students were asked to complete an evaluation on the presentation. Most students agreed that the presentation increased their understanding of the factors affecting teen pregnancy and made them think that they will more than likely wait to have sexual intercourse in the future. The majority of students also reported that they would strongly agree to using birth control in the future and that the presentation increased their understanding of how to use decision-making and assertive skills effectively to promote healthy sexuality. Students were also asked to identify issues that they pondered after listening to the presentations and many thought about the importance of safe sex, responsible decision making, an awareness about sexually transmitted infections and challenges of teen parenting. Students also identified that a public health nurse (PHN) in their school setting could be a trusted resource of support for discussing sexual health issues. Regarding feedback for future presentations, the majority of students stated a need for male presenters to be involved in this program.

Teachers also completed evaluations, and preliminary data show that teachers believed Teen Panel increased the students' understanding of how to use decision-making and assertive skills to promote

healthy relationships. The majority of teachers also strongly agreed that Teen Panel increased the students' understanding of the factors affecting teen pregnancy.

The Future of Teen Panel

Based on discussion within the Advisory Committee and an evaluation of the time and finances required for Teen Panel implementation, questions around the sustainability of the program have arisen. Currently, the Committee is looking for a more comprehensive approach to administering teen pregnancy prevention programs within Middlesex-London. In response to these concerns, Focus Groups have been formed and are currently being facilitated by members of the Young Adult Team with the aim of surveying youth to determine what strategies would be most effective to address teen pregnancy. Based on the qualitative information obtained from participants, a report with recommendations and an action plan will be developed in June 2011 for the Committee's review.

Summary

Preliminary results from 2011 have highlighted that Teen Panel has an impact on student's knowledge and awareness about teen parenting and healthy sexuality. However, there is still the need to encompass the diversity of the pregnancy experience, by including a male perspective. While Teen Panel has been well received in schools, the finances and time needed for this program prove to be challenging for Committee members. Questions have also arisen as to whether Teen Panel provides a comprehensive approach to addressing teen pregnancy. An understanding of the social determinants of health that affect pregnancy, such as finances, education, working conditions, and relationships, is necessary. It is also important to recognize that female teens become pregnant for a variety of reasons and that programs need to acknowledge the spectrum of motivations and attitudes toward teen pregnancy within a defined population. With this in mind, the Advisory Committee looks forward to analyzing the results of the Focus Groups, with the hope of constructing a program that brings out the positive elements of Teen Panel, while providing a strategy that is more comprehensive.

This report was prepared by Ms. Laura Elliott, PHN, Young Adult Team, and Ms. Christine Preece, Manager, Young Adult Team, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Sexual Health, STIs, and Blood-borne Infections 4,5,6

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 072-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Being Positive About Young Mothers

Recommendation

It is recommended that Report No. 072-11 re Being Positive About Young Mothers be received for information.

Background

Mommy and Me is a parenting program designed for young mothers aged 14 to 25 years and their children. The program was developed in 2003 and is facilitated by a public health nurse (PHN) from the Young Adult Team and a Parent Educator from Childreach. The drop-in group meets weekly on Thursday evenings at Childreach from September to June. Participants are involved in skill development opportunities such as cooking, healthy living, employment seeking and parenting. Attendance over the years has increased and currently averages about 25 mothers and their children each week. There have been as many as 55 young mothers involved in the program. The average age of the young mothers in the group is 19 years. Almost 50% of the participants are working towards the goal of obtaining a secondary school certificate, while the other 50% are either working or attending post secondary institutions.

Common Experiences of Young Mothers

Over the past years, the young mothers have identified a common theme: discrimination. These mothers have often talked about their experiences of judgemental, negative responses from those they meet in their everyday lives, including health care and social service professionals. The judgemental responses come from a social stereotype which suggests adolescent mothers are immature, live off the government, are poor parents and have no education or future. The stigma begins as soon as it is known that a young woman is pregnant and continues into her foreseeable future. The reason for this perceived discrimination is not well documented, but it is felt that society's norms and media influence may play a role in this stigmatization of young mothers.

Supporting Literature

The notion of young mothers as "bad" mothers is challenged by the many young mothers who fare better in the long-term than dominant discourse would predict. Studies have shown that many young mothers have positive outcomes; researchers have described adolescent pregnancy as a motivator for positive behaviour change and future planning and as life changing and joy giving. While other studies have shown that certain characteristics are common to the studies of adolescent motherhood such as it is positively transforming; it is a turning point for their future and the baby is a stabilizing influence.

Similarly, the facilitators of Mommy and Me have become witnesses to these positive outcomes and have seen the difference the child has made in a young mother's life by motivating her to create a positive future for herself and her child. Often, these young mothers plan for their future and set goals for themselves such as returning to school, attending parenting classes, obtaining employment and providing a supportive environment for the child. In addition, young mothers do not usually share the societal view that having a child at a young age ruins their life or limits their future.

Understanding Young Mothers

In the Fall of 2009, one of the young mothers from the Mommy and Me Group applied and received a grant to write a book, 'Dare to Dream: Shared Stories- Young Mothers' Perspective on Discrimination.' Through her story telling, it was her hope to change society's view of young mothers. Inspired by the book, the mothers developed a plan with the assistance of a PHN and a Parent Educator to address society's need to understand young mothers. The components of the plan are comprehensive in nature, planned over a period of three years and outlined below:

- Curriculum Focus – Fall 2011 - incorporate 'Dare to Dream: Shared Stories' as mandatory reading for nursing and medical students at the University of Western Ontario for the purpose of increasing awareness and building empathy for adolescent mothers by health professionals.

- T-shirt Design- Fall of 2011- have t-shirts designed for the children with a creative slogan “My mom is young and she’s awesome.”

- Social Marketing - Fall 2011- work with young mothers to develop a poster campaign which would include a group photo of the young moms and their children. The posters will create awareness about young moms and their positive abilities and attributes. Posters will be disseminated throughout London and Middlesex County.

- Partnerships - Beginning January 2012 - work on the formation of a coalition with partnership from London Health Science Centre, the University of Western Ontario (Nursing and Medical schools), 2-3 young mothers, Childreach, and Health Unit to develop a mandatory training curriculum, including a video, which could to be used to educate students, and professional staff in the community about the harmful effects discrimination has on young mothers.

- Bus Card Design – Winter 2013 - Work with Childreach and the young mothers to develop an advertisement which will be posted inside area transit buses.

Summary

The relationship developed by Childreach and Health Unit staff with young mothers in the Mommy and Me Group assists in building capacity and engages the mothers to develop action plans to address their concerns. The opportunity for the mothers to meet and support each other builds their resilience, coping skills, self confidence which in turn impacts their parenting skills.

This report was prepared by Ms. Brooke Clark, PHN, Young Adult Team, and Ms. Christine Preece, Manager, Young Adult Team, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health 1,4,5,6,7,8.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 073-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Click for Babies

Recommendation

It is recommended that Report No. 073-11 re Click for Babies be received for information.

Background

Shaken Baby Syndrome (SBS), also known as the Period of Purple Crying, is a form of violent child abuse. It is the leading cause of traumatic infant death in North America. Up to 30% of abused infants die from their injuries. One-half of the remaining infants experience blindness and various global neurological impairments, including seizures, spasticity, paralysis, and developmental delays. In Canada, 85% of inflicted infant head trauma survivors require long-term care. Total costs of comprehensive medical care for a single shaken infant can exceed one million dollars.

As reported at the February 17, 2011, Board of Health meeting (Report No. 020-11 re Final Strategy of Shaken Baby Syndrome, Period of Purple Crying, Implementation Program attached as Appendix A), the Southwestern Ontario Maternal Newborn Child and Youth Network has recently agreed to take on SBS as one of its strategic directions.

New Initiative – Click for Babies

Click for Babies is a national, public education initiative which involves distributing during the month of November hand-knit, baby caps (using baby-friendly purple yarn) to families along with Purple Program materials. The Health Unit, in partnership with London Health Sciences Centre (LHSC) Trauma Program and Southwest hospitals and health units, has joined the initiative to create a cultural change in how the public understands normal infant crying and thus prevent infant abuse. Many parents and caregivers are unaware that all infants cry more in the first few weeks and months of life. They do acknowledge how frustrating it can be.

Knitters of all ages across southwest Ontario are being asked to click their knitting needles together to knit the purple, newborn caps. The caps will be distributed to babies via hospitals/public health units during the November campaign. The national Click for Babies: Period of Purple Crying Caps campaign is sponsored by the National Center on Shaken Baby Syndrome (NCSBS) and organized throughout Southwestern Ontario by the South West Shaken Baby Syndrome Prevention Working Group. The Group is collecting hats from now until the end of October in an effort to provide enough caps that every baby born during November receives one.

Through the generosity of knitters everywhere, a meaningful gift is being provided to the babies to help remind parents that increased crying is normal, and it is never okay to react in frustration to the crying by shaking or harming an infant.

Next Steps

The Health Unit will be inviting the public to knit purple caps for babies. Plans have been made to hold "knit ins" at the Health Unit and LHSC over the coming months in an effort to unite all knitters. More can be learned about the initiative through www.clickforbabies.org . Questions or comments about the campaign can be directed to Bonnie Wooten, Manager, Family Health Services, Healthy Babies Healthy Children (HBHC) East Team.

This report was prepared by Bonnie Wooten, Manager, Family Health Services HBHC East Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Reproductive Health Standard Requirements 4 and Child Health Standard Requirement 6.

REPORT NO. 020-11

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: 2011 February 17

FINAL STRATEGY OF SHAKEN BABY SYNDROME, "PERIOD OF PURPLE CRYING," IMPLEMENTATION PROGRAM

Recommendation

It is recommended that Report No. 020-11 re Final Strategy of Shaken Baby Syndrome, "Period of Purple Crying," Implementation Program be received for information.

Background

Shaken Baby Syndrome (SBS), also known as the Period of Purple Crying, is a form of violent child abuse. It is the leading cause of traumatic infant death in North America. Up to 30 % of abused infants die from their injuries. In order to address this situation, staff partnered with London Health Science Centre (LHSC) to plan and implement a series of community initiatives focused on the prevention of SBS.

In 2008, a Regional Shaken Baby Syndrome Forum was held as a kick off for a series of activities. In January 2009, staff entered into a Memorandum of Understanding with the United States National Center on Shaken Baby Syndrome. As part of the agreement, the Health Unit's responsibility was to implement the program using the Triple Dose Approach. Dose one occurs in the hospital with education provided to both mothers and fathers following the birth of a baby. Dose two provides follow up by public health nurses, family home visitors, pediatricians, and family doctors who reinforce the message by talking to parents about the concepts taught in The Period of Purple Crying program. Dose three is the media campaign. In 2010, the third and final Dose of the strategy was completed.

Dose Three - Media Campaign

In 2010, the Health Unit and LHSC collaborated on the development of a media campaign for the Period of Purple Crying Campaign. The campaign's objective was to reinforce and raise awareness of PURPLE messages (SBS prevention); target parents of newborns and future parents, family, friends and caregivers; and to drive the community to visit www.purplecrying.info for additional information.

Methodology

The National Centre on SBS provided and tested all the materials used in the campaign. The campaign was launched in April 2010 and extended over a period of six to eight weeks. To get a sense of community awareness of the campaign, the Health Unit and LHSC (Trauma Program) collaborated on the development of a survey module as part of the Rapid Risk Factor Surveillance System (RRFSS). RRFSS is an ongoing telephone survey of the general adult population ages 18+ in Middlesex-London. Data obtained from 404 randomly selected adults from May 5 to September 2, 2010, were analyzed.

Results showed that the campaign was successful in garnering the attention of about 43% of the main target group, 25 to 44 year-olds, who reported having either seen or heard of the campaign. Younger adults, ages 18 to 24, were somewhat less aware at 35%. Older adults were significantly less aware (17% for 45 to 64 year-olds, 5% for those over 65). Over two-thirds of those surveyed recalled that the main message was about either crying babies or shaking babies. The media campaign consisted of advertisements on the backs of city buses, strategically located billboards and transit shelters, public service announcements (PSAs) at Rainbow and Western movie theatres, radio PSAs and interviews. The most commonly cited source of recognition by far was radio, reported by 42%. It appears that the campaign was not successful in getting people to visit the Period of Purple Crying website as only 1% reported having done so.

A more formal evaluation has been conducted by the LHSC Trauma Program Epidemiologist over the past year which includes follow up phone calls with clients who participated in the PURPLE education. The final work will be available in the near future.

Next Steps

The Southwestern Ontario Maternal Newborn Child and Youth Network has recently agreed to take SBS on as one of its strategic directions. Health Unit staff is taking a lead role in this working group. The goal is to engage 100% of the hospitals and public health units in the region in the implementation of SBS. Part of this plan will be to develop a regional media campaign for the fall of 2011.

This report was prepared by Evelyn Crosse, Epidemiologist, FHS, and Bonnie Wooten, Manager, Family Health Services HBHC East Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

BW/ls

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Family Health Services, Child Health.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 074-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Expansion of Publicly Funded Immunization Program

Recommendation

It is recommended that Report No. 074-11 re **Expansion of Publicly Funded Immunization Program** be received for information.

Background

On May 5, 2011, the Ministry of Health and Long-Term Care (MOHLTC) announced that starting August 2011, the province will offer two new vaccines as part of its publicly-funded immunization program and expand the availability of two others vaccines.

Newly Funded Vaccines

1. Rotavirus vaccine **-** Rotavirus is a common intestinal virus that appears one to three days after exposure and begins with a sudden fever and vomiting followed by watery diarrhea, usually 10 to 20 times a day. Almost all children will be infected at least once by five years of age. Most recover within three to eight days without serious or long term effects; however, one-third of parents seek medical care for their child. Dehydration is the most common complication. The rotavirus vaccine is given to infants between the ages of six weeks and eight months of age. The vaccine comes in a liquid form and is administered by mouth. Two doses are required.
2. Combined Measles, Mumps, Rubella, Varicella (MMRV) vaccine - This vaccine combines two currently available vaccines: one which protects against Measles, Mumps and Rubella (MMR) and the other which protects against chickenpox (varicella). The publicly-funded immunization program in Ontario currently provides access to two doses of the measles-mumps-rubella (MMR) vaccine and one dose of varicella vaccine. Now that two doses of both vaccines will be publicly-funded, the combined measles-mumps-rubella-varicella (MMRV) vaccine will reduce the number of injections a child requires.

Vaccines with Expanded Availability

1. Varicella Vaccine (a second childhood dose of varicella vaccine to enhance protection against chickenpox) - Chickenpox results in an itchy rash; however, complications include secondary bacterial skin infections, ear infections, pneumonia, brain damage or death. Complications are more common in adolescents, adults and those who have a weakened immune system. Unlike most other viruses, the varicella virus is able to persist in the body after an attack of chickenpox. It stays within nerve cells and can reactivate later in life resulting in a painful rash called shingles.
   Children currently receive one dose of the varicella vaccine at 15 months of age. Recent studies have suggested that a second dose of the varicella vaccine would help to improve protection and reduce varicella cases by 22%, which in turn will reduce the number of children who develop complications from chickenpox and help to prevent the development of shingles. Based on the 2010 recommendation of the National Advisory Committee on Immunization, children up to the age of eleven years who have not had chickenpox will be eligible to receive two doses of varicella beginning in August 2011.

2. Pertussis Vaccine (a one-time adult dose of diphtheria-tetanus-pertussis for adults 19-64 years of age who did not receive pertussis protection in their teen years) - Ontario's immunization program currently provides a tetanus-diphtheria-pertussis combination vaccine for adolescents at age 14-16 years, but adult booster shots, which are provided every 10 years, only contain tetanus and diphtheria and not pertussis.
   Pertussis or whooping cough is a highly infectious respiratory infection which can cause severe coughing. The cough gets worse until the child coughs without being able to stop to take a breath. At the end of a coughing spell, the characteristic "whoop" sound may occur once the child takes a deep breath. The cough can last for several weeks. Infants and young children may become exhausted by the frequent, severe coughing spells. Because they often vomit after coughing and feed poorly, infants may become dehydrated and lose weight. Other complications include pneumonia, seizures,

brain damage and death. Infants under one year of age are most at risk for the complications of pertussis.

Adolescents and adults who are infected with pertussis can develop a cough which can last for more than three weeks. Adolescents and adults with untreated pertussis (due to failure to recognize the infection) are the most common sources of infection of infants living in the same household. This dose of pertussis vaccine will provide protection to adults and will prevent them from spreading infection to infants for whom pertussis can cause serious complications.

Implementation in Middlesex-London

The majority of publicly-funded vaccines in Ontario are provided in doctors' and nurse practitioners' offices. The Health Unit also provides these vaccines at its walk-in Immunization Clinics at 50 King Street in London and in the Kenwick Mall in Strathroy. On May 5, 2011, staff informed health care providers of the newly announced vaccine changes via email and fax. As additional information becomes available from the MOHLTC, it will be forwarded to local health care providers. For Health Unit clinics, information sheets for the clients and medical directives to support Public Health Nurses in providing the new vaccines will be developed. The client fact sheet and other educational material will be shared with community health care providers to support them in the use of the new vaccines and implementation of the new vaccine schedule. An educational session for health care providers is also being considered.

This report was prepared by Ms. Marlene Price, Manager, Vaccine Preventable Diseases.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Vaccine Preventable Diseases

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 075-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Continuing Education for Board of Health Members

Recommendation
It is recommended that Report No. 075-11 re Continuing Education for Board of Health Members be received for information.

At the September 16, 2010, Board of Health meeting, Board members reviewed recommendations from the Orientation and Continuing Education for Board of Health Members Working Group. Included in these recommendations was one calling for the holding of a half to full day Board of Health Retreat in March or April with the focus being on a Board identified continuing education topic. Owing to Board of Health involvement in the strategic planning process, with two lengthy Board of Health strategic planning meetings, the scheduling of a continuing education session has not been addressed. It is therefore recommended that this item be deferred for 2011.

A second recommendation of this Working Group was that a follow-up orientation session be held for new Board Members six to eight months after their initial orientation. Staff members are requesting that new Board Members advise them if this session would be helpful so that the appropriate arrangements can be made.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 076-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Elevator Repairs at 50 King Street – Final Costs

Recommendation
It is recommended that Report No. 076-11 re Elevator Repairs at 50 King Street – Final Costs be received for information.

Attached as Appendix A is Report No 131-10 re 50 King Street Elevator Situation Update which provides the background for the need to repair the elevator at the 50 King Street office.

Early in 2011, Board members were advised that the repairs to the elevator at 50 King Street had been completed. The repairs totaled $ 45,643.55, and the Health Unit's 50% share is $22,821.78. The Health Unit expensed $11,411.14 in 2010, which leaves $11,410.64 to be paid out of the 2011 building maintenance budget.

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

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 131-10

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: 2010 October 21

---

50 KING ST. ELEVATOR SITUATION

Recommendation

It is recommended that Report No. 131-10 re 50 King St. Elevator Situation be received for information.

Background

The premises at 50 King St. are leased from Middlesex County. The building has one elevator which is essential for the day to day operation of programs and services. Under the terms of the lease, elevator maintenance is the responsibility of the Landlord, and any major repairs are considered a capital expenditure.

Hydraulic Oil Loss Incidents

At the end of January 2010, the elevator maintenance company, Schindler Elevator Corporation, closed the elevator at 50 King St. due to hydraulic oil loss. The investigation, which lasted approximately two weeks, failed to uncover the reason for the oil loss. After completing safety checks, Schindler advised the elevator could be put back into service. The company increased the frequency of maintenance inspections.

There were no discernable operational issues with the elevator noticed by staff (and nothing reported to Health Unit management by either Schindler or the Landlord, Middlesex County) until the beginning of October. On Monday, October 4, 2010, several staff riding the elevator became alarmed by an unusual noise and uneven movement of the unit. It was immediately closed to operation and Schindler was requested to make an urgent visit.

Inspection Findings

Schindler staff reported that a significant loss of hydraulic oil (approximately 9-10 gallons) had occurred since the last inspection at the beginning of September. Company staff initiated an investigation and undertook further safety checks. No cause for the loss of oil was uncovered. The elevator remained out of service. However, on October 12, 2010, Schindler staff advised the elevator could be put back in service. As with the January incident, they committed to increase the frequency of maintenance visits.

Continued Elevator Shutdown

The Medical Officer of Health refused to remove the out of service signs. The reasons for this decision were: that this was the second occurrence within eight months; the size of the hydraulic oil loss and relatively short period of time over which it occurred; a failure on the part of the

company to uncover the cause of the leak, consequently a repair has yet to be made; and most importantly, the risk posed to clients and staff because of these factors.

He advised the County Chief Administrative Officer, Mr. Bill Rayburn, that the elevator would remain out of service until the cause of the hydraulic oil loss was determined and repaired. In addition to “Out of Service” signs, caution tape was placed across each elevator door. Electronic and voicemail messages were sent to all staff advising them of the situation. Contingency strategies were immediately put in place for movement of items between floors, service provision for clients unable to negotiate stairs, etc.

Mr. Rayburn arranged a teleconference meeting for October 13 which included himself, the Medical Officer of Health and representatives from Schindler. Prior to the meeting, Health Unit staff had found on the Technical Standards and Safety Authority (TSSA - the provincial agency responsible for elevators) website, Appendix A to the Regulation 223/01 of the Technical Standards and Safety Act, 2000 (Appendix A). As can be seen from the Background section of Appendix A,

> *“Oil loss which cannot be accounted for, is an indication that corrosion may have developed and should be viewed as a critical warning indicator before further corrosion causes a catastrophic failure.”*

The Regulation also requires that all unexplained losses of hydraulic oil must be reported to the TSSA.

During the teleconference, Schindler representatives maintained their position that the elevator was safe to be placed back in service, even after being confronted with the regulatory requirements highlighted above. The Medical Officer of Health insisted that the elevator remain out of service. The teleconference ended with agreement that Health Unit staff would contact the TSSA.

Technical Standards and Safety Authority Inspection

This was done, with direction given by the TSSA staff person that the elevator was not to be placed in service until inspected by the Authority. The following day, October 14, a TSSA Inspector visited the premises and placed a seal on the power switch for the elevator ensuring it could not be turned on. On October 15, the TSSA delivered to Middlesex County, with a copy to the Health Unit, the inspection report attached as Appendix B. It requires that the elevator remain shutdown “until the reason for the oil loss has been determined.”

Next Steps

A review of the existing contract with Schindler Elevator Corporation is presently underway to determine whether or not the repair must be completed by this company. In the meantime, with concurrence from the landlord, another company has been asked to undertake an independent assessment including providing a repair cost estimate.

An important issue has arisen regarding the timing of the repair. Under Section 275 of the Municipal Act, because of the impending election, County Council is in what is referred to as a “Lame Duck” position. That is, County Council cannot take any action that is not budgeted or is not an emergency that would involve or incur an expenditure of more than $50,000. It is estimated that the repair will exceed this amount. The repair has not been budgeted for and although it is a major inconvenience, it is not considered an emergency. This would mean that County Council could not deal with this matter until December at the earliest.

There is another option to address this situation. Under Article 12 of the lease between Middlesex County and the Board of Health for the 50 King St. premises, in situations where the Landlord cannot or does not undertake designated repair/maintenance services on a timely basis, the Health Unit can pay the costs of such repairs and recover the costs either through repayment from the County or setting off the costs against future rental payments. In this way, the repair actions would be undertaken by the Health Unit thereby not requiring any action on the part of County Council. Because it is action taken by the Board of Health, there would be no contravention of Section 275 of the Municipal Act. The Health Unit Solicitor, who also acts for Middlesex County Council, recommends this approach. Attached as Appendix C is Article 12 of the lease.

A verbal update will be provided at the October 21, 2010, Board of Health meeting.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 077-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 June 16

Board of Health Performance Assessment

Recommendation
It is recommended that Report No. 077-11 re Board of Health Performance Assessment be received for information.

Background
On November 18, 2010, the Board of Health approved the use of the Board of Health Performance Assessment Tool. The tool is to be used three times per year i.e., March, June and November. Attached as Appendix A is the survey document for the second quarter review. This document is also available online at http://fluidsurveys.com/surveys/program-evaluator/board-self-assessment-survey/ . The latter option will be available until June 24, 2011. An email will be sent to Board of Health members immediately following the June meeting with the survey link included. Completed hard copies can either be left with the Executive Assistant to the Board of Health, Ms. Sherri Sanders, or mailed directly to her at 50 King St., London, N6A 5L7.

The purpose of the assessment is to:

A. Focus on the performance of the Board of Health as a whole, not the performance of individual Board members;
B. Identify areas of Board strength; and
C. Identify areas that could be enhanced.

A summary of the results will be provided at the September Board of Health meeting.

This report was prepared by Ms. Sherri Sanders, Executive Assistant to the Board of Health.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses **Board of Health direction given to Board Working Group # 3 and the draft Ontario Public Health Organizational Standards.**

MIDDLESEX-LONDON HEALTH UNIT

Board of Health Performance Assessment Tool

This survey is expected to take approximately 10-15 minutes.

Please complete by Friday March 25, 2011.

As part of the Board's commitment to good governance and continuous quality improvement, all Board members are invited to complete the Board of Health Performance Assessment Tool. The tool is intended to 1) focus on the Board as a whole, 2) identify areas of strength, and 3) areas that could be enhanced.

Please note however, that your participation is voluntary and you may choose not to participate or not to respond to all questions.

"*Performance of Individual Board Members*" should not be submitted. It is provided to support self-reflection on your role as a Board member.

The results will be summarized and shared with the Board. All responses will be handled in confidence and individual responses will not be identifiable from the summary.

Once the summary has been shared with the Board, the questionnaires will be destroyed.

Please return your questionnaire in a sealed envelope to Sherri Sanders, Executive Assistant to the Board of Health. If you have any questions about the survey, please contact Sherri Sanders, 519-663-5317, Ext. 3011 or at sherri.sanders@mlhu.on.ca

Thank you

The electronic copy has the same content, yet will look different to accommodate the formatting required for the on-line survey.

A. How Well Has the Board Done Its Job?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

Please indicate the extent to which you agree with the following statements?

The Board:

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
1. Has a common understanding of the Board's mandate, scope and authority.	❑	❑	❑	❑	❑	❑	❑	❑
2. Keeps abreast of relevant trends, events and emerging issues.	❑	❑	❑	❑	❑	❑	❑	❑
3. Understands the Health Unit's mission.	❑	❑	❑	❑	❑	❑	❑	❑
4. Has a working knowledge of Board bylaws.	❑	❑	❑	❑	❑	❑	❑	❑
5. Ensures that the Health Unit has a long-term strategic plan.	❑	❑	❑	❑	❑	❑	❑	❑
6. Ensures that the Health Unit is responsive to needs of local communities.	❑	❑	❑	❑	❑	❑	❑	❑
7. Ensures processes are in place to identify, assess and manage any risks to the Health Unit	❑	❑	❑	❑	❑	❑	❑	❑
8. Focuses on long-term results and substantial policy issues rather than operational detail.	❑	❑	❑	❑	❑	❑	❑	❑
9. Is able to interpret, analyze and assess financial information, reports and proposals.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
10. Has adequate information to monitor organizational performance. e.g. financial management; delivery of Ontario Public Health Standards ; work force issues, etc.	❑	❑	❑	❑	❑	❑	❑	❑
11. Ensures that decisions are based on accurate, timely and the best available information.	❑	❑	❑	❑	❑	❑	❑	❑
12. Has a process for handing urgent matters between meetings.	❑	❑	❑	❑	❑	❑	❑	❑
13. Is knowledgeable of the programs and services offered by the Health Unit.	❑	❑	❑	❑	❑	❑	❑	❑
14. Regularly assesses the performance of the MOH/CEO in a systematic way.	❑	❑	❑	❑	❑	❑	❑	❑

15. Additional observations, comments or suggestions about how well the Board has done its job:

B. How Well Has the Board Conducted Itself?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

Please indicate the extent to which you agree with the following statements?

	Strongly Disagree 1	2	3	Neither Agree or Disagree 4	5	6	Strongly Agree 7	Don't Know
1. Board members are aware of what is expected of them.	❑	❑	❑	❑	❑	❑	❑	❑
2. The roles and responsibilities of the board are clearly defined and separate from those of staff.	❑	❑	❑	❑	❑	❑	❑	❑
3. <u>Complete ONLY If a New Board member</u> New Board members receive an effective orientation to their responsibilities as a Board member.	❑	❑	❑	❑	❑	❑	❑	❑
4. The Board is satisfied with the ongoing education it receives in order to fulfill its responsibilities.	❑	❑	❑	❑	❑	❑	❑	❑
5. Board information packages provide the right information and are received in a timely manner.	❑	❑	❑	❑	❑	❑	❑	❑
6. Board meeting agendas are well planned so that all necessary board business is addressed.	❑	❑	❑	❑	❑	❑	❑	❑
7. Agendas are appropriate e.g. topics are relevant to the mission and goals of the Health Unit; items are clearly identified as for information, discussion or decision.	❑	❑	❑	❑	❑	❑	❑	❑
8. Board members come prepared to participate in the discussion and decision–making.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
9. The Board uses its meeting time effectively and efficiently i.e. discussion is focused, clear, concise and on topic.	❑	❑	❑	❑	❑	❑	❑	❑
10. All board members participate in important board discussions.	❑	❑	❑	❑	❑	❑	❑	❑
11. Board members do a good job of encouraging and dealing with different points of view.	❑	❑	❑	❑	❑	❑	❑	❑
12. Board members respect the rules of confidentiality	❑	❑	❑	❑	❑	❑	❑	❑
13. Decisions are supported once made.	❑	❑	❑	❑	❑	❑	❑	❑
14. Board decisions and processes are available to staff and community partners.	❑	❑	❑	❑	❑	❑	❑	❑
15. The Board Chair runs the meetings effectively.	❑	❑	❑	❑	❑	❑	❑	❑

16. Additional observations, comments or suggestions about how well the Board has conducted itself:

C. Open-Ended Questions

1. **What I like most about our meetings:**

2. **What I like least about our meetings:**

3. **Please indicate what training opportunities you would like as a board member.**

4. **What is the most important thing the Board could do to improve its performance as a Board?**

5. **Do you have additional comments that will help the Board increase its effectiveness?**

Thank you!

MIDDLESEX-LONDON HEALTH UNIT

Performance of Individual Board Members
(Not to be Submitted)

Are you satisfied with your performance as a board member in the following areas?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree or Agree 4	5	6	Strongly Agree 7	Don't Know
1. I am aware of what is expected of me as a board member.	❑	❑	❑	❑	❑	❑	❑	❑
2. I have a good record of meeting attendance.	❑	❑	❑	❑	❑	❑	❑	❑
3. I read the minutes, reports and other materials in advance of the board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
4. I frequently encourage other board members to express their opinions at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
5. I am encouraged to express my opinions at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
6. I feel comfortable to ask questions if I do not understand something.	❑	❑	❑	❑	❑	❑	❑	❑
7. I am a good listener at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
8. I follow through on things I have said I would do.	❑	❑	❑	❑	❑	❑	❑	❑
9. I maintain the confidentiality of all board decisions.	❑	❑	❑	❑	❑	❑	❑	❑
10. When I have a different opinion than the majority, I raise it.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree or Agree 4	5	6	Strongly Agree 7	Don't Know
11. I support board decisions once they are made even if I do not agree with them.	❑	❑	❑	❑	❑	❑	❑	❑
12. I stay informed about issues relevant to the Health Unit mission and bring information to the attention of the board.	❑	❑	❑	❑	❑	❑	❑	❑
13. I understand my legal responsibilities.	❑	❑	❑	❑	❑	❑	❑	❑

14. Additional observations, comments or suggestions about my own performance as a Board Member:

THIS QUESTIONNAIRE IS FOR INDIVIDUAL USE ONLY AND IS NOT TO BE SUBMITTED.