AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:15 p.m.
2013 May 9

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

SCHEDULE OF APPOINTMENTS

7:30 p.m. Mr. Chirag Shah, Partner, Audit and Assurance Group; Mr. Maurice Chang, Director Management Consulting; and Ms. Erin Dragasevich, Senior Associate; PricewaterhouseCoopers, Item #3 – Report No. 063-13 re "PricewaterhouseCoopers Interim Report – May 9, 2013"

REPORTS

	Report No. and Name	Link to Appendices and Key Additional Information	Delegation	Recommendation	Information	Brief Overview
1	Report No. 061-13 re "Minister Approval – Medical Officer of Health"	Appendix A			X	To report that the Minister of Health and Long-Term Care has approved the appointment of Dr. Christopher Mackie as Medical Officer of Health and Chief Executive Officer
2	Report No. 062-13 re "Election of Secretary-Treasurer"	Appendix A Appendix B		X		To elect a Secretary-Treasurer for the Board of Health now that a permanent Medical Officer of Health and Chief Executive Officer has been hired
3	Report No. 063-13 re "PricewaterhouseCoopers Interim Report – May 9, 2013"	Appendix A Appendix B	X	X		To request that the Board of Health select an option with respect to next steps regarding the recommendations of the PricewaterhouseCoopers interim report

OTHER BUSINESS

Next scheduled Board of Health Meeting: 7:00 p.m. – Thursday, May 16, 2013

ADJOURNMENT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 061-13

TO: Members of the Board of Health

FROM: Mr. Marcel Meyer, Chair

DATE: 2013 May 9

MINISTER APPROVAL – MEDICAL OFFICER OF HEALTH

Recommendation

It is recommended that Report No. 061-13 re "Minister Approval – Medical Officer of Health" be received for information.

Key Points

- On May 1, 2013 the Board of Health received confirmation that The Honourable Deb Matthews, Minister of Health & Long-Term Care approved the appointment of Dr. Christopher Mackie as the Medical Officer of Health.

On February 19th, 2013 the Board of Health passed a resolution to appoint Dr. Christopher Mackie to the position of Medical Officer of Health and Chief Executive Officer. Further to this appointment the Board of Health sent a request to The Honourable Deb Matthews, Minister of Health & Long-Term Care to approve this appointment as required under Section 64 (c) of the *Health Protection and Promotion Act*.

Attached as Appendix A, is the approval letter from Minister Matthews.

Mr. Marcel Meyer
Chair, Board of Health

Ministry of Health and Long-Term Care

Office of the Minister

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80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
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Ministère de la Santé et des Soins de longue durée

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Ontario

HLTC2966MC-2013-2082

MAY 01 2013

Marcel Meyer
Chair
Middlesex-London Board of Health
50 King St.
London ON N6A 5L7

Dear ~~Mr. Meyer:~~ Marcel

I am writing with respect to the Board of Health's resolution of February 19, 2013 to appoint Dr. Christopher Mackie to the position of Medical Officer of Health and Chief Executive Officer for the Middlesex-London Health Unit.

Dr. Mackie has met the eligibility requirements specified in the *Health Protection and Promotion Act (HPPA)* to be appointed as a full-time Medical Officer of Health.

I am pleased to approve the appointment of Dr. Mackie as the Medical Officer of Health.

This approval is granted in accordance with Clause 64(c) of the *Health Protection and Promotion Act.*

Yours sincerely,

Deb Matthews

Deb Matthews
Minister

c: Dr. Christopher Mackie, Middlesex-London Health Unit
Teresa J. Armstrong, MPP, London--Fanshawe
Constituency Office, London North Centre
Monte McNaughton, MPP, Lambton--Kent--Middlesex
Jeff Yurek, MPP, Elgin--Middlesex--London
Dr. Arlene King, Chief Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 062-13

TO: Members of the Board of Health

FROM: Mr. Marcel Meyer, Chair

DATE: 2013 May 9

ELECTION OF SECRETARY-TREASURER

Recommendation

It is recommended that Dr. Christopher Mackie be elected Secretary-Treasurer of the Board of Health.

Key Points

- Dr. Bryna Warshawsky has been the Secretary-Treasurer since the retirement of the former Medical Officer of Health, Dr. Graham Pollett at the end of September 2012.
- The Board of Health has hired Dr. Christopher Mackie as the Medical Officer of Health and Chief Executive Officer effective May 1, 2013, and it is therefore recommended that Dr. Christopher Mackie be elected Secretary-Treasurer of the Board of Health.

On September 13, 2012 (Report No. 099-12), the Board of Health elected Dr. Bryna Warshawsky as the Secretary-Treasurer for the remainder of the 2012 calendar year. On January 17, 2012 (Report No. 001-13), Dr. Warshawsky was again elected Secretary Treasurer until such time a successor was in place for the position of Medical Officer of Health, and the Board of Health could elect a new Secretary-Treasurer.

Historically, the practice of the Board of Health has been to name a staff member (i.e. the Medical Officer of Health and CEO) as the Secretary-Treasurer, due to the administrative nature the position. Policy No. 1-010 (attached Appendix A) entitled "Structure and Responsibilities of the Board of Health" deals with the election of Officers. Attached as Appendix B are the Board of Health Bylaws which set out the duties and responsibilities of the Secretary-Treasurer. Bylaw No. 1 highlights the Treasurer component of the Secretary-Treasurer position whereas Bylaw No. 2 – Section 7 summarizes the secretarial duties of the position.

It is recommended that the Board of Health elect Dr. Christopher Mackie as the new Secretary-Treasurer of the Board of Health at the May 9th Board of Health meeting.

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

Marcel Meyer
Chair, Board of Health

SUBJECT: **STRUCTURE AND RESPONSIBILITIES OF THE BOARD OF HEALTH** **POLICY NUMBER: 1-010**

SECTION: Board of Health Page 1 of 7

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

PURPOSE

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

POLICY

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

PROCEDURE

1.0 Board of Health Structure

1.1 Board of Health Appointments

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

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

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

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

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

1.2 Vacancies and Re-appointments

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

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

1.3 Committee Structure

Each year at its inaugural meeting, the Board will:

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

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

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

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

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

2.0 Responsibilities

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

2.1 Leadership

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

- Delivery of the Ontario Public Health Standards (including the program, foundational, and organizational standards);
- Organizational effectiveness through evaluation of operational and strategic plans;

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

2.2 Advocacy and Policy Development

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

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

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

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

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

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

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

The Board of Health may enter into an agreement with qualified physicians to temporarily fulfill the duties of a Medical Officer of Health during short absences of the Medical Officer of Health, any acting Medical Officer of Health and any associate Medical Officer of Health.

2.4 Dismissal of a Medical Officer of Health

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

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

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

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

2.5 Medical Officer of Health Reporting

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

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

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

2.6 Provision of Services on Aboriginal Reserves

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

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

3.0 Access to the Board of Health

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

Directors may attend all Board of Health meetings.

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

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

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

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

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

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

4.0 Informing Municipalities of Financial Obligations

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

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

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

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

5.0 Recognition and Access to Collective Agreements

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

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

6.0 Ratification of Collective Agreements

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

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

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

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

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

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

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

APPENDIX A
To Policy 1-010

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON BOARD OF HEALTH

BYLAWS

IMPLEMENTATION DATE: September 25, 1986

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

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

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.0 General

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

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

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

1.4 No persons shall smoke in the Board meeting room.

2.0 Convening Meeting

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

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

3.0 Special Meetings

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

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

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

4.0 Notifying Board Members of Meetings

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

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

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

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

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

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

5.0 Notifying the Public of Board Meetings

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

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

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

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

6.0 Meetings Open to the Public

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

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

7.1 Pre-requirements for in-camera sessions

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

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

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

7.2 Criteria for in-camera meetings

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

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

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

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

(d) labour relations or employee negotiations;

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

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

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

7.3 Criteria for in-camera voting

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

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

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

7.4 In-camera record keeping requirements

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

8.0 Preparation of the "Agenda"

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

(a) Call to Order and Declarations of Interest;

(b) Minutes of Previous Meeting;

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

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

(e) Other Business from the Floor;

(f) Date of Next Meeting;

(g) Adjournment

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

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

9.0 Commencement of Meetings

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

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

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

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

10.0 Rules of Debate and Conduct of Members of the Board

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.0 Motions and Order of Putting Questions

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

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

(a) to adopt;

(b) to amend;

(c) * to table;

(d) to refer;

(e) to receive;

(f) * to adjourn the meeting; or

(g) * that the vote be now taken.

* these items are to be voted on without debate.

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

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

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

12.0 Voting

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

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

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

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

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

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

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

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

13.0 Minutes

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

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

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

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

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

14.0 Adjournment

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

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

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

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

15.0 Communications

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

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

16.0 Proceedings on Bylaws

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

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

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

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

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

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

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

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

17.0 Secretary-Treasurer and Board Solicitor

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

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

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

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

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

17.2 It shall be the duty of the Board Solicitor:

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

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

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

18.0 Elections and Appointment of Committees

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

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

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

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

19.0 Conduct of Business in Committees

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

19.2 It shall be the duty of the Committee:

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

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

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

19.3 The procedures of the Board with respect to:

(a) incurring of liabilities and paying of accounts;

(b) contracts and expenditures;

(c) petty cash;

(d) tenders and quotations;

shall be in accordance with the Agreement.

20.0 Corporate Seal

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

21.0 Execution of Documents

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

22.0 Duties of Officers

22.1 The Chair of the Board shall:

(a) preside at all meetings of the Board;

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

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

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

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

23.0 Remuneration

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

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

24.0 Board of Health Performance Assessment

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

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

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

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

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

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

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

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

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

25.0 Amendments

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

26.0 General

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

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

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

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

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

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

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

2. The Auditor shall:

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

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

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

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

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

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

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

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

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

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

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

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

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

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

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

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

Ms. Viola Poletes Montgomery
Chair

Dr. Graham L. Pollett
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

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

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

_____

Ms. Viola Poletes Montgomery
Chair

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 063-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 May 9

PRICEWATERHOUSECOOPERS INTERIM REPORT – MAY 9, 2013

Recommendations:

That the Board of Health select an option with respect to next steps regarding the recommendations of the PricewaterhouseCoopers interim report.

Option A: *Direct that Health Unit staff conduct a detailed analysis of the findings in the interim report and provide recommendations to the Board of Health regarding proceeding with next steps with respect to improving operational efficiency as outlined in the report;*

Option B: *Identify priority recommendations immediately and direct that Health Unit staff work with PricewaterhouseCoopers to prepare a proposal regarding proceeding with Phase III of the review to further explore operational efficiencies as outlined in the interim report;*

Option C: *Identify priority recommendations immediately and direct that PricewaterhouseCoopers proceed with Phase III as outlined in the interim report within the total project budget of $135,000;*

Option D: *Receive the interim report for information.*

Key Points

This report presents the "Efficiency and Shared Services Review, Interim Report for Phases I and II" prepared by PricewaterhouseCoopers.

The considerations of the Board in the development of the interim report are outlined, as is the review process involving staff members from the Health Unit, City of London and Middlesex County.

The Board of Health is asked to provide recommendations on next steps following review of the interim report.

Background

At its June 21, 2012 meeting, the Board of Health requested a review of the cost efficiencies that could be realized through shared services arrangements. At its meeting in November 15, 2012 (Report No. 133-12), Terms of Reference for this review were approved by the Board which included that:

- the review would be conducted by PricewaterhouseCoopers;
- the scope of the review would cover Information Technology, Finance and Operations, Human Resources and Labour Relations, and the Office of the Medical Officer of Health.

At its January 17, 2013 meeting, the Board of Health approved PricewaterhouseCoopers' proposal to conduct Phase I and Phase II of the review which would result in an interim report. As stated in Report No. 002-13:

> *The interim report will identify any potential efficiencies or cost savings in existing administrative functions, and will also identify which functions the Board may want to consider investigating further for potential sharing with the City of London and/or Middlesex County.*

Phase I and II was estimated to cost $65,000 to $75,000. At the end of Phase II and after review of the interim report, the Board of Health was to determine if they would like PricewaterhouseCoopers to proceed with Phase III of the review, which is described in Report No. 002-13 as follows:

> *Phase III of the review will involve a more in-depth analysis of the areas the Board decides should be explored further. Phase III is anticipated to cost as much as $40,000 - $65,000, but this will depend on decisions the Board makes with respect to areas for further exploration in response to the findings of the interim report.*

Report No. 002-13 also outlines that $135,000 of municipal surpluses from 2012 has been set aside to perform the review.

For a complete summary of Board of Health reports related to the PricewaterhouseCoopers review leading up to the interim report, please refer to Appendix A. Appendix A also outlines the Board of Health reports that provide detailed information on the Health Unit administrative services that are covered in the PricewaterhouseCoopers review.

At the May 9, 2013 Board of Health meeting, the Board will be reviewing the interim report prepared by PricewaterhouseCoopers entitled "Efficiency and Shared Services Review, Interim Report for Phases I and II" which is attached as Appendix B.

Process for Preparing the Interim Report

The process for preparing the interim report was outlined in Appendix A of Report No. 032-13 that was presented to the Board of Health by PricewaterhouseCoopers on March 21, 2013. As indicated in slide 10 of Appendix A, Directors Committee received the report on Friday, April 26, 2013. Written feedback was provided to PricewaterhouseCoopers on April 29 and a meeting was held involving Health Unit Directors and PricewaterhouseCoopers on April 30, 2013. On May 1, 2013, a meeting took place involving PricewaterhouseCoopers and representatives from the City of London, Middlesex County and Health Unit to further review the report. The purpose of these reviews was to ensure clarity and accuracy of the factual elements of the report. The opinions and conclusions in the interim report are those of PricewaterhouseCoopers and not subject to input by the Health Unit, City or County staff.

Recommendations for consideration by the Board of Health

With regard to next steps, the Board of Health can consider recommending one of the following options:

Option A: Direct that Health Unit staff conduct a detailed analysis of the findings in the interim report and provide recommendations to the Board of Health regarding proceeding with next steps with respect to improving operational efficiency as outlined in the report;

Option B: Identify priority recommendations immediately and direct that Health Unit staff work with PricewaterhouseCoopers to prepare a proposal regarding proceeding with Phase III of the review to further explore operational efficiencies as outlined in the interim report;

Option C: Identify priority recommendations immediately and direct that PricewaterhouseCoopers proceed with Phase III as outlined in the interim report within the total project budget of $135,000;

Option D: Receive the interim report for information.

PricewaterhouseCoopers consultants Mr. Chirag Shah, Partner, Audit and Assurance Group; Mr. Maurice Chang, Director Management Consulting; and Ms. Erin Dragasevich, Senior Associate will be in attendance at the May 9, 2013 Board of Health meeting to assist the Board with the review of the interim report.

This report was prepared by Dr. Bryna Warshawsky, Associate Medical Officer of Health; Mr. John Millson, Director, Finance and Operations; and Dr. Christopher Mackie, Medical Officer of Health and Chief Executive Officer.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Background reports regarding PricewaterhouseCoopers review

The following provides a chronology of Board of Heath reports related to the PricewaterhouseCoopers review:

- Report No. 102-12 – September 13, 2012 - Shared Services Review – Update
- Report No. 133-12 – November 15, 2012 - Terms of Reference for a Review of Administrative Functions, Including Shared Services
- Report No. 140-12 – December 13, 2012 – Update on the Shared Services Review – December 2012
- Report No. 002-13 – January 17, 2013 – Shared Services Review – Proposal
- Report No. 032-13 – March 21, 2013 – Review of Administrative Functions, Including Shared Services, Being Conducted by PricewaterhouseCoopers – March Update

The following Board of Health reports provide detailed background information about the Health Unit administrative areas covered in the review by PricewaterhouseCoopers:

- Report No. 007-13 – January 17, 2013 – Overview of Health Unit Administrative Functions
- Report No. 017-13 – February 19, 2013 – Overview of Information Technology Services
- Report No. 033-13 – March 21, 2013 – Overview of Human Resources & Labour Relations Services
- Report No. 034-13 – March 21, 2013 – Overview of Finance and Operations Services
- Report No. 035-13 – March 21, 2013 – Overview of the Office of the Medical Officer of Health

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Middlesex-London Health Unit

Efficiency and Shared Services Review

Interim Report for Phases I & II

May 2, 2013

pwc

Important Preamble to Final Report

This report is issued by PricewaterhouseCoopers LLP ("PwC") to the Board of Health of the Middlesex London Health Unit("MLHU").

Our work did not constitute an audit conducted in accordance with generally accepted auditing standards, an examination of internal controls or other attestation or review services in accordance with standards established by the Canadian Institute of Chartered Accountants ("CICA"). Accordingly, we do not express an opinion or any other form of assurance on the financial or other information, or operating and internal controls, of MLHU.

Our work was based primarily on information supplied by the management of MLHU, the City of London, and the County of Middlesex and was carried out on the basis that such information is accurate and complete. Information was not subject to checking or verification procedures, except to the extent expressly stated to form part of the scope of our work.

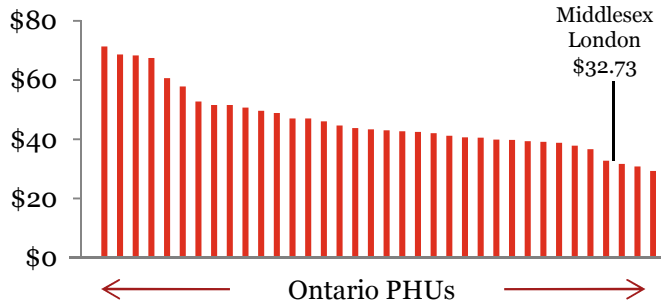
We make no representation regarding the sufficiency of our work either for the purposes for which this report has been requested or for any other purpose.

Table of Contents

Context and Background

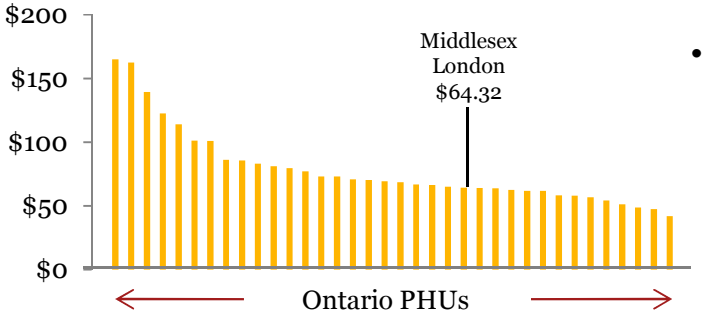
Post-SARS, MLHU's funding almost doubled due to increased funding from the provincial government to meet Middlesex-London's public health needs

Total per capita funding, 2003



Source: Middlesex London Health Unit, Report No. 131-12

Total per capita funding, 2007



Source: Middlesex London Health Unit, Report No. 131-12

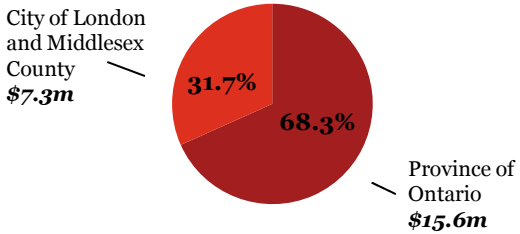
- MLHU has increased its cost-shared budget from about $14m in 2003 to about $23m in 2012 due to increased funding from the provincial government
- This was based on a response from the provincial government as a result of the SARS epidemic and an increased focus on public health
- In 2003, MLHU was 34th in total per capita funding out of 37 provincial health units, and so there was a need to improve funding to support public health in the region
- MLHU continues to be in the bottom half of health units in terms of total per capita funding, approximately 23rd out of 36 Public Health Units (PHUs)
- The increase in budget has been borne entirely by the province, with municipal assistance staying flat or declining over this same period
- MLHU relies on municipal government for approximately 31% of its funding, versus the proposed model of 25% municipal/75% provincial. It should be noted, however, that many PHUs are still funded greater than 25% from municipalities and there is no legislative requirement for cost-shared funding to be split on a 25/75 basis

Key Observation: MLHU has been asked by the City of London to move more quickly towards a 25/75 model in order to help the City achieve their fiscal objectives. MLHU, the City of London and Middlesex County collectively want to minimize the costs through efficiencies in administrative functions at MLHU.

Context and Background (cont'd)

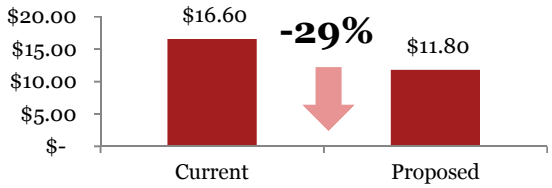
Provincial funding increases are slowing and there are increasing budgetary pressures on MLHU

MLHU sources of funding for cost-shared programs



Middlesex-London Health Unit, Questions and Answers to Assist in Understanding the Health Unit's Budget, October 26, 2012

Municipally-funded public health, per person per year



Middlesex-London Health Unit, Questions and Answers to Assist in Understanding the Health Unit's Budget, October 26, 2012, PwC Analysis

- The MLHU has rising costs, and expect marginal to flat revenue growth for the foreseeable future
- Both the City and County have been able to reduce the impact of increasing costs to the tax payer, over the past number of years
- As part of the City's current budget targets, City Council has requested the Board of Health to move more expeditiously to a 25/75 funding arrangement for public health programs that are cost-shared with the municipality
- Currently, MLHU receives $16.60 per person, per year from the Municipalities
  - Assuming no population changes or changes in provincial funding received, in order to achieve the 25/75 model:
    - Municipally funded public health would have to decrease to approximately $11.80 per person per year, which means MLHU would have to cut costs by $2.1m over 3 years, including having to cut its 2013 budget by $0.5m
- At the same time, the provincial increases in funding to public health have continually decreased over the past ten years from 5% to 2% (2012)
- Further pressures are expected on provincial funding for public health as the province works to improve its fiscal situation

Key Observation: MLHU will need to continue to identify ways to become more cost-efficient in order to meet increasing budget pressures for the current and future years. The impact of achieving the desired 25/75 model will have to be assessed, as there is a potential risk of reducing MLHU's ability to provide public health services.

Context and Background (cont'd)

The MLHU Board engaged PwC to determine potential efficiencies and cost savings in the Health Unit's administrative functioning, including the possibility of shared services with the City of London and Middlesex County

Objectives

- Establish the baseline to **determine potential efficiencies and cost savings** in the administrative functioning of the Middlesex-London Health Unit including the possibility of a shared services arrangement between MLHU, the City of London and the County of Middlesex
- Decision point to **pursue further exploration of potential efficiencies/ cost savings opportunities** (which may include shared services)
- Develop a Target Operating Model to achieve the cost savings identified in Phases I & II
- Requirements for Implementation

Scope

PwC shall undertake a **review of administrative functions**, to include specifically the following scope:

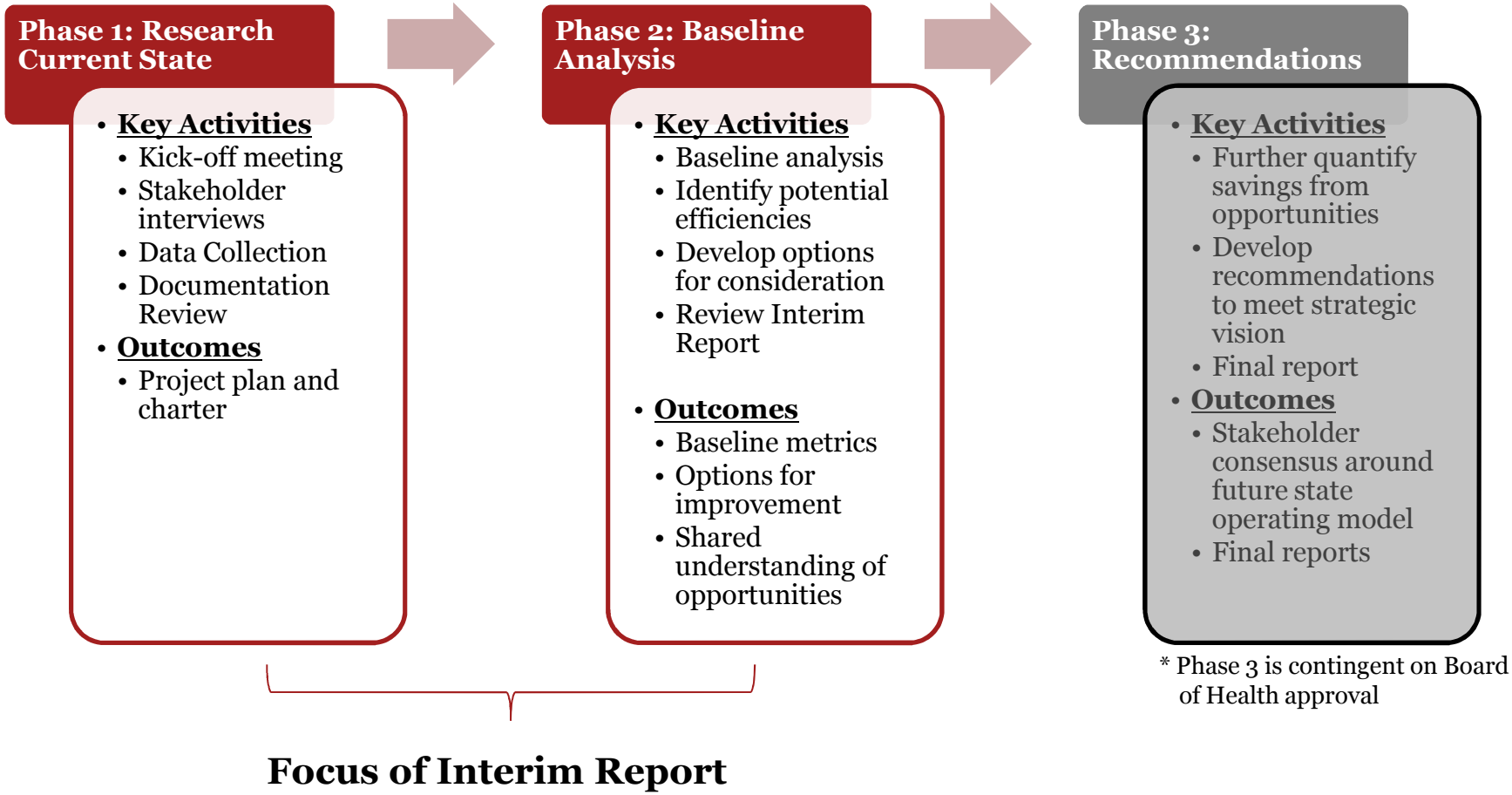
- Finance & Operations
- Purchasing
- Information Technology
- Human Resources
- Facility Management
- Office of the Medical Officer of Health
  - Communications, Privacy, Occupational Health & Safety, Emergency Preparedness, Special Projects

Guiding Principles

- **Independent** review of administrative services
- **Evidence-based** analysis
- Efficiencies or cost savings to be achieved provided that the public health **programs provided by the Board are not negatively impacted**
- Parties **are not bound** to implement any recommendations for cost savings through shared services
- Accountability and overall management related to shared services shall remain with the **Board**

Approach

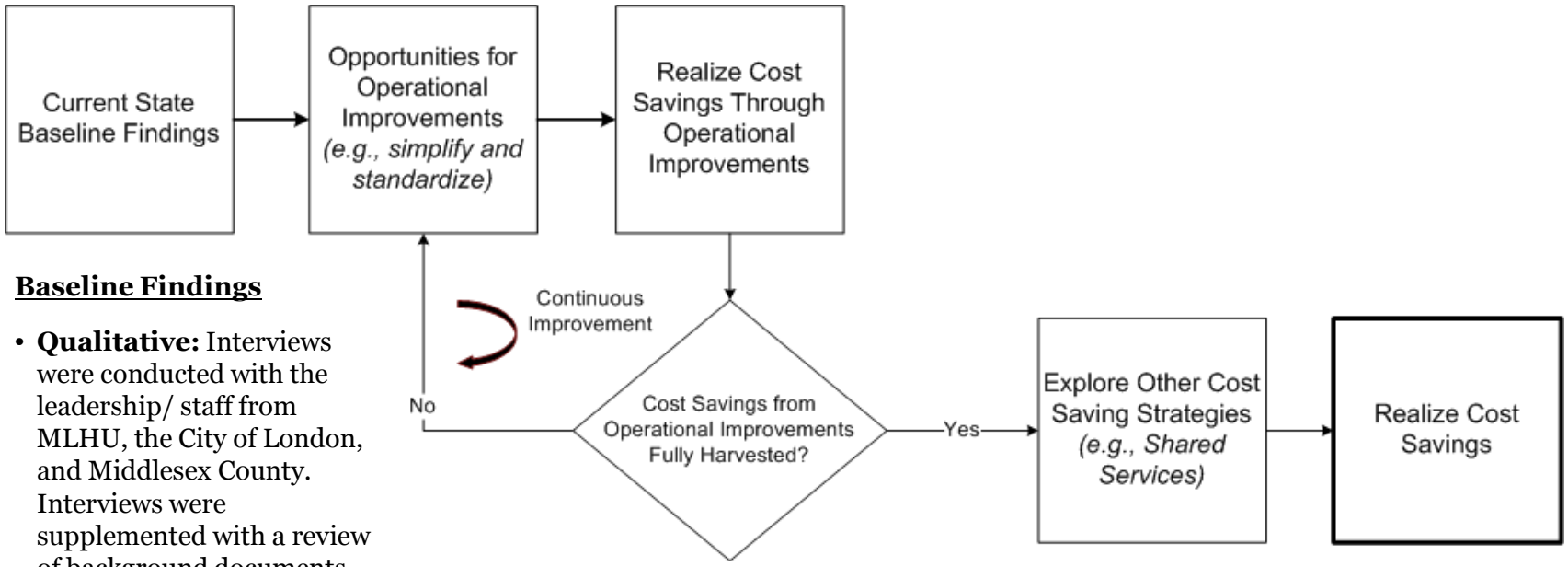
The engagement was structured into three phases, with the Interim Report concluding Phase Two



Approach (cont'd)

PwC's approach was guided by a roadmap to achieve cost savings

Roadmap to Achieve Cost Savings



Baseline Findings

- **Qualitative:** Interviews were conducted with the leadership/ staff from MLHU, the City of London, and Middlesex County. Interviews were supplemented with a review of background documents
- **Quantitative:** A Level of Effort (LOE) Survey and organizational benchmarking was conducted

Key Baseline Findings

MLHU's administrative functions have some notable strengths

While strengths were identified within MLHU's administrative functions, there are opportunities for operational improvements.

Key Baseline Findings (cont'd)

Quantitative findings from the baseline analysis indicate that MLHU has a lean administration, but when compared to other organizations, some functions could be more productive

		Level of Effort By Administrative Function (expressed in FTEs)						
		Finance and Operations	Human Resources	Information Services	OMOH	Enterprise / Organizational	Other	**TOTAL**
Department (Actual FTE)	Finance and Operations	8.5	0.1	0.1	0.0	0.4	0.0	**9.2**
	Human Resources	0.1	5.1	0.0	0.1	1.2	0.3	**6.7**
	Library/Reception	0.0	0.0	0.0	0.0	4.5	0.1	**4.6**
	Information Services	0.1	0.1	7.6	0.0	0.6	0.0	**8.4**
	OMOH	0.0	0.0	0.0	9.3	0.0	0.0	**9.3**
	TOTAL	**8.7**	**5.3**	**7.7**	**9.4**	**6.7**	**0.4**	**38.2**
	% Overlap	1.6%	3.9%	1.6%	1.5%	N/A	N/A	N/A

MLHU has a lean administration…

- The Level of Effort survey shows that there is minimal overlap in administrative functions being performed across the various administrative service areas
- The level of effort allocated to each administrative function appears to be reasonable

MLHU could be more productive…

- Metrics from other organizations indicate that some administrative functions could be performed more efficiently, for instance:
  - The City of London[1] and Middlesex County[2] process approximately 2.3x and 1.5x more vendor invoices per 1 AP FTE (respectively) and 2.1x and 1.2x more payroll direct deposits and cheques per 1 Payroll FTE (respectively) than MLHU – mainly due to greater technology enablement

Sources: [1] 2011 Ontario Municipal CAO's Benchmarking Initiative (OMBI) Performance Measurement Report, 2012, [2]data provided by Middlesex County

Operational Improvements

Based on the baseline analysis, PwC has identified key findings and opportunities for improvement

Key Findings

- Highly manual processes and sub-optimal technology/software
- Processes are not consistently following lean principles
- Currently untapped opportunities for cost savings and generation of new revenues

- Internal disconnect and lack of integration between various activities/functions
- Sub-optimal policies and lack of consistent policy enforcement

- Existing metrics are transactional/volume-driven and fail to describe the efficiency/effectiveness for which activities are being performed
- Monitoring, evaluation and recognition of achievement against key performance measures was not fully evident

- Broad stakeholder network has not been fully leveraged to achieve shared goals and promote value for money

Opportunities for Improvement

Strategic investments to achieve efficiency-related cost-savings

Internal integration and cohesiveness

Adoption of a performance-focused culture

Greater partnerships and collaboration with other organizations

Recommendation 1: MLHU should make strategic investments to achieve efficiency-related cost savings in administrative functions

Description
MLHU has not fully realized the cost savings through technology enablement (e.g., increased automation, implementing additional software modules) in its administrative functions. Highly manual processes and sub-optimal systems are resulting in ineffective use of resources. MLHU needs to optimize its current processes and utilize more technology/ increased automation as an enabler for efficiency.

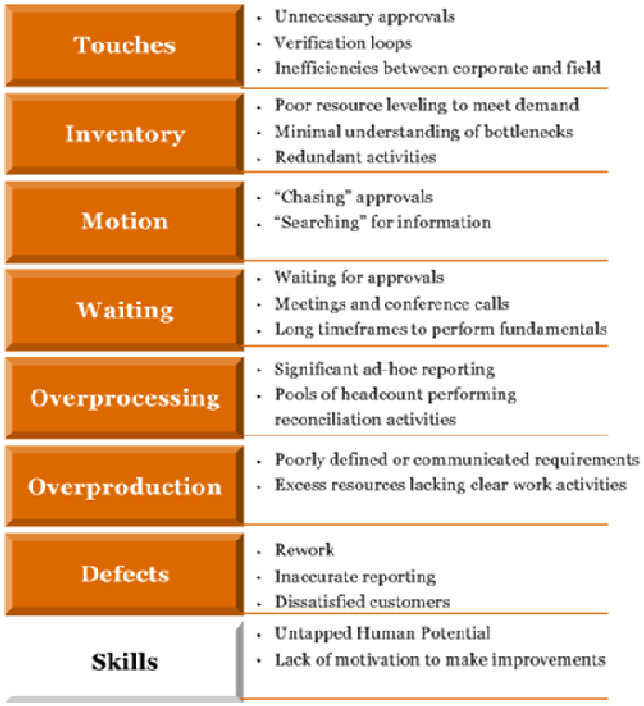
#	Supporting Initiatives
1a.	Process redesign should focus on the elimination of wastes and be supported through optimized technology.
1b.	The identified cost savings/new revenues should be utilized to fund the technology-enabled enhancements.

1a. Core administrative functions are inefficient and highly manual

Observations

- Paper-based forms comprise many of the high-volume administrative processes
  - **Timesheets** – 400 paper weekly-timesheets are completed every month
  - **Attendance Management** – paper forms are required for sick days/vacation time
  - **Expense Reimbursement** –Six different paper expense forms: including mileage, travel allowance, registration costs, program expenses, etc.
  - **Purchase Requisition –** paper forms are manually created by employees
  - **Enrollment** of new employees is completely paper-based
- MLHU functions are not supported by optimal tools and cumbersome workarounds have been established for:
  - **Purchasing -** MLHU has not implemented the procurement module for its accounting system– and purchase orders are created manually
  - **Human Resources –** Attendance Management is completed using a payroll module. HR reporting is limited due to complex software. There are no modules/programs to support Learning and Development, resume tracking, legislative certification, etc.
  - **Occupational Health & Safety** - MLHU does not have an automated system for the management of critical incidents
- Data suggests that the level of effort being spent on financial processes could be reduced
  - Metrics from other organizations indicate there may be the potential to realize 2.3X more vendor invoices per 1 AP FTE
  - The LOE survey revealed that 44% of total finance effort is spent processing accounts payable – this suggests there are opportunities to reduce effort in one area (AP) to be re-allocated elsewhere to enhance capacity

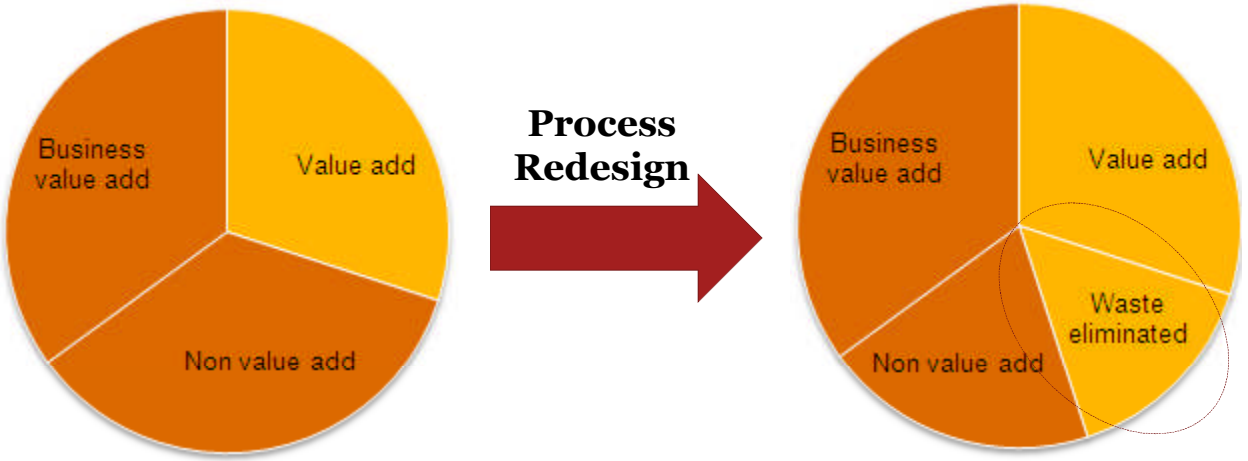
The "7+1" Wastes in *Service Environments*



Inefficient processes result in non-value add activities, classified as "wastes"

Implication: Manual/ sub-optimal processes have resulted in inefficient/ ineffective use of resources (e.g. printing, delivery, distribution, storage, labour (e.g., completion, data entry, validations).

Process redesign should focus on the elimination of wastes and be supported through optimized technology



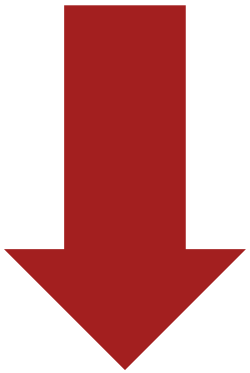
Themes and Initiatives

- Implement "Kaizen" events for core administrative functions
  - "Kaizen" translates into "*change – good*"
  - Kaizen events are used to deliver quick wins or instant improvements. This is achieved by focussing on reducing or eliminating waste and non-value add activities
- Enhance processes through optimized technology
  - Identify and implement software to optimize the efficiency and effectiveness of administrative functions

Value to MLHU

- Costs can be reduced with the time and resources saved
- Time and resources saved can be utilized for more productive activities/ the gains can be reinvested for further improvement

1b. There are opportunities to reduce costs and potentially to increase MLHU revenues

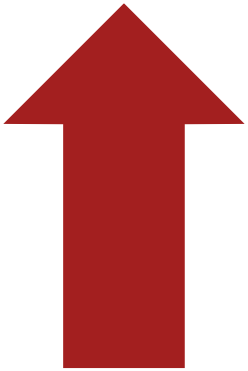


Decrease Costs

- Reduce offsite inventory storage costs
- Reduce offsite record storage costs
- Space related cost savings
- *Refer to cost savings from other initiatives*

Increase Revenues

- Generate revenue from the use of MLHU facilities
- Fit Testing for respirators
- Admission fees for guest speakers
- Fees for the review of Emergency Plans



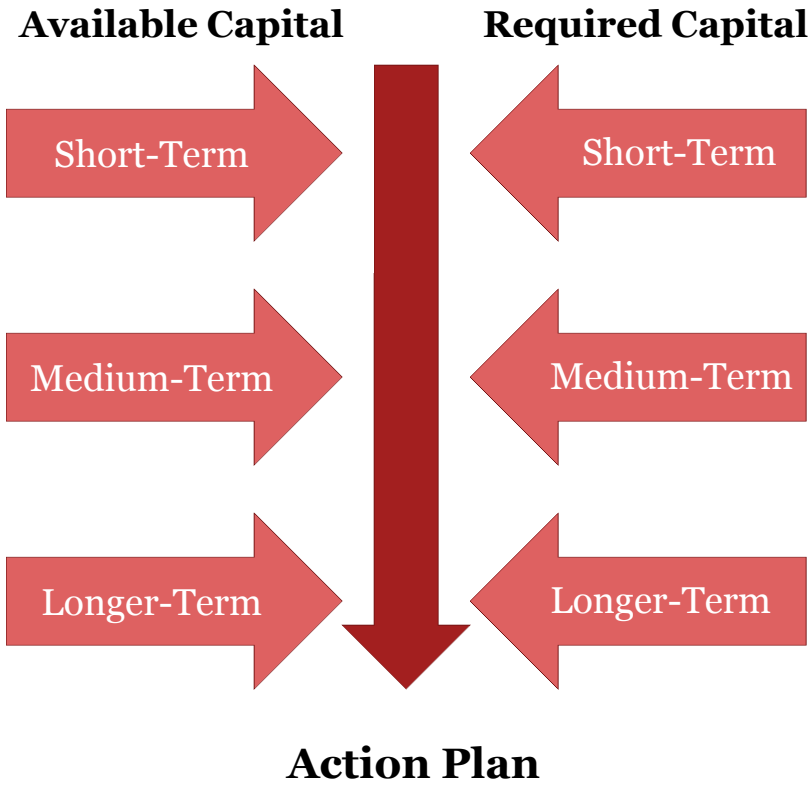
Implication: MLHU has the potential to decrease its costs and increase its revenues.

Observations

- MLHU has not had the resources to support the required IT needs due to budget pressures:
  - MLHU's IT spending per employee is 39% lower than other healthcare providers, as per the 2012 Gartner Healthcare Providers Analysis[1]
- MLHU needs to secure the capital through decreased costs and increased revenues
- Decreased costs:
  - MLHU has a large quantity of bulk inventory, and over 900 boxes of paper-based records that necessitates both on-site and off-site storage
  - MLHU has created a Strategic Action Group to examine space requirements and determine if MLHU can reduce its footprint
- Increased revenues:
  - Revenue derived from the use of MLHU facilities is variable (e.g., revenues are collected for the provision of the "Food Handlers Course" but overhead is not collected from physician-led clinics)
  - The Emergency Preparedness function could be generating revenue
    - MLHU has the equipment to fit-test health care personnel for N95 and P100 respirators. No other organization in the community provides this service – which is a requirement for all health care graduates
    - Admission fees are not consistently charged for guest speakers
    - Service fees are not being charged to private organizations for the review of their Emergency Plans

[1]*Sources: Gartner Healthcare Providers Analysis, Gartner Report "Key Infrastructure Measures: IT Service Desk: 2012"*

The identified cost savings/revenue should be utilized to fund the technology-enabled enhancements



Themes and Initiatives

- Robust analysis should be performed to identify and quantify the potential for cost savings/ revenue generation in the:
  - Short term (less than 3 months)
  - Medium term (3 – 6 months)
  - Longer term (6 – 12 months)
- Robust analysis should be performed to identify:
  - The costs associated for the required technology enhancements (i.e. automation, paper-less forms)
  - The potential implementation timeframes
- Planned capital spending should occur in conjunction with projected cost savings/revenue generation, and a corresponding action plan should be created

Value-Add to MLHU

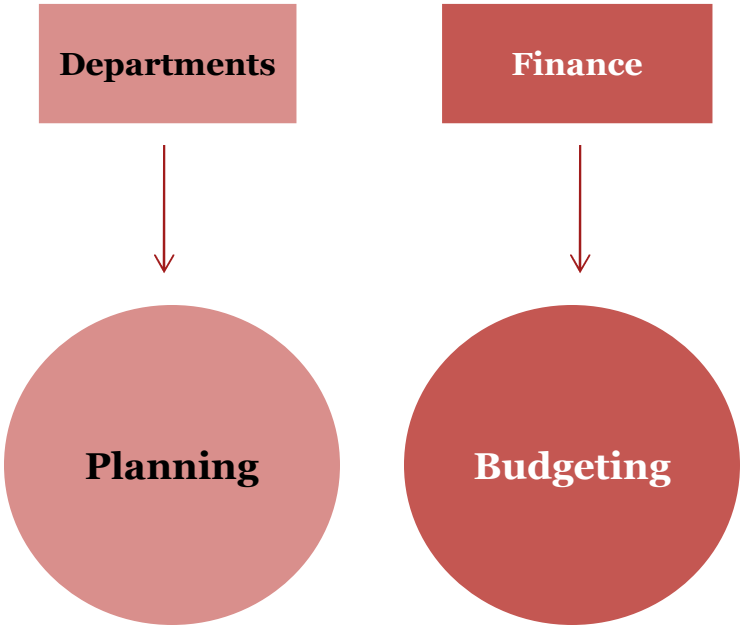
- MLHU can become more efficient and effective through enhanced technology and optimized processes

Recommendation 2: MLHU needs to become a more integrated and cohesive organization

Description
Various administrative activities and functions are performed in isolation from one another, creating a disconnect and potential misalignment of administrative resources. Additionally, sub-optimized administrative policies and lack of consistent policy enforcement are creating inefficiencies and diminishing operational and organizational cohesiveness. MLHU should aim to integrate certain key processes through improved collaboration of the various service areas and/or centralization of activities.

#	Supporting Initiatives
2a.	Integrate and align service area planning and budgeting activities to mitigate against risk of unplanned expenditures and to support optimal allocation of resources to key initiatives.
2b.	Move towards increased centralization of certain administrative functions in order to control costs and support shared goals through leveraged collective capacity.
2c.	Revisit, re-communicate, and enforce certain administrative policies which are currently causing internal inefficiencies.

2a. There appears to be a disconnect between planning and budgeting activities

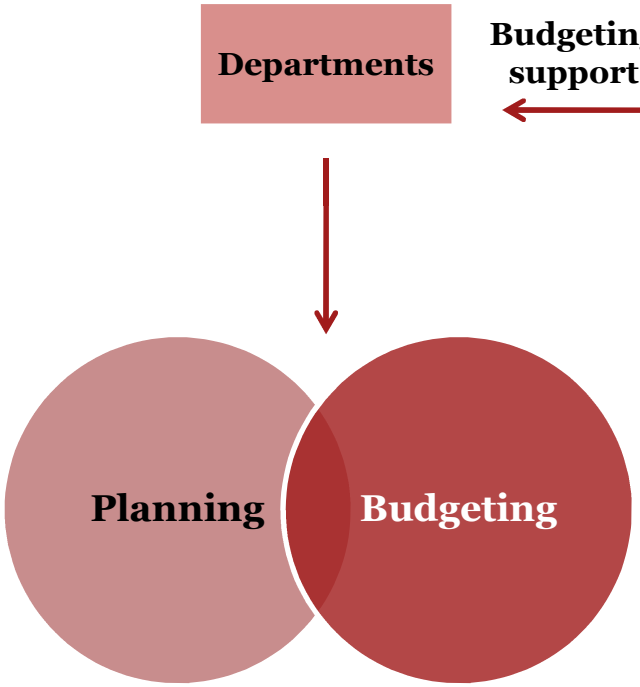


Observations

- In general, the MLHU's operational plans are based on available budget. Finance provides estimates of grant revenues to the senior leadership team who then decides on the allocation of resources departments
- Budgeting at the department level is based on historical "carry-over" budgets as opposed to using a ground-up budgeting approach
- Operational plans are therefore driven more by the budget than by actual operational requirements – there is an inherent disconnect between planning and budgeting activities
- Operational plans are also not known or available at the time resources are allocated
- There is a need to formalize a process to reallocate resources "in-year," after the original budget has been approved

Implication: Lack of integration between planning and budgeting results in internal confusion, inefficiencies and increases the risk of unplanned expenditure and sub-optimal allocation of resources.

Departments should prepare budgets to reflect their operational plans, with Finance providing consultation, oversight and consolidation procedures



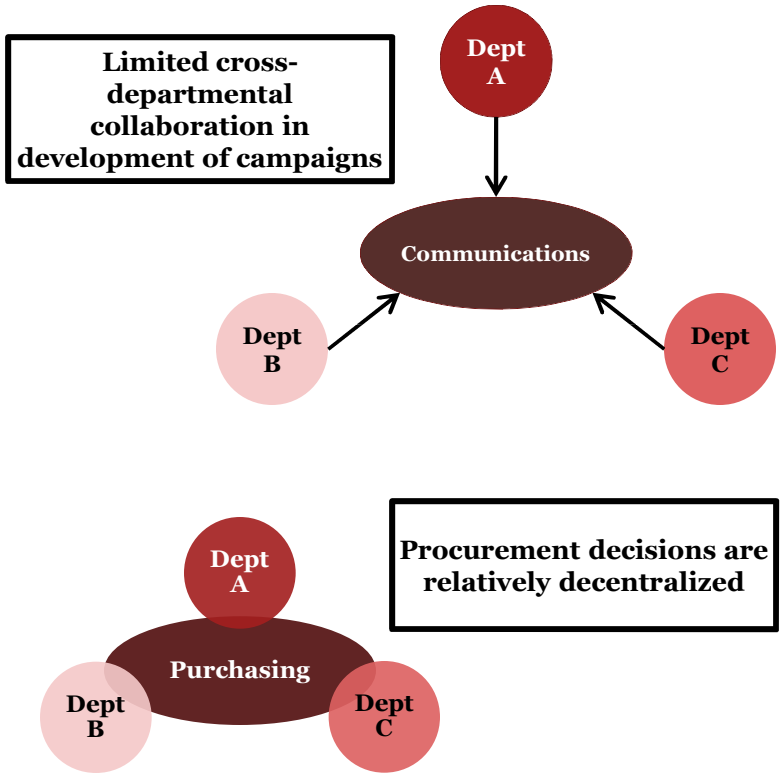
Themes and Initiatives

- Departments should prepare budgets that align with their operational plans, while Finance performs consolidation of the budgets and provides consultation and oversight to the departments, as needed
- Key considerations for implementation include clarification of roles, communication of expectations from all parties involved, and discussion of ongoing collaborative support

Value to MLHU

- Improved internal communication and alignment of resources
- Optimized allocation of resources to key initiatives
- Increased accountability for adherence to budgets may reduce the need to reallocate spending between departments after the budget has been approved

2b. Decentralization of certain activities is impeding the ability to effectively control and monitor costs and support shared goals

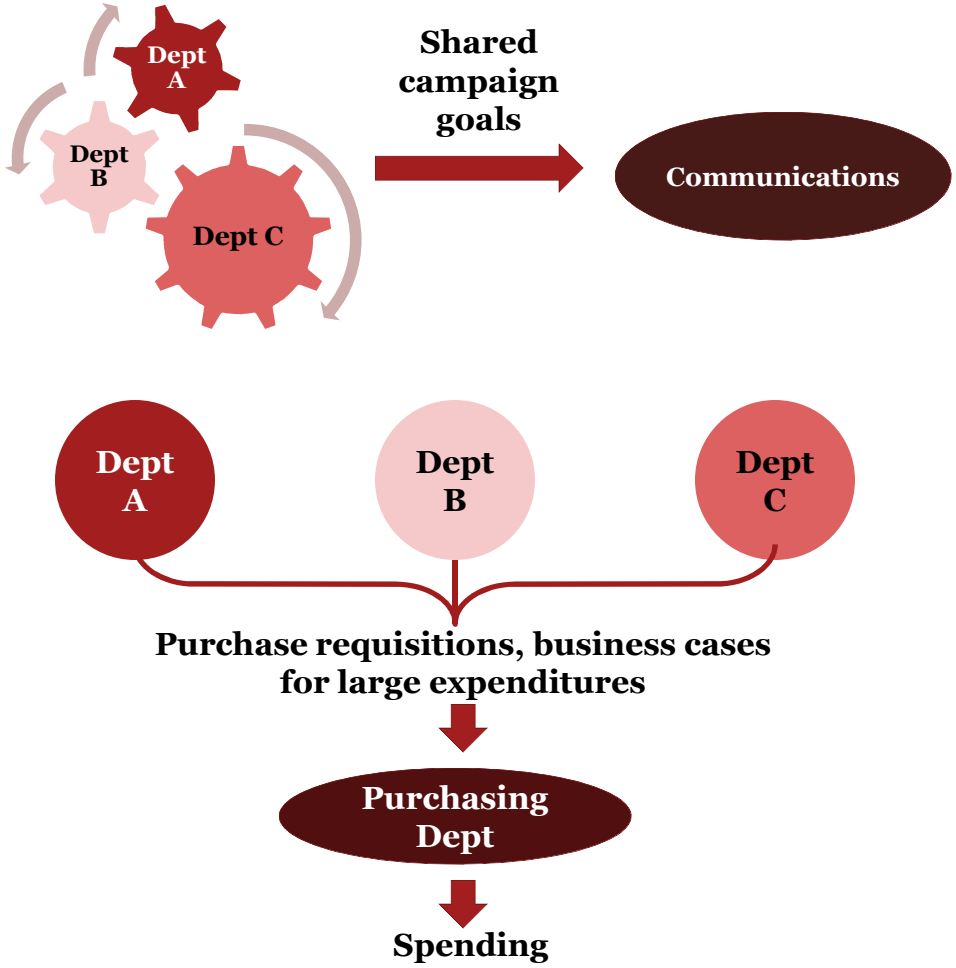


Observations

- Individual departments control their marketing budgets and work with Communications to develop campaigns. Campaigns are primarily run independently:
  - Through the development of campaigns, Communication staff have identified similar efforts and recommended alignments / partnerships. There may be opportunities to further increase cross-departmental collaboration on campaigns
- Procurement decisions are relatively decentralized. MLHU service areas:
  - Have their own budgets and make independent purchasing decisions for some types of purchases (and do not have to complete business cases for large purchases)
  - Make bulk purchases (especially close to year-end) to leverage volume discounts and utilize funding. In some cases, this creates additional costs such as storage and other handling costs
- The decentralization of procurement is evidenced by the fact that the Purchasing department only spends 0.3 FTEs on Purchasing activities (remainder of departmental time (0.6 FTEs) is spent on Contract Management, per the Level of Effort Survey). It is PwC's assessment that this is a low level of allocation for purchasing activities

Implication: The decentralization of procurement and campaign development activities diminish management's ability to control and monitor spending and hinders departments from leveraging their collective capacity to support inter-related and/or shared goals.

MLHU should move towards increased centralization of procurement and campaign development activities



Themes and Initiatives

- Departments should proactively collaborate when planning annual campaign initiatives to determine whether opportunities for partnership and sharing of resources exist. Planning should include Communications to ensure the development of integrated campaigns and prevent duplication of effort
- MLHU should increase centralization of the purchasing function and require business cases for large expenditures

Value to MLHU

- Supports shared communication goals through leveraged collective capacity for similar/inter-related initiatives / campaigns
- Increased ability to control costs, monitor spending and proactively identify opportunities for savings

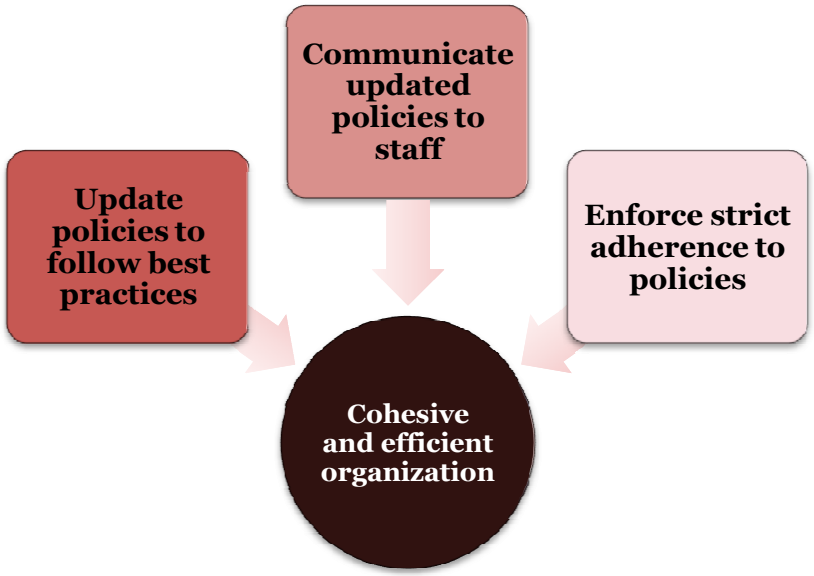
2c. Gaps in administrative policy development, adherence and reinforcement are creating bottlenecks and hindering departments' abilities to operate effectively and cohesively

Observations

- Finance
  - MLHU is in the process of updating its financial policies (e.g., expense reimbursement). Current gaps identified included travel accommodation (i.e., preferred hotels/rates), catering (e.g., when /who), etc.
  - Knowledge, adherence, and enforcement of the current policies is at times inconsistent (e.g., travel, expense reimbursement, mileage)
- Purchasing
  - Staff utilize their corporate purchasing cards (Visa) to procure materials/supplies at their discretion. Tools exist to aggregate this data and conduct analysis on corporate card spending, however this analysis is currently not conducted
- HR
  - MLHU does not have a formalized succession planning program, and the need for management training programs/courses was identified
  - The pay scale/ educational requirements (e.g., Masters degree required) make the Manager positions difficult to fill
- Emergency Preparedness
  - MLHU does not have an organizational standard for first aid training

Implication: Sub-optimal policies combined with inconsistent application and enforcement of existing policies could diminish inter-departmental operational cohesiveness and lead to bottlenecks/inefficiencies, unnecessary spending, and lack of departmental control over processes.

MLHU needs to revisit, re-communicate, and enforce certain administrative policies which are currently causing internal inefficiencies



Themes and Initiatives

- Finance should update expense, travel, mileage, catering, and procurement policies to ensure they are in accordance with best practices and support effective control and monitoring of costs. MLHU should then re-communicate key points and/or notable changes to staff and educate Managers regarding enforcement expectations and accountabilities
- Finance should update its corporate purchasing card policy to restrict use to a defined set of expense types
- HR should develop a succession planning program and provide professional development opportunities for potential successors of critical positions within the organization
- MLHU should develop an organizational standard for first aid training

Value to MLHU

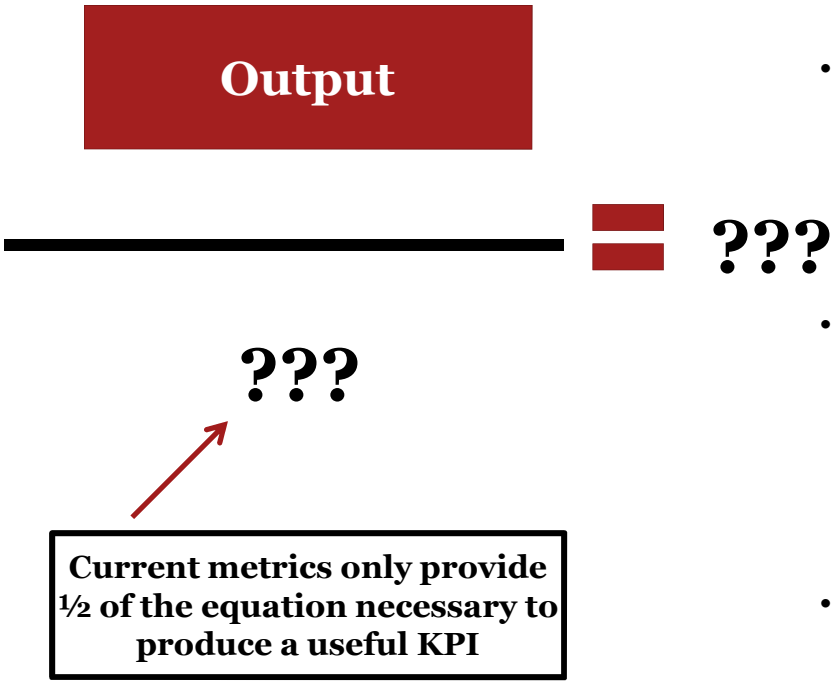
- Potential for improved cost containment (taking advantage of preferred rates, developing stricter expense policies, monitoring/analyzing spending, improved cost control, etc.)
- Clearly defined policies mitigate against internal confusion regarding rules and expectations, thereby improving operational / organizational efficiency and cohesiveness
- Development of succession planning program and first aid training policy support continuity and mitigate against operational risk

Recommendation 3: MLHU needs to adopt a performance-focused culture

Description
Clearly defined, measureable, outcomes-focused internal Key Performance Measures (KPIs) do not exist for all administrative functions within MLHU. Many existing metrics appear to be transactional/volume-driven, and fail to describe the efficiency or effectiveness of which activities are being performed. Furthermore, formalized evaluations measuring achievement against stated goals/targets was not fully evident.

#	Supporting Initiatives
3a.	Develop outcomes-focused, internal key performance indicators (KPIs) for administrative functions.
3b.	Monitor, evaluate, and recognize performance.

3a. Performance metrics utilized do not reveal level of operational efficiency or effectiveness



Observations

- Clearly defined, measureable, outcomes-focused KPIs do not exist for all administrative departments at MLHU
- KPIs are largely transactional/volume-driven and are not tied to a stated level of performance. Examples include:
  - Number of vendor invoices paid/processed
  - Number of competitive bid processes
  - Number of interviews conducted
- More meaningful, performance-based metrics might include, for example:
  - Number of vendor invoices paid/processed per 1 AP FTE
  - 1st choice candidates hired as a percent of total interviews conducted
- The costs are reported at a service area/ aggregate level

Implication: Lack of clearly-defined, measureable, outcomes-focused internal KPIs prevents the organization from developing meaningful operational goals and measuring/evaluating operational performance.

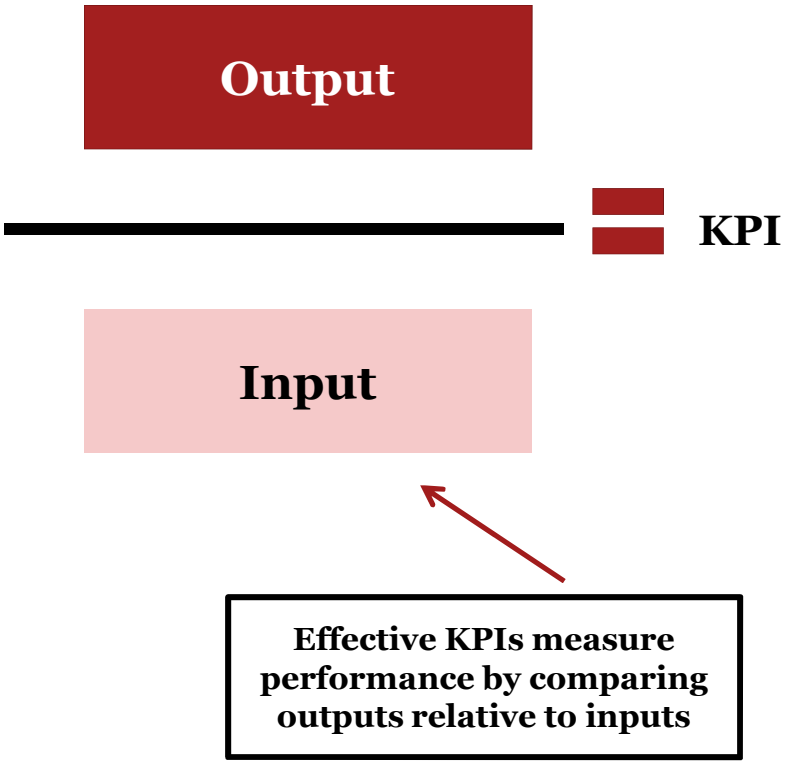
MLHU should develop and monitor clearly-defined, measurable, outcomes-focused KPIs that support operations and are congruent with organizational strategy

Themes and Initiatives

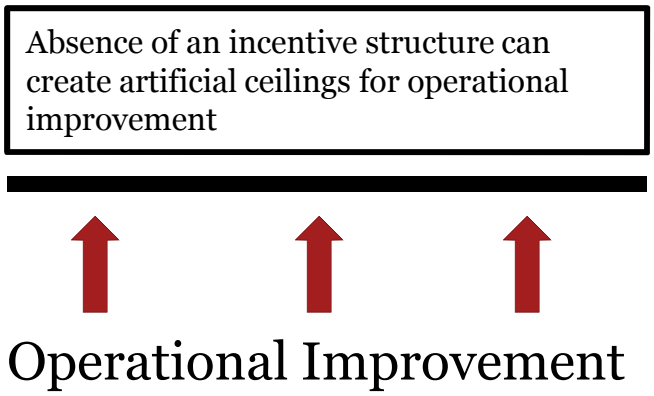
- MLHU should develop clearly-defined, measurable, outcomes –focused internal KPIs that provide meaningful direction for desired operational improvement which focus efforts on the efficiency and effectiveness of operations
- Internal KPIs should describe performance in relation to operational success, rather than simply focusing on transactional/ volumetric data, which does not indicate how efficiently or effectively the organization is functioning
- Internal KPIs should be developed in a manner which supports organization-wide objectives and strategies

Value to MLHU

- Improved operational performance (increased efficiency and effectiveness of operations)
- Reduction of costs
- Clear direction and goals for staff
- Alignment of operational goals with organizational strategy increases the long-term likelihood of achieving that strategy



3b. Formalized monitoring activities and regular evaluations measuring achievement against stated goals/targets was not fully evident



Observations

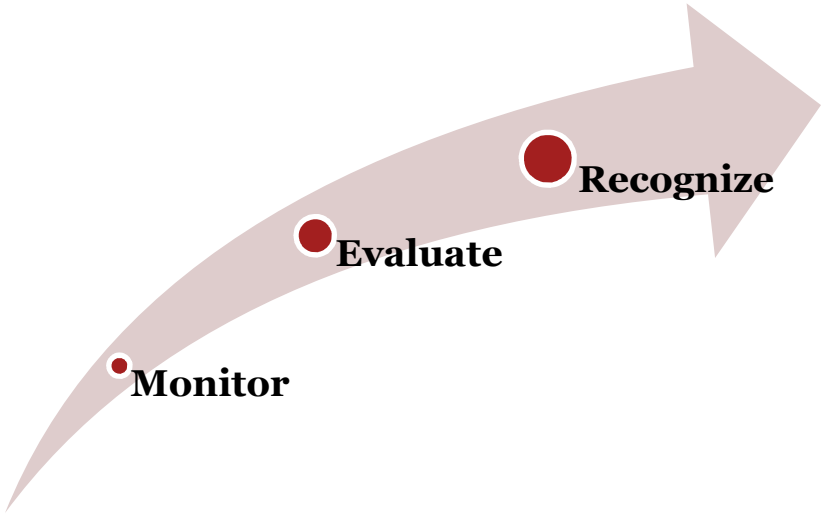
- Budgets
  - There is no formalized mechanism for "in-year" reallocation of budget resources
  - Unutilized service area budgets cannot be carried forward into future years
- General operating efficiency and effectiveness
  - Similarly, there is no structure in place to motivate and incent continuous operational improvement

Implication: The lack of incentive structure / motivational enticement for continuous operational improvement, combined with the inability to carry-forward unutilized budgeted funds, can stifle operational improvement and produce a 'use-it-or-lose-it' mentality, resulting in unnecessary spending.

MLHU should monitor, evaluate, and recognize performance

Themes and Initiatives

- MLHU should actively monitor, evaluate, and recognize performance against goals and internal KPIs:
  - On a regular and consistent basis, MLHU should evaluate performance relative to prior periods and current goals
  - MLHU should develop an incentive structure which provides motivation for cost-containment and continuous operational improvement amongst departments



Value to MLHU

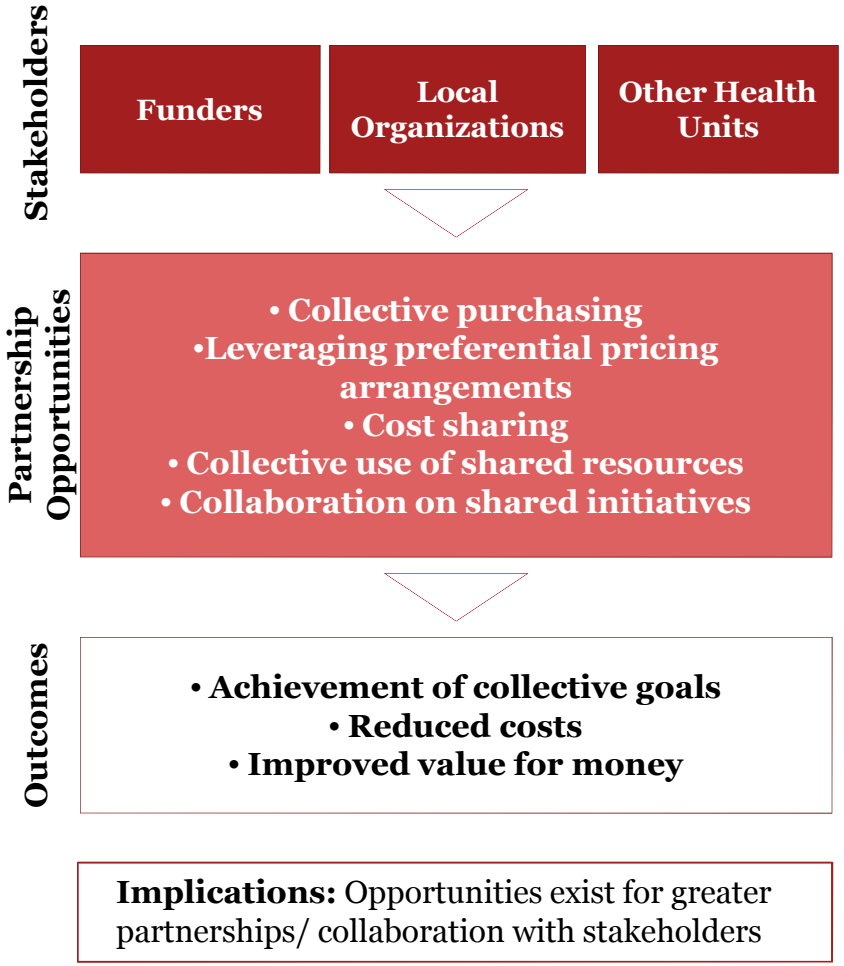
- Level of organizational performance revealed by KPIs is useful in guiding and informing decision-making
- Improved operational efficiency and effectiveness
- Reduction in costs

Recommendation 4: MLHU should pursue greater integration with its stakeholders

Description
MLHU has a broad stakeholder network that has not been fully leveraged to achieve shared goals and promote value for money. Enhanced collaboration within this network could achieve mutual benefits, including the potential for cost savings and establishment of a foundation for shared services.

#	Supporting Initiatives
4a.	MLHU should pursue greater partnerships and collaboration with other organizations.

4a. MLHU has not fully harnessed its broad stakeholder network



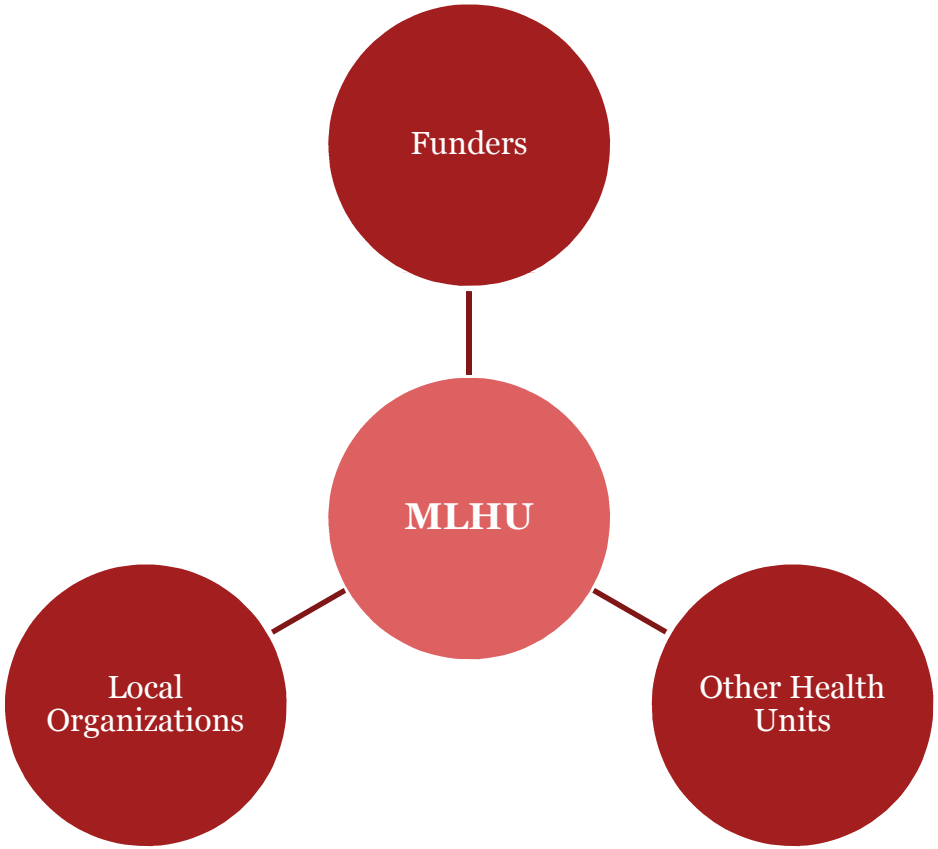
Implications: Opportunities exist for greater partnerships/ collaboration with stakeholders

Observations

- MLHU has a broad stakeholder network: its funders (e.g., the City, the County, Ministries), local organizations (e.g., the LHIN, the CCAC, hospitals), and other Health Units
- Previous collaboration efforts have produced mixed results, however there is an overall willingness to build on the successes and pursue greater partnerships:
  - **Purchasing** – MLHU participates in collective purchasing arrangements with other organizations (e.g., Elgin, Middlesex, Oxford, Purchasing (EMOP) co-operative, Provincial contracts), however the use of collective purchasing could be expanded
  - **HR** - MLHU manages its own tendering and contracts for its benefits coverage (recently changing to Great West Life)
  - **IT** - MLHU has successfully collaborated with other Health Units to leverage applications/ tools. Cost avoidance or savings through cost sharing arrangements may be possible through further collaboration with other Health Units/ partners
  - **Communications** – MLHU has collaborated with other Health Units to share initiatives. Through enhanced collaboration with partners, MLHU may have further opportunity to share/avoid costs for common, provincial, and/or national campaigns or leverage additional resources (e.g., completed campaign materials, additional staff to support large shared initiatives)

MLHU should pursue greater partnerships and collaboration with other organizations

MLHU's Partnership Strategy



Themes and Initiatives

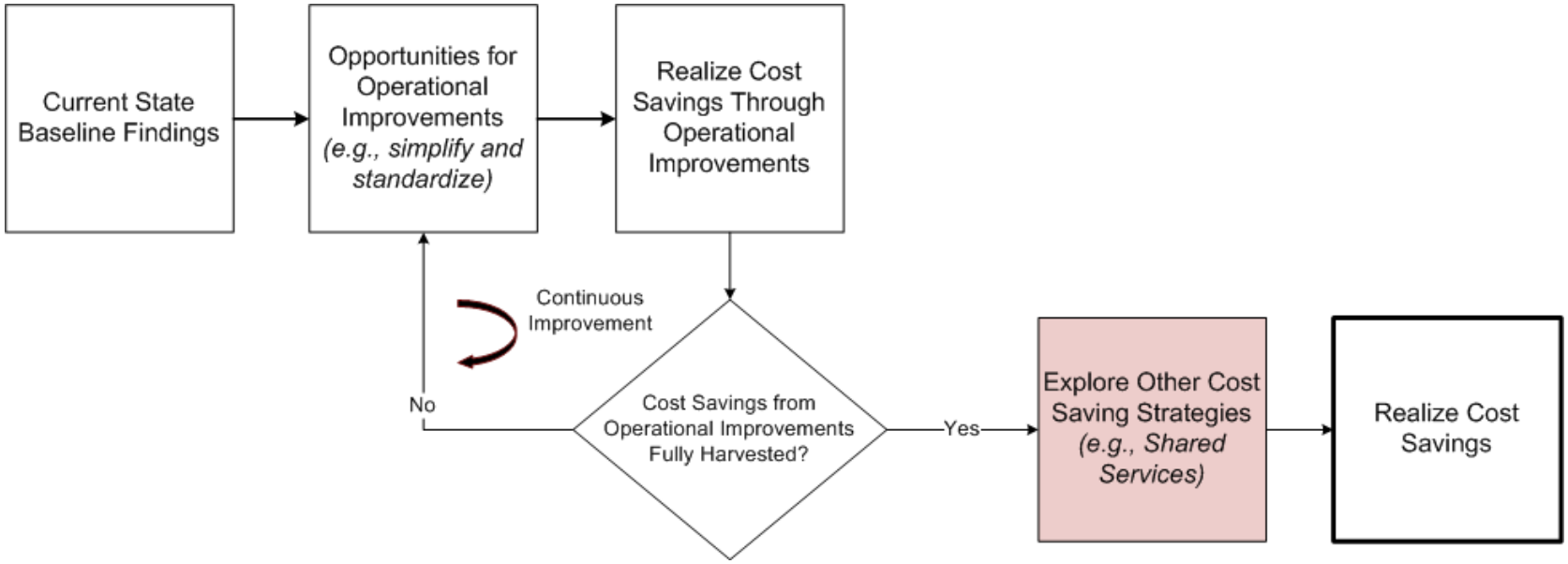
- MLHU should adopt the enhancement of partnerships with external stakeholders as an organizational priority
- Each function should develop a stakeholder map and identify potential partnership opportunities
- Appropriate due diligence should be performed to identify the most suitable partners and to quantify the impact of the enhanced partnerships
- An action plan should be developed, mapping the steps required to establish the partnerships and achieve the intended benefits
- The partnerships should serve as a stepping stone to potential shared service arrangements in the future

Value to MLHU

- Potential for cost reduction/ avoidance
- Leverage additional resources
- Strengthened relationship with stakeholders

Preliminary Shared Services Assessment

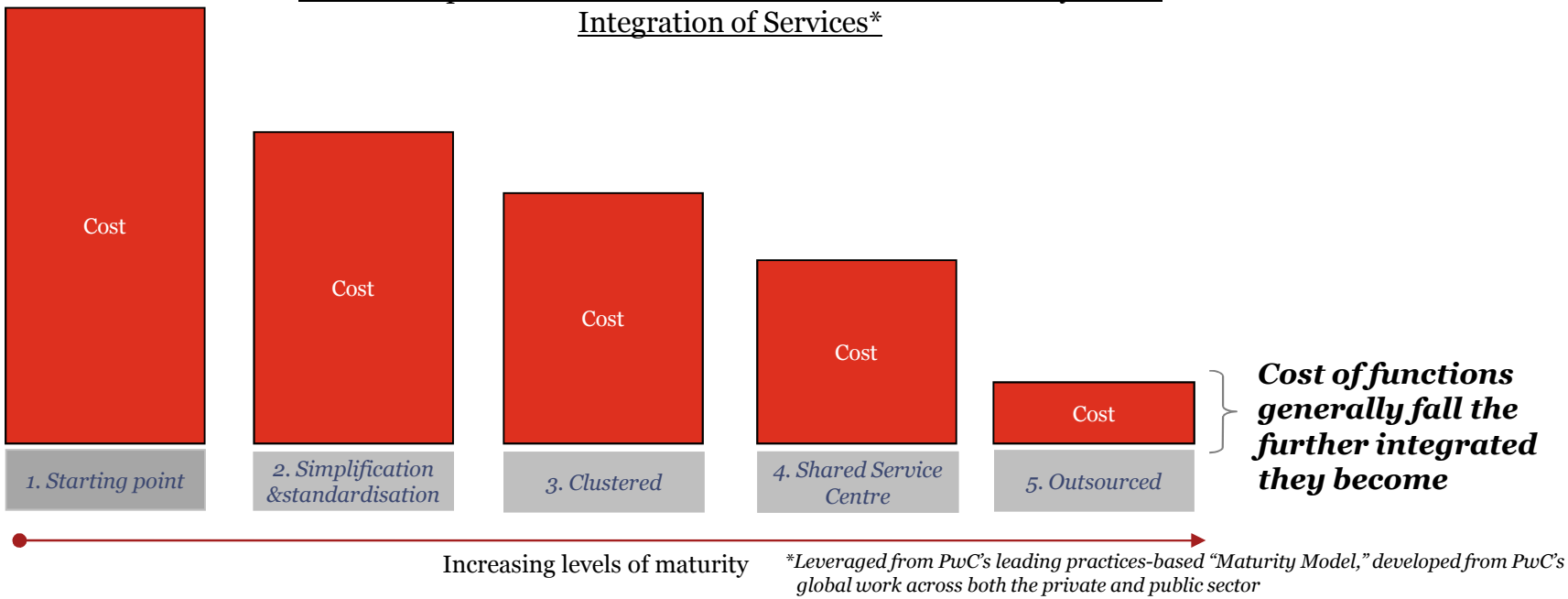
As part of this review, PwC also conducted a preliminary assessment of shared services as a means to achieve future cost savings after operational improvements have been fully implemented



Shared Services: Impact on Cost Structure

Shared services may result in cost savings – if the "right" services are targeted and the organization is sufficiently mature to achieve the intended benefits

Relationship Between Cost of Services and Level of Maturity on the Integration of Services*



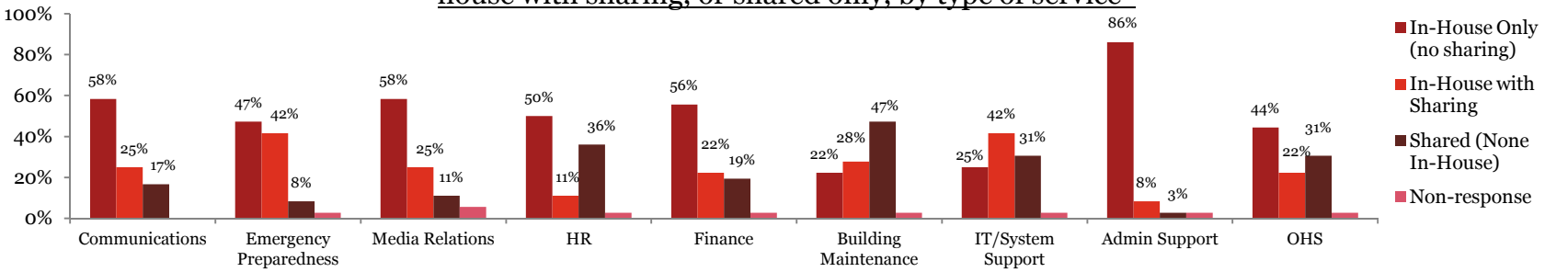
*Leveraged from PwC's leading practices-based "Maturity Model," developed from PwC's global work across both the private and public sector

- In the pursuit of reduced costs, organizations across the public and private sector are looking to shared services
- As the level of "sharing" increases, the overall cost to deliver those services generally decreases
- The ability to achieve shared services is driven by:
  - The "sharability" of each service
  - Organizational maturity for shared services

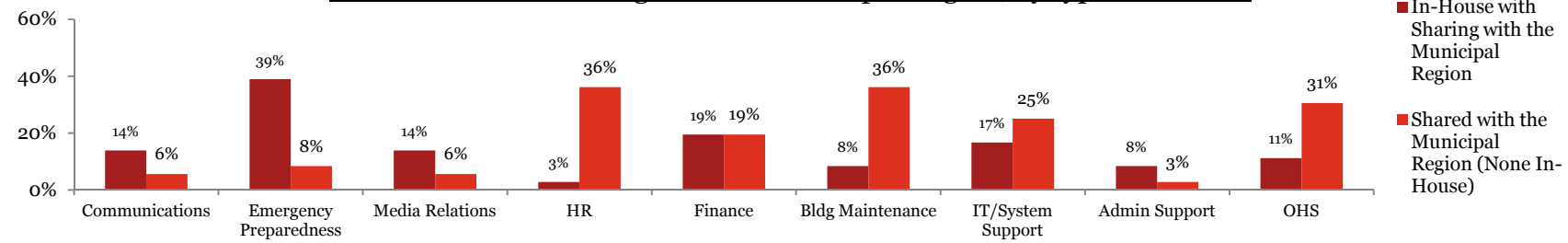
Sharing in Ontario Public Health Units

A provincial study conducted in 2005 identified instances of sharing for each administrative function

Percent of Public Health Units' (PHUs) services performed in-house only, in-house with sharing, or shared only, by type of service*



Percent of PHUs sharing with the Municipal Region, by type of service*



**Source: 2005 study of Ontario's Health Units: http://www.health.gov.on.ca/en/common/ministry/publications/reports/capacity_review06/ssa_implementation.pdf*

Key Observation: The majority of PHU services were performed primarily in-house with no sharing. However, there are instances of sharing with municipal regions for each of the services. This sharing could be the result of integrated governance structures between some PHUs and regional governments, but indicates that there may be potential for shared service arrangements with the City of London/Middlesex County.

Expanded Criteria for Sharing

Additional considerations contribute to the determination of how shareable a function is and whether the benefits of sharing outweigh the costs

Criteria	Consideration
1. Industry Specific Considerations	
Legislation/ Regulation	Is this function legislatively required to be completed by the Health Unit?
Collective Agreements	Are staff covered by collective agreements?
2. Organizational Considerations	
Impact Front Line Service	What is the impact of this function on front line service provision?
Culture/Change Management	What is the impact of this function on organizational culture?
Strategic to Organizational Mandate	How strategic is this function to the MLHU's mandate?
Locality	How important is it for this function to be "on-site"?
3. Service Considerations	
Unit-Specific Processes	How specific are the processes in this function to MLHU?
Specialized Expertise	What degree of MLHU-specific expertise is required to complete this function?
Technological Compatibility	How compatible is MLHU's current technology with potential partners?
4. Degree of Impact Considerations	
Volume of Transactions	Is this function comprised of high-volume transactions?
Scale	Does this function have a high number of staff?
Cost Savings Potential	How significant is the expected savings potential?

Expanded Criteria for Sharing

Some MLHU in-scope functions are more shareable than others – however at present, none of these functions meet all of the expanded criteria for sharing

Expanded Criteria	Fin.	Pur.	Fac.	IT	HR	Comm.	Priv.	OH&S	Emer. Prep.	Spec. Proj.
1. Industry Specific Considerations										
Legislation/ Regulation	●	●	●	●	●	●	●	●	○	●
Collective Agreements	◐	●	◐	◐	◐	◐	◐	◐	◐	◐
2. Organizational Considerations										
Impact Front Line Service	●	●	●	◐	◐	◐	●	◐	◐	●
Culture/ Change Management	●	●	●	●	◐	◐	●	◐	●	●
Strategic to Org. Mandate	◐	●	●	○	○	○	●	●	○	○
Locality	●	●	◐	◐	○	◐	●	◐	●	○
3. Service Considerations										
Unit-Specific Processes	●	●	●	◐	◐	◐	◐	●	○	○
Specialized Expertise	●	●	●	◐	○	◐	◐	●	○	○
Technological Compatibility	◐	●	●	◐	●	●	●	●	●	●
4. Degree of Impact										
Volume of Transactions	●	●	◐	●	●	◐	○	○	○	○
Scale	◐	○	○	◐	○	○	○	○	○	○
Cost Savings Potential	◐	◐	○	◐	○	○	○	○	○	○
Degree of "Sharability"	**Relatively High***			**Relatively Moderate***					**Relatively Low***	

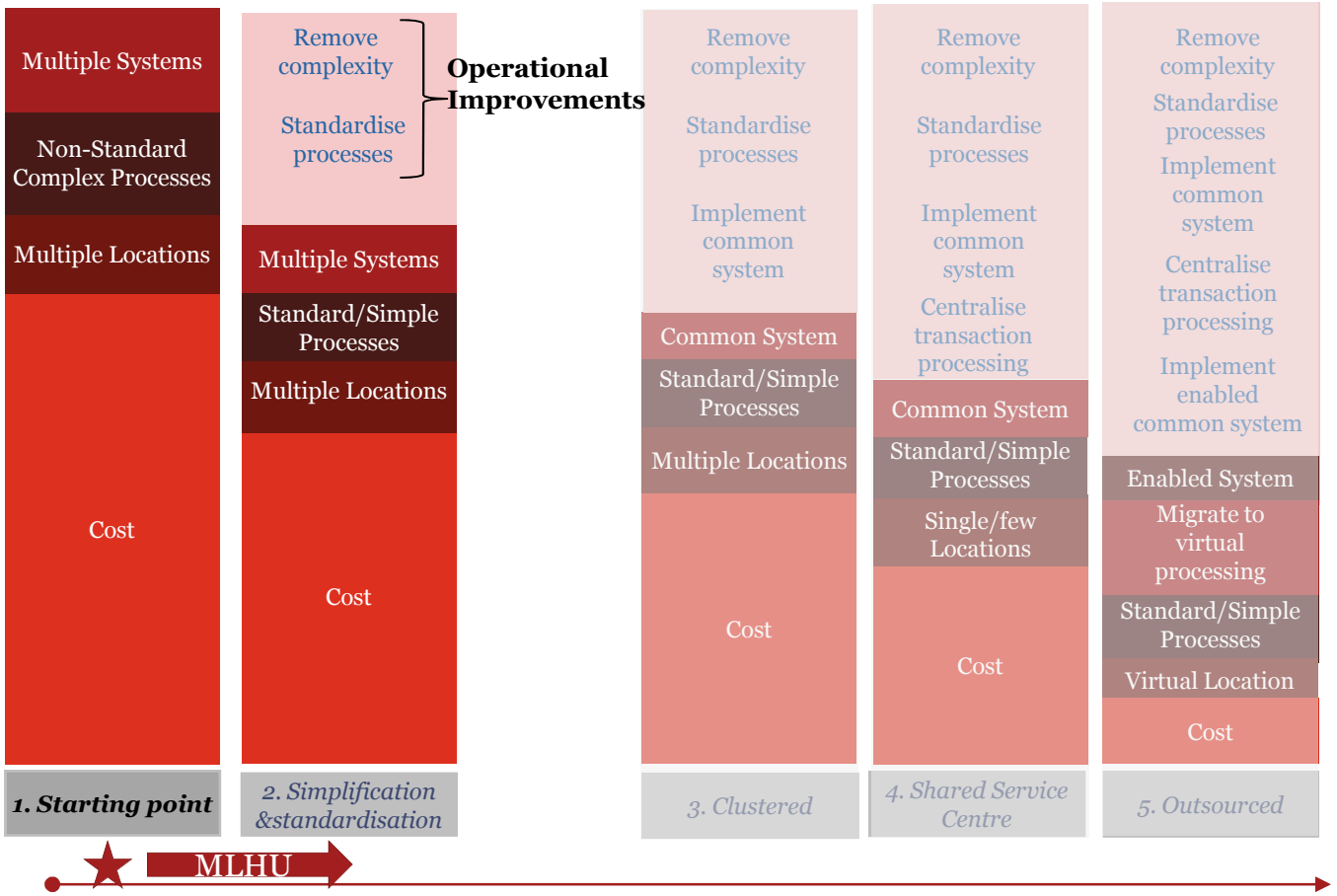
* *As determined by PwC, within the scope of the engagement*

Legend:
Relative suitability of functions for sharing: High (●), Medium (◐), Low (○)

Functional Maturity for Shared Services

PwC recommends MLHU to achieve cost savings through operational improvements first, before exploring other options which may include shared services

Functional Maturity for Shared Services*



- The model depicts the typical steps and shows an organization's progress through increasingly advanced levels of functional maturity
- The first step is to achieve *"simplification and standardization"* by focusing on operational improvements
- Once cost savings have been fully harvested from operational improvements, MLHU may seek other ways to achieve cost savings

**Leveraged from PwC's leading practices-based "Maturity Model," developed from PwC's global work across both the private and public sector*

Summary of Concluding Thoughts

MLHU has a lean administration, but there are opportunities to achieve cost savings through operational improvements

- *First steps…*
  - Strategic investments are required to modernize and enable productivity-related efficiencies
    - Savings from efficiencies achieved should be reinvested back into MLHU
  - MLHU should strengthen the integration of functions and policies to help optimize the allocation of resources, better control and monitor costs, and support collective goals
  - MLHU should practice effective use of KPIs in order to provide clearer direction and goals for staff, reduce costs, and increase likelihood of operational success
  - Opportunities for greater partnerships and collaboration with other organizations should be explored, with the aim of leveraging resources, reducing costs and achieving shared goals
- *Next steps…*
  - MLHU should do a "deeper dive" to further explore the opportunities for cost savings/ efficiencies and develop implementation roadmaps

Next Steps

The MLHU Board is at a decision point

- Board needs to proceed to Phase 3 in order to:
  - Quantify savings through operational improvements
  - Prioritize operational improvement initiatives
  - Formulate an implementation plan for operational improvements