AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2013 June 20

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

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

MEMBERS OF THE BOARD OF HEALTH

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

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

7:10 – 7:25 p.m.	Mr. John Millson, Director, Finance & Operations, Item #1 – Report No 076-13 re Finance & Facilities Committee – Draft Terms of Reference
7:25 - 7:40 p.m.	Mr. David Ross, Audit Manager, KPMG LLP, and Mr. John Millson, Director, Finance & Operations, Item #2 - Report No 077-13 re 2012 Consolidated Financial Statements
7:40 – 7:55 p.m.	Mr. John Millson, Director, Finance & Operations, and Dr. Chris Mackie, Medical Officer of Health, Item #3 – Report No 078-13 re 2014 Cost-Shared Budget – City Of London Target
7:55 – 8:10 p.m.	Students from Youth Create Healthy Communities, Item #4 – Report No. 087-13 re Student Bus Pass Advocacy Update #1

REPORTS

	Report No. and Name	Link to Appendices and Key Additional Information	Delegation	Recommendation	Information	Brief Overview
1	Report No. 076-13 re Finance & Facilities Committee – Draft Terms of Reference	Appendix A	x	x		To seek Board approval of the Terms of Reference for the Finance and Facilities Committee
2	Report No 077-13 re 2012 Consolidated Financial Statements	Appendix A Appendix B Appendix C	x	x		To approve the 2012 financial statement as presented by KPMG, LLP
3	Report No. 078-13 re 2014 Cost-Shared Budget – City Of London Target	Appendix A	x		x	To provide the Board with options for how to proceed with development of the 2014 budget in light of the PwC recommendations and the City of London target of 0% for MLHU
4	Report No. 087-13 re Student Bus Pass Advocacy Update #1		x		x	To provide an update on the student bus pass advocacy initiative as requested at the February BOH meeting
5	Report No. 079-13 re 2012 Reserve/Reserve Fund Balances	Appendix A		x		To request Board approval to use funds from the Dental Treatment Reserve and potential contributions to the Stabilization Reserve.
6	Report No. 080-13 re 2013 Healthy Babies Healthy Children Budget	Appendix A		x		To seek Board approval of the HBHC grant request.
7	Report No. 081-13 re Increased Access to Nicotine Replacement Therapy (NRT) Through Public Health Units	Appendix A		x		To show the board's endorsement of NRT Action by sending a letter to the Minister of Health and Long-Term Care
8	Report No. 082-13 re Volunteer Resources				x	To provide an annual summary of the Health Unit Volunteer Program
9	Report No. 083-13 re Oral Health Month	Appendix A			x	To summarize for the Board of Health activities during Oral Health Month
10	Report No. 084-13 re Health Unit Engagement with ReThink London Process				x	To update the Board of Health on MLHU's engagement in the ReThink London process
11	Report No. 085-13 re Smoking Near Recreation Amenities and Entrances Bylaw	Appendix A Appendix B			x	To provide an update on London's new Smoke-Free Outdoor Spaces bylaw
12	Report No. 086-13 re Be Brighter with Breakfast Secondary School Initiative				x	To describe the BBB program to improve learning through promoting eating a healthy breakfast
13	Report No. 088-13 re Physician Outreach Initiative				x	To provide an update to the program by which the health unit disseminates information to Physicians

14	Report No. 089-13 re Implementing the Shared Services Review Recommendations				x	To outline how staff will begin to implement the recommendations found in the PwC report.
15	Report No. 090-13 re Medical Officer of Health Activity Report – June				x	To outline activities of the Medical Officer of Health in May/June
16	Confidential				x	To go *in camera* to discuss personnel matters about an identifiable individual

CONFIDENTIAL

OTHER BUSINESS

Next scheduled Board of Health Meeting: Thursday, September 19, 2013 7:00 p.m.

CORRESPONDENCE

a) Date: 2013 April 29 (Received 2013 May 5)
Topic: Menu Labelling – To urge the provincial government to develop menu labeling legislation without further delay
From: Ms. Delia Ting, Secretariat, Toronto Board of Health
To: Distribution List, including Premier of Ontario, Minister of Health and Long-Term Care, Ontario's Chief Medical Officer of Health, alPHa, etc.

b) Date: 2013 May 17 (Received 2013 May 23)
Topic: Menu labelling - A copy of correspondence urging the Ontario Government to enact Bill 59 without delay
From: Mr. Barry Ward, Chair, Board of Health, Simcoe Muskoka District Health
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

c) Date: 2013 April 25 (Received 30 April 2013)
Topic: No Time to Wait: The Healthy Kids Strategy Report - A copy of correspondence endorsing the Healthy Kids Panel and requesting the Working Group to develop a comprehensive action plan to implement the Strategy
From: Mr. Daryl Vaillancourt, Chairperson, North Bay Parry Sound District Health Unit
To: The Honourables Deb Matthews, Minister of Health and Long-Term Care; and Teresa Piruzza, Minister of Children and Youth Services

d) Date: 2013 May 14 via email
Topic: Financial data related to PricewaterhouseCoopers Report – answers to questions from the May 9, 2013 Board of Health meeting
From: Dr. Christopher Mackie, Medical Officer of Health and CEO, Middlesex-London Health Unit
To: Middlesex-London Board of Health Members

ADJOURNMENT

PUBLIC SESSION - MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2013 MAY 16

MEMBERS PRESENT:	Mr. David Bolton Ms. Denise Brown (Vice-Chair) Mr. Al Edmondson Ms. Trish Fulton Mr. Marcel Meyer (Chair) Mr. Stephen Orser Mr. Ian Peer Ms. Nancy Poole
REGRETS:	Ms. Viola Poletes Montgomery Mr. Mark Studenny
ABSENT:	Ms. Sandy White
OTHERS PRESENT:	Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services Ms. Marylou Albanese, Manager, Healthy Communities and Injury Prevention Team Mr. Dan Flaherty, Manager, Communications Mr. Ross Graham, Manager, Special Projects Ms. Kim Leacy, Registered Dietitian Ms. Heather Lokko, Manager, Reproductive Health Team Dr. Christopher Mackie, Medical Officer of Health & CEO Mr. John Millson, Director, Finance and Operations Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder) Ms. Pat Simone, Manager, Emergency Preparedness Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team Ms. Louise Tyler, Director, Human Resources and Labour Relations Services Mr. Alex Tyml, Online Communications Coordinator Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease & Sexual Health Services
MEDIA OUTLETS:	Mr. Craig Gilbert London Community News

Board of Health Chair, Mr. Marcel Meyer, called the meeting to order at 7:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Meyer inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by, Mr. Peer, seconded by Mr. Orser *that the **AGENDA** for the May 16, 2013 Board of Health meeting be approved with the addition of **Report No. 063-13** re" PricewaterhouseCoopers Interim Report" that was deferred from the May 9, 2013 Board of Health meeting. Report No. 063-13 will be discussed after the three scheduled appointments.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Brown, seconded by Ms. Fulton *that the Board of Health **MINUTES** for the April 18, 2013 Board of Health meeting be approved.*

Carried

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Board of Health **MINUTES** for the May 9, 2103 Board of Health meeting be approved.*

Carried

On behalf of the Board of Health, Chair Meyer recognized Dr. Bryna Warshawsky, Acting Medical Officer of Health & CEO and Director, Oral Health, Communicable Disease & Sexual Health Services for her contributions and commitment to the Health Unit over her tenure as Acting Medical Officer of Health and Chief Executive Officer from October 1, 2012 to April 20, 2013.

APPOINTMENTS

1) **Report No. 067-13** re "Draft Reserve/Reserve Fund Policy"

Mr. John Millson, Director, Finance & Operations, assisted Board members with their understanding of this report using a PowerPoint presentation. A copy of the presentation is filed with the minutes.

Under the POLICY section of **Appendix B** to Report No 067-13), it was recommended that the statement be edited as follows: "The maximum cumulative reserves shall be 10% of gross revenues found on the annual statement of operations of the audited financial statements".

It was suggested that the last statement be removed from the policy. It was also suggested that a Finance Committee be considered that could use the statement as an overall guiding philosophy for the Health Unit.

In response to a question about contingency funds, Mr. Millson replied that there is no contingency amount that the Health Unit sets aside each year.

In response to a question about the Memorandum of Agreement (**Appendix C** to Report 067-13), Dr. Christopher Mackie, Medical Officer of Health and CEO, clarified that only the money returned to the City and the County has to be returned according to the apportionment agreement. Money put into a reserve fund does not have to be spent according to the apportionment arrangement. It was recommended to strike out the sentence that states the actual apportionment percentages from the Memorandum of Agreement.

Dr. Mackie clarified that the 10% recommended to be set aside in reserves would be a ceiling – not a goal; If a Finance Committee were developed, it could set such a goal.

It was moved by Mr. Bolton, seconded by Ms. Fulton *that the Board of Health endorse Appendix B – Draft Reserve/Reserve Fund Policy and direct staff to engage the City of London and Middlesex County regarding the related Memorandum of Understanding in Appendix C to Report No. 067-13.*

Carried

2) **Report No. 064-13** re "Accountability Agreements: 2012 Performance and 2013 Targets"

Mr. Ross Graham, Manager, Special Projects, and Dr. Mackie, assisted Board members with their understanding of this report. Mr. Graham announced that the Health Unit met or exceeded performance targets on seven out of nine indicators measured in 2012. Dr. Mackie outlined the proposed targets for 2013.

It was moved by Ms. Brown, seconded by Mr. Peer *that Board of Health members receive the 2012 Accountability Agreement Performance Indicators for information, and approve the 2013 targets.*

Carried

3) **Report No 065-13** re "Harvest Bucks: A Farmers' Market Vegetable and Fruit Program"

Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services, introduced Ms. Kim Leacy, Registered Dietitian, who assisted Board members with their understanding of this report. A copy of Ms. Leacy's PowerPoint presentation is filed with the minutes.

The Health Unit will be posting more information about the Harvest Bucks program on **www.healthunit.com**. It was suggested that more of data collected about the use and success of the program should be reported as the data definitely show encouraging impacts.

It was moved by Mr. Orser, seconded by Ms. Brown *that Report No. 065-13 re "Harvest Bucks: A Farmers' Market Vegetable and Fruit Program" be received for information.*

Carried

REPORT DEFERRED FROM MAY 9, 2013 MEETING

Report 063-13 re "PricewaterhouseCoopers Interim Report – May 9, 2013"

It was discussed that Health Unit staff members should move forward on recommendations to implement cost savings where possible. Dr. Mackie suggested that the Senior Management Team meet with PWC to discuss areas on which staff could focus. It was also suggested that staff prepare a Report for the June Board of Health meeting that contains ideas for a Finance Committee.

It was moved by Ms. Brown, seconded by Mr. Orser:

1. *That Health Unit staff meet with PricewaterhouseCoopers (PWC) to discuss the next steps and report back to the Board of Health in September; and further*

2. *That the Board of Health supports staff identifying opportunities to move forward, and beginning implementation of the PricewaterhouseCoopers recommendations in the interim, including using PwC as consultants where appropriate.*

Carried

REPORTS

4) **Report No. 066-13** re "Community Resources for Newcomers with No Health Insurance"

Dr. Mackie assisted Board members with their understanding of this report. He clarified that the resource materials (Booklet and Resource Map) are for use by primary care givers and those engaging the clients who require the assistance.

It was moved by Mr. Bolton, seconded by Mr. Peer, *that Report No. 066-13 re "Community Resources for Newcomers with No Health Insurance" be received for information.*

Carried

5) **Report No. 068-13** re "Identifying Priority Populations for Reproductive Health"

6) **Report No. 069-13** re "Baby-Friendly Initiative"

7) **Report No. 070-13** re "Smart Start for Babies: Improving Outcomes"

8) **Report No. 071-13** re "Creating Healthier Nutrition Environments in Local Group Homes"

9) **Report No. 072-13** re "Drug Awareness Events – Child Health Team"

10) **Report No. 073-13** re "Stepping Out Safely: Healthy Aging 2012"

11) **Report No. 074-13** re "H7N9 Influenza and Novel Coronavirus – Emerging Infections and the Health Unit's Role"

12) **Report No. 075-14** re "Medical Officer of Health Activity Report – May"

It was moved by Mr. Orser, seconded by Mr. Bolton *that Items #5 through #12 be received for information.*

Carried

CORRESPONDENCE

There were no questions about the correspondence.

OTHER BUSINESS

Next scheduled Board of Health Meeting: **Thursday, June 20, 2013 at 7:00 p.m.**

Please note: the taking of the Board of Health photo has been tentatively scheduled for Thursday, June 20, prior to the June Board meeting. Please advise the Executive Assistant to the Board of Health if you cannot make it on June 20th at 6:30 p.m.

ADJOURNMENT

At 8:45 p.m., it was moved by Mr. Edmondson, seconded by Ms. Fulton *that the meeting be adjourned.*

Carried

_____ _____

MARCEL MEYER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 076-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

FINANCE & FACILITIES COMMITTEE – DRAFT TERMS OF REFERENCE

Recommendations

It is recommended:

1) ***That the Board of Health review and approve the draft terms of reference for the Finance & Facilities Committee attached as Appendix A; and further,***

2) ***That the Board of Health appoint members of the committee as per the terms of reference; and further,***

3) ***That the Board of Health select a meeting date for the first meeting of the committee.***

Key Points

- To provide additional oversight to the financial management of the Health Unit, the Board of Health wishes to form a Finance & Facilities Committee.
- The draft Terms of Reference for this proposed committee are attached as Appendix A.

At the February 19, 2013 meeting the Board reviewed Report No. 019-13 in regards to implementing a new committee with the purpose of providing an advisory and monitoring role to the Board, the Medical Officer of Health and Chief Executive Officer, and the Director of Finance & Operations in administrative and risk management matters relating to the finance and facilities of the organization.

The minutes of the meeting reflect the Boards decision to table Report No. 019-13 until Dr. Christopher Mackie, Medical Officer of Health & Chief Executive Officer, begins his employment.

Attached for the Board's consideration as Appendix A is the draft terms of reference for the Finance & Facilities Committee.

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

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

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

FINANCE & FACILITIES COMMITTEE

Draft Terms of Reference – June 20, 2013

PURPOSE

The committee serves to increase Board of Health oversight of Middlesex-London Health Unit finances and facilities by providing an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer (MOH/CEO), and the Director of Finance & Operations in the administration and risk management of matters related to the finances and facilities of the organization.

REPORTING RELATIONSHIP

The Finance & Facilities Committee is a committee reporting to the Board of Health of the Middlesex-London Health Unit. The Chair of the Finance & Facilities Committee, with the assistance of the Director, Finance and Operations and the MOH/CEO, will make reports to the Board of Health as a whole following each of the meetings of the Finance & Facilities Committee.

MEMBERSHIP

The membership of the Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board Member, one City of London Board Member and two provincial Board Members.

The Secretary-Treasurer will be an ex-officio member

Staff support: - Director, Finance and Operations
- Executive Assistant to the Board of Health

Other Board of Health members are able to attend the Finance & Facilities Committee but are not able to vote.

CHAIR

The Committee will elect a Chair at the first meeting of the year to serve at least one year, and optimally two years.

TERM OF OFFICE

The members of the committee will be determined, by majority vote, at the first Board of Health meeting of the year and the appointment will be for at least one year. Optimally and if feasible, the members will serve at least a two-year term. A member may serve on the committee as long as they remain a Board of Health member. Attempts will be made to maintain a balance of new and continuing members.

DUTIES

The Committee will seek the assistance of and consult with the MOH/CEO and the Director of Finance & Operations for the purposes of making recommendations to the Board of Health on the following matters:

1. Reviewing detailed financial statements and analyses.
2. Reviewing the annual cost-shared and 100% funded program budgets, for the purposes of governing the finances of the Health Unit.
3. Reviewing the annual financial statements and auditor's report for approval by the Board.
4. Reviewing annually the types and amounts of insurance carried by the Health Unit.
5. Reviewing periodically administrative policies relating to the financial management of the organization, including but not limited to reserves and reserve funds, procurement, investments, and signing authority.
6. Monitoring the Health Unit's physical assets and facilities.
7. Reviewing annually all service level agreements.
8. Reviewing all funding agreements.

FREQUENCY OF MEETINGS

The Committee will meet quarterly (excluding July & August) or more frequently as required (at the call of the Chair).

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director of Finance & Operations and the Medical Officer of Health & Chief Executive Officer (MOH/CEO), will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the Executive Assistant to the Board of Health.
4. Agenda & minutes will be made available at least 5 days prior to meetings.
5. Agenda & meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable.
This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every 2 (two) years.

Implementation Date: TBD

Revision Dates:

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 077-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

2012 CONSOLIDATED FINANCIAL STATEMENTS

Recommendation

It is recommended that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, December 31st, 2012 as appended to Report No. 077-13.

Key Points

- Attached as Appendix A are the draft Consolidated Financial Statements for the Middlesex-London Health Unit relating to the operating period January 1st, 2012 to December 31st, 2012.
- The preparation of the consolidated financial statements is the responsibility of the Health Unit's management. The consolidated financial statements have been prepared in compliance with legislation, and in accordance with Canadian public sector accounting standards.
- A summary of the significant accounting policies are described in Note 1 to the consolidated financial statements.

Financial Overview

This report provides an overview of the financial information found in both the Consolidated Statement of Financial Position and the Consolidated Statement of Operations. The Consolidated Statement of Financial Position can be found on page three of the consolidated financial statements. It is often referred to as the balance sheet as it contains the financial assets and liabilities of the organization. The Health Unit has approximately $5.5 million in cash and near cash financial assets to offset its $4.3 million short-term financial liabilities, and $1.9 million in long-term liabilities. These financial liabilities as at December 31, 2012 include the following:

Short-term liabilities: (often paid in the next operating year)

1) $1.4 million in amounts owing to all four funders
2) $1.9 million in unpaid accounts payable and accrued liabilities
3) $1.0 million in accrued wages and benefits

Long-term liabilities: (often extends past the next operating year)

4) $0.2 million is sick leave liability (which is funded through a reserve fund)
5) $1.7 million in post-employment benefits

With regards to the $1.7 million post-employment benefits liability above, this is the estimated amount required to fund all future costs associated with providing post-retirement benefits. This liability is currently unfunded, however, each year an estimated amount required for the current year is included as part of the operating budget. In 2012, $111,458 was paid for post-retirement benefits (2012 budget was $121,560).

The non-financial assets which total $3.1 million include the net book value of the Health Unit's tangible capital assets, such as lease hold improvements and computer systems, and prepaid expenses.

The last amount on the Consolidated Statement of Financial Position is the Accumulated Surplus for the Health Unit. It represents the net financial and physical resources available to provide future services. As can be seen the accumulated surplus fell by $1,024,319 (equal to the annual deficit) as a result of 2012 operations. This is mainly due to depreciation of capital assests. This is important as it indicates a lack of investment in capital.

Turning to page 4 of the consolidated financial statements you can find the Consolidated Statement of Operations which details the Health Unit's revenue and expenditures for 2012. As can be seen, the total revenue of $34.5 million comprised of $32.7 million (94.8%) in grant revenue from four sources, the Province of Ontario ($25.6 million or 74.2% of total revenue), the Government of Canada ($0.1 million or 0.3% of total revenue), The Corporation of the City of London ($5.9 million or 17.1% of total revenue), and The Corporation of the County of Middlesex ($1.1 million or 3.2% of total revenue). The remaining $1.8 million (5.2% of total revenue) comes from program revenue, interest, and other off-set revenues.

The revenues provided for expenditures of $35.6 million, which includes a $1.5 million (4.2% of total expenditures) charge (non-cash) for amortization expense which is the decreasing value of the tangible capital assets for 2012. Note #4 beginning on page 12 provides a schedule of changes to the tangible capital assets. The majority of the expenditures continue to be salaries and benefits which total $ 24.0 million (67.4%). The remaining $10.1 million (28.4%) consists of travel (1.0%), materials and supplies (5.1%), professional services (10.1%), rent and maintenance (4.5%), and other expenses (7.7%)

Draft Schedule of Revenues and Expenditures

Attached as Appendix C, is a draft Schedule of Revenues and Expenditures for 2012 that is also prepared by Health Unit management and audited by KPMG on an annual basis. This additional schedule is required by the Ministry of Health & Long-Term (MOHLTC) as part of their settlement process. This process is separate from the annual audit of the consolidated financial statements and has not been completed as the ministry has not yet provided public health units with the settlement reporting templates for the 2012 operating year. However, the draft Schedule of Revenue and Expenditures provides some level of detail in regards to revenues and expenditures by program which is useful for Board members to review.

There are a few important issues that this schedule highlights and should be brought to the Board's attention. First, represented in the column marked with an "A" are the revenue and expenditures for the Dental Treatment Clinic. This clinic is intended to be self-funded through dental fees. Historically these fees come from dental supports programs such as Ontario Works, Children In Need of Treatment, and the Healthy Smile Ontario programs. For the 2012 operating year the clinic generated a deficit of $40,577 (In 2011 the clinic generated a surplus of $17,194). This deficit will reduce the amount in the Dental Treatment Reserve Fund by a corresponding amount. Please see Report No. 079-13 of this agenda for the details of this reserve fund. At the September 2012 Board of Health meeting, staff will provide a report that will detail the reasons for the deficit and provide a plan to mitigate any future loses. In the columns marked with a "B" and "C" are revenues and expenditures of the Infection Prevention Control Nurse (IPCN) position (1.0 FTE), and the Social Determinants of Health Nursing (SDOH) positions (2.0 FTE) respectively. These positions, when implemented, were 100% funded by the MOHLTC, however funding

levels have not kept pace with increases in salary and benefit costs. A contribution of $4,289 for the IPCN position, and $12,437 for the SDOH positions were required from the participating municipalities.

Audit Findings Report

Attached as Appendix B is KPMG's Audit Findings Report which will be presented at the June 20 meeting. A common practice in presenting the report is for the Auditors to meet in private with a Board of Directors excluding the Chief Executive Officer, Chief Financial Officer and all other staff. While this option has not been exercised in the recent past, Board members should be aware of its existence should they so wish to avail themselves.

Mr. John Millson, Director, Finance and Operations, and Mr. David Ross, Audit Manager, KPMG LLP will be in attendance at the June 20 Board meeting to address any questions regarding this report.

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

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

DRAFT – Consolidated Financial Statements of

MIDDLESEX-LONDON HEALTH UNIT

Year ended December 31, 2012

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Financial Statements
DRAFT
Year ended December 31, 2012

Consolidated Financial Statements

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Financial Statements
DRAFT
Year ended December 31, 2012

Management's Responsibility for the Consolidated Financial Statements

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

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

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

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

Dr. Christopher Mackie, MD
Medical Officer of Health &
Chief Executive Officer

John Millson, BA, CGA
Director, Finance & Operations

Marcel Meyer, Chair
Board of Health

INDEPENDENT AUDITORS' REPORT

To the Chair and Members, Middlesex-London Board of Health

We have audited the accompanying consolidated financial statements of Middlesex-London Health Unit, which comprise the consolidated statement of financial position as at December 31, 2012, the consolidated statements of operations, change in net debt, and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the consolidated statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Middlesex-London Health Unit as at December 31, 2012, and its results of operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Chartered Accountants, Licensed Public Accountants

June 20, 2013

London, Canada

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Financial Position
DRAFT
December 31, 2012, with comparative figures for 2011

	2012	2011
Financial Assets		
Cash	$ 4,902,703	$ 5,286,720
Accounts receivable	444,232	637,862
Grants receivable	111,436	123,273
	$ 5,458,371	$ 6,047,855
Financial Liabilities		
Province of Ontario	$ 1,211,452	$ 1,383,835
Government of Canada	18,870	1,435
The Corporation of the City of London	166,465	312,054
The Corporation of the County of Middlesex	31,705	58,693
Accounts payable and accrued liabilities	1,968,134	1,871,538
Accrued wages and benefits	945,616	1,030,893
Vested sick leave liability (note 2(i))	174,986	204,028
Post-employment benefits liability (note 2(ii))	1,736,100	1,831,500
	6,253,328	6,693,976
Net Debt	(794,957)	(646,121)
Non-Financial Assets		
Tangible capital assets (note 4)	2,970,590	3,908,630
Prepaid expenses	137,355	74,798
	3,107,945	3,983,428
Commitments (note 5)		
Contingencies (note 6)		
Accumulated Surplus (note 7)	$ 2,312,988	$ 3,337,307

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

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Operations
DRAFT

Year ended December 31, 2012, with comparative figures for 2011

	2012 Budget (unaudited)	2012	2011
Revenue:			
Grants:			
Ministry of Health and Long-Term Care	$ 20,265,219	$ 20,252,178	$ 19,195,096
Ministry of Children & Youth Services	4,971,535	5,333,176	5,159,168
Government of Canada	152,430	86,275	160,256
The Corporation of the City of London	6,095,059	5,928,594	5,886,923
The Corporation of the County of Middlesex	1,160,961	1,129,256	1,121,319
	32,645,204	32,729,479	31,522,762
Other:			
Property search fees	3,750	3,051	3,794
Family planning	285,000	322,952	325,201
Dental service fees	208,407	213,148	231,565
Investment income	5,000	32,249	24,450
Prenatal class income	35,000	20,443	36,025
Other income (note 8)	393,290	1,233,739	898,497
	930,447	1,825,582	1,519,532
Total Revenue	33,575,651	34,555,061	33,042,294
Expenditures:			
Salaries:			
Medical Officers of Health	573,994	496,981	564,894
Public Health Nurses	8,657,771	8,663,701	8,333,239
Public Health Inspectors	2,318,778	2,308,423	2,214,357
Administrative staff	3,264,487	3,339,802	3,176,814
Dental staff	873,798	868,913	832,079
Other salaries	3,490,922	3,447,920	3,479,834
	19,179,750	19,125,740	18,601,217
Other Operating:			
Benefits	4,953,260	4,841,950	3,939,082
Travel	417,686	390,738	393,621
Materials & supplies	1,068,343	1,782,708	1,436,421
Professional services	3,697,675	3,606,380	3,540,524
Rent & maintenance	1,582,363	1,646,016	1,619,872
Amortization expense	520,596	1,510,204	846,834
Other expenses (note 9)	2,155,979	2,675,644	2,121,497
	14,395,901	16,453,640	13,897,851
Total Expenditures	33,575,651	35,579,380	32,499,068
Annual surplus (deficit)	-	(1,024,319)	543,226
Accumulated surplus, beginning of year	3,337,307	3,337,307	2,794,081
Accumulated surplus, end of year	$ 3,337,307	$ 2,312,988	$ 3,337,307

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

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Changes in Net Debt
DRAFT
Year ended December 31, 2012, with comparative figures for 2011

	2012	2011
Annual surplus (deficit)	$ (1,024,319)	$ 543,226
Acquisition of tangible capital assets	(572,164)	(966,546)
Amortization of tangible capital assets	1,510,204	846,834
	(86,279)	423,514
Acquisition of prepaid expenses	(137,355)	(66,028)
Use of prepaid expenses	74,798	27,757
	(62,557)	(58,271
Change in net debt	(148,836)	385,243
Net debt, beginning of year	(646,121)	(1,031,364)
Net debt, end of year	$ (794,957)	$ (646,121)

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

MIDDLESEX-LONDON HEALTH UNIT

Consolidated Statement of Cash Flows
DRAFT
December 31, 2012, with comparative figures for 2011

	2012	2011
Cash provided by (used in):		
Operating activities:		
Annual surplus (deficit)	(1,024,319)	$ 543,226
Items not involving cash:		
Amortization	1,510,204	846,834
Change in employee benefits and other liabilities	(124,442)	(28,675)
Change in non-cash assets and liabilities:		
Accounts receivable	193,630	(225,081)
Grants receivable	11,837	270,084
Prepaid expenses	(62,557)	(38,271)
Due to Province of Ontario	(172,383)	90,131
Due to Government of Canada	17,435	(28,061)
Due to The Corporation of the City of London	(145,589)	(35,201)
Due to The Corporation of the County of Middlesex	(26,988)	(6,704)
Accounts payable and accrued liabilities	96,596	126,560
Accrued wages and benefits	(85,277)	46,838
Net change in cash from operating activities	188,147	1,561,680
Capital activities:		
Cash used to acquire tangible capital assets	(572,164)	(966,546)
Net change in cash from capital activities	(572,164)	(966,546)
Net change in cash	(384,017)	595,134
Cash and cash equivalents, beginning of year	5,286,720	4,691,586
Cash and cash equivalents, end of year	4,902,703	$ 5,286,720

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

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

1. Significant accounting policies:

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

(a) Basis of consolidation:

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

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

(b) Basis of accounting:

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

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

The operations of the Middlesex-London Health Unit are funded by the Province of Ontario, The Corporation of the City of London and The Corporation of the County of Middlesex. Funding amounts not received at year end are recorded as grants receivable due from the related funding organization in the consolidated statement of financial position.

Funding amounts in excess of actual expenditures incurred during the year are either contributed to reserves or reserve funds, when permitted, or are repayable and are reflected as liabilities due from the related funding organization in the consolidated statement of financial position.

1. Significant accounting policies (continued):

(c) Employee future benefits:

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

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

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

(d) Non-financial assets:

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

(i) Tangible Capital Assets

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

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

1. Significant accounting policies (continued):

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

(ii) Contributions of tangible capital assets

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

(iii)Leased tangible capital assets

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

(e) Use of estimates:

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

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

Actual results could differ from these estimates.

2. Employee future benefits:

The Middlesex-London Health Unit provides certain employee benefits which will require funding in future periods, as follows:

(i) Vested sick leave liability:

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

The liability for these accumulated days, to the extent that they have vested and could be taken in cash by an employee on termination, amounted to approximately $174,986 (2011 - $204,028) at the end of the year.

A reserve of $307,314 has been established to meet future commitments for this liability.

(ii) Post-retirement benefits liability:

The Middlesex-London Health Unit pays certain life insurance benefits on behalf of the retired employees as well as extended health and dental benefits for early retirees to age sixty-five. The Middlesex-London Health Unit recognizes these post-retirement costs in the period in which the employees render services. The most recent actuarial valuation was performed as at January 1, 2012.

	2012	2011
Accrued employee future benefit obligations	$ 2,086,300	$ 1,831,500
Unamortized net actuarial loss	(350,200)	-
Employee future benefits liability as of December 31st	$ 1,736,100	$ 1,831,500

Retirement and other employee future benefit expenses included in the benefits in the consolidated statement of operations consist of the following:

	2012	2011
Current year benefit cost	$ 95,900	$ 92,600
Interest on accrued benefit obligation	92,700	87,900
Amortization	12,500	12,300
Total benefit cost	$ 201,100	$ 192,800

Benefits paid during the year were $ 147,500 (2011 - $147,200).

2. Employee future benefits (continued):

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

(a) Interest (discount) rate:

The obligation as at December 31, 2012, of the present value of future liabilities and the expense for the year ended December 31, 2012, are determined using a discount rate of 3.75% (2011 - 5%).

(b) Medical costs:

Medical costs are assumed to increase at the rate of 7.0% per year (2011 - 8%) declining to 4% per year over 20 years.

(c) Dental costs:

Dental costs are assumed to increase at the rate of 4% per year (2011 - 4%).

3. Pension agreement:

The Middlesex-London Health Unit contributes to the Ontario Municipal Employees Retirement Fund (OMERS) which is a multi-employer plan, on behalf of 282 members of its staff. The plan is a defined benefit plan which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay.

During 2012, the plan required employers to contribute 8.3% of employee earnings up to the year's maximum pensionable earnings and 12.8% thereafter. The Health Unit contributed $1,596,358 (2011 - $1,348,361) to the OMERS pension plan on behalf of its employees during the year ended December 31, 2012.

4. Tangible Capital Assets:

Cost	Balance at December 31, 2011	Additions	Disposals	Balance at December 31, 2012
Leasehold Improvements – 15 yrs	$ 2,569,642	$ 73,072	$ -	$ 2,642,714
Leasehold Improvements – 5 yrs	172,879		-	172,879
Computer Systems	1,690,806	144,122	(219,248)	1,615,680
Motor Vehicles	35,014	-	(35,014)	
Furniture & Equipment	2,224,825	354,970	(101,824)	2,477,971
Total	$ 6,693,166	$ 572,164	$ (356,086)	$ 6,909,244

Accumulated amortization	Balance at December 31, 2011	Amortization expense	Disposals	Balance at December 31, 2012
Leasehold Improvements – 15 yrs	$ 553,559	$ 818,910	$ -	$ 1,372,469
Leasehold Improvements – 5 yrs	74,278	40,312	-	114,590
Computer Systems	872,247	343,092	(219,248)	996,091
Motor Vehicles	35,014		(35,014)	
Furniture & Equipment	1,249,438	307,890	(101,824)	1,455,504
Total	$ 2,784,536	$ 1,510,204	$ (356,086)	$ 3,938,654

	Net book value December 31, 2011	Net book value December 31, 2012
Leasehold Improvements – 15 yrs	$ 2,016,083	$ 1,270,245
Leasehold Improvements – 5 yrs	98,601	58,289
Computer Systems	818,559	619,589
Motor Vehicles		-
Furniture & Equipment	975,387	1,022,467
Total	$ 3,908,630	$ 2,970,590

4. Tangible Capital Assets (continued):

Cost	Balance at December 31, 2010	Additions	Disposals	Balance at December 31, 2011
Leasehold Improvements – 15 yrs	$ 2,196,042	$ 373,600	$ -	$ 2,569,642
Leasehold Improvements – 15 yrs	151,427	21,452	-	172,879
Computer Systems	1,565,949	459,101	(334,244)	1,690,806
Motor Vehicles	35,014	-	-	35,014
Furniture & Equipment	2,185,846	112,393	(73,414)	2,224,825
Total	$ 6,134,278	$ 966,546	$ (407,658)	$ 6,693,166

Accumulated amortization	Balance at December 31, 2010	Amortization expense	Disposals	Balance at December 31, 2011
Leasehold Improvements – 15 yrs	$ 394,703	$ 158,856	$ -	$ 553,559
Leasehold Improvements – 15 yrs	41,847	32,431	-	74,278
Computer Systems	882,424	324,067	(334,244)	872,247
Motor Vehicles	31,513	3,501	-	35,014
Furniture & Equipment	994,873	327,979	(73,414)	1,249,438
Total	$ 2,345,360	$ 846,834	$ (407,658)	$ 2,784,536

	Net book value December 31, 2010	Net book value December 31, 2011
Leasehold Improvements – 15 yrs	$ 1,801,399	$ 2,016,083
Leasehold Improvements – 5 yrs	109,580	98,601
Computer Systems	683,525	818,559
Motor Vehicles	3,501	0
Furniture & Equipment	1,190,973	975,387
Total	$ 3,788,918	$ 3,908,630

During the year, the Health Unit deemed to have disposed of fully amortized assets with a cost basis of $356,086 (2011 - $407,658).

5. Commitments:

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

Future minimum payments to expiry are as follows:

2013	$ 905,770
2014	880,934
2015	815,392
2016	756,208
2017	-

6. Contingent liabilities:

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

7. Accumulated Surplus:

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

	2012	2011
Surpluses:		
Invested in tangible capital assets	$ 2,970,590	$ 3,908,630
Unfunded:		
Sick leave benefits	(174,986)	(204,028)
Post-employment benefits	(1,736,100)	(1,831,500)
Total Surplus	1,059,504	1,873,102
Reserves set aside by the Board:		
Accumulated sick leave	307,314	344,164
Funding stabilization	765,957	899,251
Environmental – septic tank	6,044	6,044
Dental Treatment reserve	174,169	214,746
Total reserves	1,253,484	1,464,205
Accumulated surplus	$ 2,312,988	$ 3,337,307

8. Other income:

The following revenues are presented as other income in the consolidation statement of operations:

	2012 Budget (unaudited)	2012 Actual	2011 Actual
Collaborative project revenues	$ 237,076	$ 735,618	$ 429,937
Food handler training	25,500	62,649	71,385
Miscellaneous revenues	53,947	154,256	242,883
Vaccine sales	61,925	261,969	96,960
Workshop fees	14,842	19,247	57,332
	$ 393,290	$ 1,233,739	$ 898,497

9. Other expenses:

The following expenditures are presented as other expenses in the consolidation statement of operations:

	2012 Budget (unaudited)	2012 Actual	2011 Actual
Communications	$ 197,422	$ 209,626	$ 193,564
Health promotion/advertising	395,048	498,495	636,163
Miscellaneous expenses	554,557	637,951	780,404
Postage and courier	89,595	80,703	87,105
Printing	203,667	169,675	191,216
Staff development	205,690	179,194	233,045
UWO – GA facility support	510,000	900,000	0
	$ 2,155,979	$ 2,675,644	$ 2,121,497

9. Prepaid leave trust funds:

The Prepaid Leave Plan is a self-funded program for participating employees. A portion of the employees' salary is held in trust to be paid in the year of leave. The employees are credited with interest income from the trust funds annually, prior to the year end. The balance of the Prepaid Leave Plan at December 31, 2012 is $20,914, (2011 - $92,642). These amounts have not been included in the Consolidated Statement of Financial position nor have their operations been included in the consolidated statement of operations.

10. Budget data:

The unaudited budget data presented in these consolidated financial statements is based upon the 2012 operating budgets approved by the Board of Health on March 22, 2012. Amortization was not contemplated on development of the budget and, as such, has not been included. The chart below reconciles the approved budget to the budget figures reported in these consolidated financial statements

Revenues:		
Operating budget	$	33,575,651
Expenses:		
Operating budget		33,055,055
Capital budget		520,596
Total Expenses	$	33,575,651
Annual surplus, as budgeted		-
Amortization		1,510,204
Capital Expenditures		(572,164)
Annual surplus / (deficit)	$	938,040

AUDIT

Middlesex-London Health Unit

Audit Findings Report

For the year ending December 31, 2012

KPMG LLP, Chartered Accountants, Licensed Public Accountants

kpmg.ca

Contents

For KPMG's audit committee resources,
please visit kpmg.ca/auditcommittee

Executive summary

Overview

The purpose[1] of this Audit Findings Report is to assist you, as a member of the Board, in your review of the results of our audit of the financial statements of Middlesex-London Health Unit ("MLHU") as at and for the period ended December 31, 2012.

We appreciate the assistance of management and staff in conducting our audit. It was clear that the management and the finance team made the audit a priority. This level of cooperation and support was invaluable to the timely completion of an audit.

We hope this audit findings report is of assistance to you for the purpose above, and we look forward to discussing our findings and answering your questions.

Status

As of the date of this report, we have completed the audit of the financial statements, with the exception of certain remaining procedures which include:

- completing our discussions with the Board
- obtaining evidence of the Board's approval of the financial statements
- receipt of the signed management representations letter

We will update you on significant matters, if any, arising from the completion of the audit, including completion of the above procedures. Our auditors' report will be dated upon completion of any remaining procedures.

[1] This Audit Findings Report should not be used for any other purpose or by anyone other than the Board of Health. KPMG shall have no responsibility or liability for loss or damages or claims, if any, to or by any third party as this Audit Findings Report has not been prepared for, and is not intended for, and should not be used by, any third party or for any other purpose.

Significant audit, accounting and reporting matters

Included in this report are significant matters we have highlighted for discussion at the upcoming Board meeting. We look forward to discussing these matters and our findings with you.

Matters related to management's judgment and estimates

We have highlighted below significant matters related to management's judgment and estimates that we would like to bring to your attention:

Manulife benefit asset
• MLHU makes contributions to Manulife on a monthly basis to cover employee benefit costs and maintain a surplus with Manulife to cover the fluctuations of these costs. • At December 31, 2012, the surplus with Manulife totalled $448,547 (2011 - $581,841). • This surplus is reported as part of the Cash balance of MLHU.
KPMG comments regarding effect on the audit
• KPMG reviewed the agreement with Manulife to verify that MLHU has the ability to withdraw the excess funds at any time. • KPMG reviewed the Manulife Activity Summary as at December 31, 2012 to verify the accuracy of the amount reported by management.
Misstatements
• No misstatements were identified relating to the Manulife benefit asset.

Amortization of leasehold improvements
• During 2012 MLHU adjusted the estimated useful life of leasehold improvements. • The adjusted estimated useful life is based on the remaining term of the existing lease. • A change in an accounting estimate is accounting for prospectively, as required by accounting standards. Therefore, the revised amortization expense calculation applies to 2012 and future years. All prior period financial results are not affected.
KPMG comments regarding effect on the audit
• KPMG discussed the nature of the change in estimate with management. • We also recalculated the amortization expense recorded for leasehold improvements based on the revised useful life.
Misstatements
• No misstatements were identified relating to the amortization of leasehold improvements.

Significant qualitative aspects of accounting policies and practices

Our professional standards require that we communicate our views regarding the matters below, which represent judgments about significant qualitative aspects of accounting policies and practices. Judgments about quality cannot be measured solely against standards or objective criteria. These judgments are inherently those of the individual making the assessment: the engagement partner. However, although judgments about quality are those of the engagement partner, the views discussed below are not contrary to positions KPMG has taken.

The following are the matters we plan to discuss with you:

Significant accounting policies	• All significant accounting policies are disclosed in notes to the financial statements. • KPMG reviewed accounting policies adopted by management, including management's assessment of all accounting policies adopted by the entity, and all are considered appropriate.
Critical accounting estimates	• Management's identification of accounting estimates • Management's process for making accounting estimates • There are no indicators of management bias as a result of our audit over estimates • Disclosure of estimation uncertainty in the financial statements is included in the notes to the financial statements. The notes provide information on areas in the financial statements that include estimates. • Management evaluates these estimates on a regular basis to ensure they are appropriate
Critical disclosures and financial statement presentation	• We identified no inconsistencies with the overall neutrality, consistency, and clarity of the disclosures in the financial statements • Overall, the disclosures in the financial statements are clear and are consistent with prior periods.

Misstatements

Identification of misstatements

Misstatements identified during the audit have been categorized as follows:

- uncorrected misstatements in excess of $48,750, including disclosures
- corrected misstatements in excess of $48,750 including disclosures

Uncorrected misstatements

We identified no misstatements that remain uncorrected.

Corrected misstatements

We identified no misstatements that were corrected by management.

Control deficiencies

Background and professional standards

As your auditors, we are required to obtain an understanding of internal control over financial reporting (ICFR) relevant to the preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances for the purpose of expressing an opinion on the financial statements, but not for the purpose of expressing an opinion on internal control. Accordingly, we do not express an opinion on the effectiveness of internal control].

Our understanding of ICFR was for the limited purpose described above and was not designed to identify all control deficiencies that might be significant deficiencies and therefore, there can be no assurance that all significant deficiencies and other control deficiencies have been identified. Our awareness of control deficiencies varies with each audit and is influenced by the nature, timing, and extent of audit procedures performed, as well as other factors.

Identification

No control deficiencies have been identified.

Appendices

Independence letter

Management representation letter

Draft auditors' report

Independence letter

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Middlesex-London Health Unit
50 King Street
London, ON
N6A 5L7

June 20, 2013

Ladies and Gentlemen

Professional standards specify that we communicate to you in writing all relationships between the Entity (and its related entities) and our firm, that may reasonably be thought to bear on our independence.

In determining which relationships to report, we consider relevant rules and related interpretations prescribed by the relevant professional bodies and any applicable legislation or regulation, covering such matters as:

a) provision of services in addition to the audit engagement

b) other relationships such as:

- holding a financial interest, either directly or indirectly, in a client
- holding a position, either directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of a client
- personal or business relationships of immediate family, close relatives, partners or retired partners, either directly or indirectly, with a client
- economic dependence on a client

PROVISION OF SERVICES

The following summarizes the professional services rendered by us to the Entity (and its related entities) from January 1, 2012 up to the date of this letter:

Description of Professional Services
Audit • Audit of December 31, 2012 Financial Statements • Audit of March 31, 2013 Consolidated Programs

Professional standards require that we communicate the related safeguards that have been applied to eliminate identified threats to independence or to reduce them to an acceptable level. Although we have policies and procedures to ensure that we did not provide any prohibited services and to ensure that we have not audited our own work, we have applied the following safeguards regarding to the threats to independence listed above:

- We instituted policies and procedures to prohibit us from making management decisions or assuming responsibility for such decisions.
- We obtained pre-approval of non-audit services and during this pre-approval process we discussed the nature of the engagement and other independence issues related to the services.
- We obtained management's acknowledgement of responsibility for the results of the work performed by us regarding non-audit services and we have not made any management decisions or assumed responsibility for such decisions.

OTHER RELATIONSHIPS

We are not aware of any other relationships between our firm and the Entity (and its related entities) that may reasonably be thought to bear on our independence from January 1, 2012 up to the date of this letter.

CONFIRMATION OF INDEPENDENCE

We confirm that we are independent with respect to the Entity (and its related entities) within the meaning of the relevant rules and related interpretations prescribed by the relevant professional bodies and any applicable legislation or regulation from January 1, 2012 up to the date of this letter.

OTHER MATTERS

This letter is confidential and intended solely for use by those charged with governance in carrying out and discharging their responsibilities and should not be used for any other purposes.

KPMG shall have no responsibility for loss or damages or claims, if any, to or by any third party as this letter has not been prepared for, and is not intended for, and should not be used by, any third party or for any other purpose.

Yours very truly,

KPMG LLP

Chartered Accountants, Licensed Public Accountants

Management representation letter

KPMG LLP
Chartered Accountants
1400-140 Fullarton Street
London, ON N6A 5P2

June 20, 2013

Ladies and Gentlemen:

We are writing at your request to confirm our understanding that your audit was for the purpose of expressing an opinion on the consolidated financial statements (hereinafter referred to as "financial statements") of Middlesex-London Health Unit ("the Entity") as at and for the period ended December 31, 2012.

We confirm that the representations we make in this letter are in accordance with the definitions as set out in **Attachment I** to this letter.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

GENERAL:

1) We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated December 1, 2010 for:

   a) the preparation and fair presentation of the financial statements

   b) providing you with all relevant information and access

   c) such internal control as management determined is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error

   d) ensuring that all transactions have been recorded in the accounting records and are reflected in the financial statements.

ACCOUNTING POLICIES:

2) The accounting policies selected and applied are appropriate in the circumstances.

3) There have been no changes in, or newly adopted, accounting policies that have not been disclosed to you and appropriately reflected in the financial statements.

4) Retrospective application has been made to the prior period financial statements for changes in accounting policies in accordance with the relevant financial reporting framework.

ESTIMATES / MEASUREMENT UNCERTAINTY:

5) We are responsible for making any fair value measurements and disclosures included in the financial statements.

6) For recorded or disclosed amounts that incorporate fair value measurements:

   a) the measurement methods are appropriate and consistently applied.

   b) the significant assumptions used in determining fair value measurements represent our best estimates, are reasonable, are adequately supported and have been consistently applied.

   c) the resulting valuations are reasonable.

   d) presentation and disclosure is complete and appropriate and in accordance with the relevant financial reporting framework.

ASSETS & LIABILITIES – GENERAL:

7) We have no knowledge of material unrecorded assets or liabilities or contingent assets or liabilities (such as claims related to patent infringements, unfulfilled contracts, etc., whose values depend on fulfillment of conditions regarded as uncertain or receivables sold or discounted, endorsements or guarantees, additional taxes for prior years, repurchase agreements, sales subject to renegotiation or price re-determination, etc.) that have not been disclosed to you.

8) We have no knowledge of shortages that have been discovered and not disclosed to you (such as shortages in inventory, cash, negotiable instruments, etc.).

9) We have no knowledge of arrangements with financial institutions involving restrictions on cash balances and lines of credit or similar arrangements and not disclosed to you.

10) We have no knowledge of agreements to repurchase assets previously sold, including sales with recourse, that have not been disclosed to you.

11) We have no knowledge of side agreements (contractual or otherwise) with any parties that have not been disclosed to you.

COMPARATIVE FIGURES/FINANCIAL STATEMENTS:

12) We have no knowledge of any significant matters that may have arisen that would require a restatement of the comparative figures/financial statements.

PROVISIONS:

13) Provision, when material, has been made for:

a) losses to be sustained in the fulfillment of, or inability to fulfill, any sales commitments.

b) losses to be sustained as a result of purchase commitments for assets at quantities in excess of normal requirements or at prices in excess of prevailing market prices.

c) losses to be sustained from impairment of property, plant and equipment, including amortizable intangible assets.

d) losses to be sustained from impairment of goodwill and/or non-amortizable assets.

FINANCIAL INSTRUMENTS, OFF-BALANCE-SHEET ACTIVITIES, HEDGING AND GUARANTEES:

14) Guarantees, whether written or oral, under which the Entity is contingently liable, including guarantee contracts and indemnification agreements, have been recorded and/or disclosed in accordance with the relevant financial reporting framework.

15) The following information about financial instruments has been properly disclosed in the financial statements:

a) extent, nature, and terms of financial instruments, both recognized and unrecognized;

b) the amount of credit risk of financial instruments, both recognized and unrecognized, and information about the collateral supporting such financial instruments; and

c) significant concentrations of credit risk arising from all financial instruments, both recognized and unrecognized, and information about the collateral supporting such financial instruments.

d) All financial assets and liabilities outstanding as of the balance sheet date have been reviewed and correctly classified or designated as either: held-for-trading, held-to-maturity, loans and receivables or available-for-sale financial assets or other financial liabilities in accordance with the relevant financial reporting framework, and have been appropriately recorded at their fair value, amortized cost or cost based on their classification or designation.

INTERNAL CONTROL OVER FINANCIAL REPORTING:

16) We have communicated to you all deficiencies in the design and implementation or maintenance of internal control over financial reporting of which management is aware.

FRAUD & NON-COMPLIANCE WITH LAWS AND REGULATIONS:

17) We have disclosed to you:

a) the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

b) all information in relation to fraud or suspected fraud that we are aware of and that affects the Entity and involves: management, employees who have significant roles in internal control, or others, where the fraud could have a material effect on the financial statements.

c) all information in relation to allegations of fraud, or suspected fraud, affecting the Entity's financial statements, communicated by employees, former employees, analysts, regulators, or others.

d) all known instances of non-compliance or suspected non-compliance with laws and regulations, including all aspects of contractual agreements, whose effects should be considered when preparing financial statements.

e) all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

COMMITMENTS & CONTINGENCIES:

18) There are no:

a) other liabilities that are required to be recognized and no other contingent assets or contingent liabilities that are required to be disclosed in the financial statements in accordance with the relevant financial reporting framework, including liabilities or contingent liabilities arising from illegal acts or possible illegal acts, or possible violations of human rights legislation

b) other environmental matters that may have an impact on the financial statements

SUBSEQUENT EVENTS:

19) All events subsequent to the date of the financial statements and for which the relevant financial reporting framework requires adjustment or disclosure in the financial statements have been adjusted or disclosed.

RELATED PARTIES:

20) We have disclosed to you the identity of the Entity's related parties and all the related party relationships and transactions of which we are aware and all related party relationships and

transactions have been appropriately accounted for and disclosed in accordance with the relevant financial reporting framework.

ESTIMATES:

21) Measurement methods and significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

NON-SEC REGISTRANTS OR NON-REPORTING ISSUERS:

22) We confirm that the Entity is not a Canadian reporting issuer (as defined under any applicable Canadian securities act) and is not a United States Securities and Exchange Commission ("SEC") Issuer (as defined by the Sarbanes-Oxley Act of 2002). We also confirm that the financial statements of the Entity will not be included in the consolidated financial statements of a Canadian reporting issuer audited by KPMG or an SEC Issuer audited by any member of the KPMG organization.

MISSTATEMENTS:

23) The effects of the uncorrected misstatements described in **Attachment II** are immaterial, both individually and in the aggregate, to the financial statements as a whole.

24) We approve the corrected misstatements identified by you during the audit described in **Attachment II**.

Yours very truly,

_____

Dr. Christopher Mackie, MD
Medical Officer of Health and Chief Executive Officer

_____

John Millson, BA, CGA
Manager, Finance & Operations

Attachment I – Definitions

MATERIALITY

Certain representations in this letter are described as being limited to matters that are material. Misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. Judgments about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both.

FRAUD & ERROR

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorization.

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

RELATED PARTIES

In accordance with Canadian Accounting Standards for the public sector, a *related party* is defined as:

- *Exist when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control or common significant influence. Two not-for-profit organizations are related parties if one has an economic interest in the other. Related parties also include management and immediate family members.*

In accordance with Canadian Accounting Standards for the public sector, a *related party transaction* is defined as:

- *A transfer of economic resources or obligations between related parties, or the provision of services by one party to a related party, regardless of whether any consideration is exchanged. The parties to the transaction are related prior to the transaction. When the relationship arises as a result of the transaction, the transaction is not one between related parties.*

Attachment II – Summary of Audit Misstatements

Summary of Uncorrected Audit Misstatements

None identified.

Summary of Corrected Audit Misstatements

None identified.

Draft auditors' report

To the Chair and Members, Middlesex London Board of Health

We have audited the accompanying financial statements of Middlesex London Health Unit, which comprise the consolidated statement of financial position as at December 31, 2012, the consolidated statements of operations, change in net debt, and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the consolidated statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Middlesex London Health Unit as at December 31, 2012, and its results of operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

DRAFT

Chartered Accountants, Licensed Public Accountants
June 20, 2013
London, Canada

www.kpmg.ca

MIDDLESEX-LONDON HEALTH UNIT

Appendix C

Draft - Schedule of Revenue & Expenditures

	A			B	C																
	Dental Treatment 100	Healthy Smiles Ontario 101	100% Infectious Disease Ctrl 108-114	Infection Prevention Control PHN 115	Social Determinants of Health 116	Chief Nursing Officer 117	Enhanced Safe Water 124	Enhanced Food Safety 125	Smoke Free Ontario 130-135	HBHC 150	HBHC Ncast-154	New Nursing Grad Prg 170	Needle Exchange 812	Public Health Awareness 813-814	Vaccine Refrigerators 811	Vector-Borne Diseases 823	Small Drinking Water Sys. 824	Children in Need of Treatment 832	Other Programs	March 31 Programs	Mandatory Programs	Total
Revenues:																					
Grants:																					
Province of Ontario-MOHLTC - PHD		1,236,799	1,166,723	86,569	173,441	65,262	35,627	80,000				31,781	234,992	17,000	20,000	461,967	23,900			402,305	15,409,792	19,446,158
Province of Ontario-MOHLTC - HPD									983,159									70,601		159,000		1,212,760
Province of Ontario-MCYS										2,383,296	372,714									2,763,931		5,519,941
Federal Government																				134,035		134,035
The Corporation of the City of London				3,603	10,447											124,907	39,825	13,230			5,736,581	5,928,593
The Corporation of the County of Middlesex				686	1,990											23,792	7,586	2,520			1,092,682	1,129,256
	-	1,236,799	1,166,723	90,858	185,878	65,262	35,627	80,000	983,159	2,383,296	372,714	31,781	234,992	17,000	20,000	610,666	71,311	86,352	-	3,459,271	22,239,055	33,370,743
Other:																					
Property search fees																					3,051	3,051
Family Planning																					322,952	322,952
Investment income	1,168								437	1,907									2	1,098	27,637	32,249
Prenatal Classes																					20,443	20,443
Dental Service Fees	213,148																					213,148
Other	9,776	390,000							32,810	5,066									61,288	72,688	662,110	1,233,739
	224,093	390,000	-	-	-	-	-	-	33,247	6,973	-	-	-	-	-	-	-	-	61,290	73,787	1,036,192	1,825,582
Total Revenue	**224,093**	**1,626,799**	**1,166,723**	**90,858**	**185,878**	**65,262**	**35,627**	**80,000**	**1,016,406**	**2,390,269**	**372,714**	**31,781**	**234,992**	**17,000**	**20,000**	**610,666**	**71,311**	**86,352**	**61,290**	**3,533,058**	**23,275,247**	**35,196,325**
Less current year surplus		(25,889)	(1)			(6,396)			(8,536)	(56,526)	(30,854)				(5,439)	(15,869)		(23,349)		(439,071)	(29,334)	**(641,265)**
Total Revenue as per F/S	**224,093**	**1,600,910**	**1,166,722**	**90,858**	**185,878**	**58,866**	**35,627**	**80,000**	**1,007,870**	**2,333,743**	**341,860**	**31,781**	**234,992**	**17,000**	**14,561**	**594,797**	**71,311**	**63,002**	**61,290**	**3,093,988**	**23,245,913**	**34,555,060**
Expenditures:																					
Salaries:																					
Medical Officers of Health																					496,981	496,981
Public Health Nurses			337,018	73,056	151,652	49,464			32,354	1,055,122	38,932	27,766							27,334		6,871,003	8,663,701
Public Health Inspectors			168,055				19,012	41,815								19,161	51,156				2,009,223	2,308,423
Administrative staff		31,664	74,707						40,808	113,360										344,384	2,734,879	3,339,802
Dental staff	181,792	217,559																			469,563	868,913
Other		476	241,665	271				21,828	419,746	604,646						258,973	343		20	95,807	1,804,143	3,447,920
	181,792	249,700	821,445	73,327	151,652	49,464	19,012	63,644	492,907	1,773,127	38,932	27,766	-	-	-	278,135	51,500	-	27,354	440,191	14,385,792	19,125,740
Other:																						
Benefits	27,758	61,283	169,454	17,531	34,225	9,403	3,931	9,335	112,338	437,763	5,862	4,015				56,253	11,099		6,005	425,711	3,449,982	4,841,950
Travel	1,007	-	22,744				619	-	39,957	54,480	-					19,638	1,650		3,181	29,562	217,899	390,738
Materials and supplies	35,172	22,732	12,761					-	89,541	14,890	297,065		234,992	17,000		31,011	1,022		10,676	208,131	649,050	1,624,044
Professional services	2,051	360,133	95,964					7,021	8,344	13,597						166,719		63,002	640	1,746,734	1,142,175	3,606,380
Rent and maintenance																				44,957	1,601,059	1,646,016
Other	4,162	900,481	44,353				12,065		264,488	14,886	-					34,534	6,039		13,434	43,064	1,338,137	2,675,643
Equipment	12,728	6,581							295	25,000					14,561	8,507				155,636	506,064	729,371
Renovations projects																					1,457	1,457
	82,878	1,351,210	345,277	17,531	34,225	9,403	16,615	16,356	514,963	560,615	302,928	4,015	234,992	17,000	14,561	316,662	19,811	63,002	33,937	2,653,796	8,905,822	15,515,599
Total Expenses before TCA	**264,670**	**1,600,910**	**1,166,722**	**90,858**	**185,878**	**58,866**	**35,627**	**80,000**	**1,007,870**	**2,333,743**	**341,860**	**31,781**	**234,992**	**17,000**	**14,561**	**594,797**	**71,311**	**63,002**	**61,290**	**3,093,988**	**23,291,615**	**34,641,339**
Less: Equipment/Renov capitalized																						(572,164)
Add: Amortization Expense																						1,510,204
Total Expenses as per F/S																						**35,579,379**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 078-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

2014 COST-SHARED BUDGET – CITY OF LONDON TARGET

Recommendations

It is recommended:

1) ***That the Board of Health direct staff to develop the 2014 Cost-Shared budget and associated operational plans based on 0% increase from the City of London and Middlesex County; and further***

2) ***That the Board of Health direct staff, in consultation with the Finance and Facilities Committee, to develop a budget process that aligns the Health Unit's planning and budget processes and provides the Board with more information to fulfill its fiduciary role***

Key Points

- The City of London has begun its 2014 budget process. The Board of Health has been provided a budget target of 0% increase over the 2013 budget and has been requested to provide business planning information and implications of the budget target to the City by September 13.
- Guidance is required from the Board on how to prioritize the implementation of a rationalized budget process relative to the City of London budget target and information requests.

Cost-Shared Budget Development & Planning Process

In 2005, the Board of Health set a policy direction to use provincial grant increases to maintain or enhance public health programs and services while keeping the municipal contribution to Health Unit funding at the 2004 level (or 0% per year). This was on the premise that with provincial increases, the 75%/25% cost-sharing arrangement would eventually be reached and public health programs and services would be enhanced. However, the provincial increases of 5% up to 2009 have fallen such that in 2013 the Board of Health is expecting only a 2% increase in certain provincial grants. The reduction in growth of provincial grants has delayed the Board achieving a 75%/25% cost-sharing arrangement, and has required the Health Unit to further explore administrative and program efficiencies to maintain current levels of service. The latest PricewaterhouseCoopers review makes some recommendations to help address this (Report No. 063-13 "PricewaterhouseCoopers Interim Report").

Historically, the Board of Health has used the City of London's budget targets for budget planning purposes. This process usually focused on developing high level expenditure estimates and comparing them to the amount of funding the Board of Health expects to receive from the Ministry of Health and Long-Term Care (MOHLTC), The City of London and from the County of Middlesex. The high level expenditure estimates focused on known or estimated amounts required to fund existing staff complement, increases in global expenditures such as rents, utility costs, or changes in revenue patterns such as changes in interest rates. The process rarely considered individual program needs or requirements. At the October 18, 2012 Board of

Health meeting Report No. 117-12, "Protecting the Gains" was reviewed and demonstrated past practice as it relates to the Health Unit's budget process, high level expenditure estimates and anticipated revenue changes for 2013.

Typically, the Board approves the operating budget with these changes and then within the first 3 months of the budget year in question, and prior to submitting the Health Unit's operating budget to the MOHLTC, Health Unit staff develop the current year's operational plans. The operational plans provide programmatic details that identify:

a) Planned activities
b) Rationale/evidence for doing the activity
c) Timelines
d) Activity lead
e) Dedicated resources
f) Partners to be involved/consulted
g) Expected output/outcomes

Currently, the budget development process and the program planning activities are separate. This creates a situation where the planning process and program needs do not directly inform the budget process. This circumstance was highlighted in the PricewaterhouseCoopers (PwC) interim report and formed the basis of recommendation #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."*

Addressing this recommendation has major implications to the current budget development and planning process for the Board of Health. Guidance is required from the Board on how to prioritize this recommendation relative to the City of London budget target and information requests.

City of London 2014 Budget Process & Target for the Board of Health

On May 22, 2013 Mr. John Millson, Director of Finance & Operations, took part in a meeting with Boards and Commissions of the City of London. At this meeting the City's 2014 budget guidelines were released and each organization was provided their 2014 budget target. The Board of Health's initial target is a 0% increase over the 2013 City of London appropriation of $6,095,059 and it is requested that the Board of Health provide the implications of achieving a 0% target through a "Service Change Business Case".

The budget guidelines package included a draft budget timetable, a business plan template, a service change business case, and budget documents collectively called Program Plans which include a Budget Summary by Service, Object of Expenditure, and Budget Forecast and Staffing overview. As part of the City's budget timetable, the budget and planning information is required to be submitted by September 13, 2013. For the 2013 budget the Health Unit did not participate in the City's business planning process but did provide the high level expenditure and revenue estimates which was reported to the Board in Appendix C of Report No. 132-12 "2013 Cost-Shared Budget". Attached as Appendix A is the draft City of London budget timetable and an excerpt from the City's guidelines illustrating the type of information requested in the City's Business Plan.

2014 Cost-Shared Budget - Board of Health Direction

Given the PwC recommendation to align health unit planning and budget processes, the Board's consideration of a new Finance & Facilities committee, and the fact that the City of London's 2014 budget target and information expectations have been set, the Board needs to provide direction to staff in regards to

how it wishes to proceed in regards to the 2014 Cost-Shared Budget. Specifically, the Board needs to provide direction as it pertains to:

A) The City of London Budget Target

While the Municipal funders can set targets for the Board, the final decision regarding budget requirements rests with the Board of Health. It is therefore essential that the Board of Health determine its approach to the development of the 2014 budget. Three options the Board may consider are:

1) Adopt the City of London direction of a 0% increase on the municipal share of the Cost-Shared programs.
2) Determine an alternative direction for staff to develop the 2014 Cost-Shared Programs budget.
3) Request more analysis before selecting a budget target for municipal funding.

B) The Middlesex-London Health Unit Budget Process

Due to time constraints, if the Board of Health participated in the City of London's planning and budget process, an additional Board of Health meeting would be required in August in order to meet the City's timelines. Further, the budget estimates provided would not be based on a new aligned planning and budget process as recommended by PwC. Three options or approaches the Board may consider are:

1) Follow the City of London's budget process.
2) Develop a Board budget process that aligns the Health Unit's planning and budget process as per the recommendation of PwC and participate in the City process as much as is feasible.
3) Follow a process similar to that used in 2013, which parallels the City process and approximates the City timelines where feasible.

Summary

The City of London has provided a 2014 budget target of 0% increase over the 2013 budget. As part of the City of London budget process, the Board is being requested to provide business planning information and implications of the budget target to the City by September 13. Guidance is required from the Board on how to prioritize the implementation of a rationalized budget process relative to the City of London budget target and information requests.

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

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

DRAFT TIMETABLE

Description	Target Date
Distribution of Guideline Package	**May 22, 2013**
Capital Budget Submission	**June 28, 2013**
Housekeeping Budget Transfers Deadline: • Information Technology Services Transfers • Other Interdepartmental Transfers	 **June 28, 2013** **July 31, 2013**
Operating Budget Submission (Business Plans, Service Changes Business Cases, Budget Documents, Forms, User Fee Schedule, Assessment Growth Business Cases)	**September 13, 2013**
Budget Strategic Reviews • Janice Verhaeghe, Ian Collins o Parking, Roadways & Snow Control, Traffic Control & Lighting, Fleet, Dispatch, Graphics Surveying • Janice Verhaeghe, Ian Collins, LTC Rep o London Transit Commission • Kyle Murray, Ian Collins o Conservation Authorities • Laurie Green, Ian Collins, LPL Rep o London Public Library • Laurie Green, Ian Collins o Culture, Economic Prosperity, Planning, Environmental Programs and Garbage, Recycling & Composting, Facilities, Energy Conservation • Janice Brown, Anna Lisa Barbon o Social & Health • Gail Devito, Anna Lisa Barbon o Social & Housing • Dave Purdy, Anna Lisa Barbon o Neighborhood & Children • Doug Drummond, Anna Lisa Barbon o Public Safety (excluding Police) • Doug Drummond, Anna Lisa Barbon, Police Rep o London Police Services • Steve Whitmore, Anna Lisa Barbon o Parks & Recreation, Cafeteria • Lisa Karlovcec, Ian Collins o Corporate	 **Sept. 23 (9am-11am)** **Sept. 24 (9am-10:30am)** **Sept. 24 (10:30am-11am)** **Sept. 25 (9am-10:30am)** **Sept. 26 (9am-11am)** **Sept. 27 (9am-11am)** **Sept. 30 (9am-11am)** **Oct. 1 (9am-11am)** **Oct. 2 (9am-11am)** **Oct. 3 (9am-11am)** **Oct. 4 (9am-11am)** **Oct. 7 (9am-11am)**
Senior Leadership Team Review	**October 15, 2013**

Description	Target Date
Senior Leadership Team Review	**October 22 and 29, 2013 (If Needed)**
Table the General Property Tax Supported Budget	**December 3, 2013**
Property Tax Budget Presentations	**January 9, 2014**
Build A Budget Workshop	**January 11, 2014**
Public Participation Meeting	**January 13, 2014**
Property Tax Supported “Operating Budget Review”	**January 30, 2014**
Property Tax Supported “Operating Budget Review”	**January 31, 2014 (If Needed)**
Property Tax Supported “Capital Budget Review”	**February 6, 2014**
Property Tax Supported	**February 7, 2014 (If Needed)**
Public Participation Meeting	**February 10, 2014**
Property Tax Supported Budget Approval	**February 27, 2014**

Completing the Business Plans

The business plan is broken down into six sub-sections. The sections are as follows:

Section 1

How does this service contribute to the results identified in the City of London Strategic Plan?

✓ A strong economy	✓ A vibrant and diverse community	✓ A green and growing City	✓ A sustainable infrastructure	✓ A caring community

*** In the section above, insert a check mark beside each of the results identified in the City of London Strategic Plan that relate to the service.*

*** Provide a short concise purpose statement. Please state who you serve, what you do and why (i.e. what is the value to the community).*

Section 2

Name the main activities done to provide this service:

Name The Activities Done To Provide This Service	How Much Did We Do? (optional)	Is The City Mandated To Provide This Service?	Can The Level Of Service Be Changed?
1.			
2.			
3.			
4.			

Section 3

What is the current state of this service?

*** Describe the current state of the service in a clear and concise manner. It is important to remember the primary audience that will be reading this document (i.e. Council and the community). The current state refers to the state of the service in 2013. General guidelines for sections to be included are:*

- *Current Objectives / Milestones*
- *What Is Driving This Service (ie. master plan, Council direction, etc)*
- *Challenges and Pressure Points*
- *Recent Achievements (competed achievements in 2013 and achievements that are likely to be completed by the end of 2013)*

Section 4

What is the future direction of this service?

*** The future state refers to the state of the service from 2014-2018. General guidelines for sections to be included are:*

- *Future Objectives (if different from above)*
- *What is driving this service (ie. master plan, Council direction, etc)*
- *Emerging Issues and Challenges*

Section 5

What do you plan to do?

2014

-
-
-

2015 – 2018

-
-
-

*** In this section, state the actions/strategies that will need to take place to achieve the desired objectives identified above. Please indicate what actions/strategies are to maintain existing service levels and which actions/strategies will change the level of service. It is important to keep the actions/strategies short and concise and to include cost estimates.*

NOTE: The 2015-2018 forecasts contained in budget documents is intended to reflect the costs to maintain existing service levels. Therefore, the actions/strategies that will change the level of service from 2015-2018 identified in business plan should be excluded from the budget documents.

Section 6

Key Performance Indicators						
Description of measure	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
How Much?						
1.						
2.						
How Well?						
3.						
4.						
Is Anyone Better Off?						
5.						
6.						

*** The reporting of key performance indicators has improved over the years. Traditionally, "hard" services have provided better key performance indicators and the "soft" or internal services have provided weaker key performance indicators. In order to improve the quality of key performance indicators contained in the business plan, the Business Administration Team is being asked to evaluate the adequacy and meaningfulness of all key performance indicators, with a focus on the internal services.*

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 079-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

2012 RESERVE / RESERVE FUND BALANCES

Recommendations

It is recommended:

1) ***That the Board of Health approve the additions, withdrawals, and adjustments to the reserve and reserve funds as identified in Appendix A "Reserve & Reserve Fund Overview" to Report No. 079-13 "2012 Reserve / Reserve Fund Balances"; and further,***

2) ***That Report No. 079-13, "2012 Reserve / Reserve Fund Balances" be forwarded to the City of London and the County of Middlesex.***

Key Points

- The purpose of the report is to provide a year over year account for the changes in the Reserves and Reserve Fund Balances as reported on the 2012 Consolidated Financial Statements of the Middlesex-London Health Unit.
- The balance of the reserve and reserve funds fell by a net amount of $210,721.

Background

At the May 16 meeting, the Board reviewed Report No. 067-13 "Draft Reserve/Reserve Fund Policy" and approved the Reserve / Reserve Fund Policy. This policy states that each year, when the draft audited financial statements are presented to the Board of Health, the Director of Finance & Operations will present a report on the funds available for transfer to reserves and/or reserve funds, and make recommendations for any contributions to be made.

2012 Funds Available For Transfer

Included in this agenda is Report No. 077-13 "2012 Consolidated Financial Statements" which provides the results of the 2012 operating year for the various programs and services. In the report an amount of $198,170 is identified as owing to The Corporation of the City of London ($166,465) and to The Corporation of the County of Middlesex ($31,705) and would therefore be available for transfer to either the Funding Stabilization Reserve or a Reserve Fund. However, in January 2013, the Board of Health passed a resolution to use up to $135,000 of any 2012 operating surplus to fund the PricewaterhouseCoopers report. This leaves a remaining balance of $63,170. This is the amount that would be available for the Board of Health to consider transferring to the reserve; however, at this point, staff have not been able to meet with the staff from the City of London or County of Middlesex to discuss the new policy or execute a Memorandum of Agreement. As such, staff are not making a recommendation to this effect.

Reserve Limits

In accordance with Policy 4-015, "Reserve / Reserve Funds", the maximum annual contribution to reserves is 2% of gross revenues as found on the annual statement of operations. For 2012 this would amount to $691,101 (2% of $34,555,061). The maximum cumulative amount of reserves is 10% of gross revenues found on the annual statement of operations which for 2012 would be $3,455,506. Attached as Appendix A, is a schedule summarizing the reserve and reserve fund balances as presented in the draft 2012 consolidated financial statements. As can be seen the current balance of $765,957 is within the cumulative maximum amount allowed under the policy.

Withdrawals and Adjustments

Also included in the 2012 Reserve & Reserve Fund overview (Appendix A) are changes that have been previously approved by the Board of Health or are being recommended as part of the draft "2012 Consolidated Financial Statements". As can be seen, the overall balances have fallen by $210,721 to fund the 2012 operating deficit in the Dental Treatment Clinic, sick leave payments made to eligible staff upon retirement, and the amount held by Manulife Financial Ltd. who, in 2012, administer the health unit's employer paid benefits. The detail of the 2012 transactions to the reserve and reserve funds can be found in Appendix A.

Mr. John Millson, Director of Finance & Operations, will be in attendance at the June 20 Board of Health meeting to address any questions regarding the report.

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

Middlesex-London Health Unit
Reserve & Reserve Fund Overview
as at December 31, 2012

		2012		2011		Change
Reserves set aside by the Board:						
Funding stabilization (2012 limit = $3,455,506)	$	765,957	$	899,251	$	(133,294)[1]
Reserve funds set aside by the Board:						
Accumulated sick leave		307,314		344,164		(36,850)[2]
Environmental – septic tank		6,044		6,044		
Dental Treatment reserve		174,169		214,746		(40,577)[3]
Total reserve funds		487,527		564,954		(77,427)
Total reserves and reserve funds	**$**	**1,253,484**	**$**	**1,464,205**	**$**	**(210,721)**

2012 Transactions:

(1) Funding stabilization

a)	($120,000)	Withdrawal of $120,000 from Manulife Financial balance to lessen the impact on the Board of Health budget reduction. (Report No. 068-12)
b)	($ 46,855)	Adjustment to correct the 2012 opening balance due to incorrect information from Manulife Financial Ltd.
c)	$ 9,303	2012 interest earned
d)	$ 24,258	Increase due to reconciliation of benefits paid
	($133,294)	**Total changes in 2012**

(2) Accumulated sick leave

a)	$ 1,723.77	2012 interest earned
b)	($ 38,573.37)	Sick leave payments to eligible staff
	($ 36,849.60)	**Total changes in 2012**

(3) Dental Treatment

a)	($40,577)	2012 operating deficit
	($40,577)	**Total change in 2012**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 080-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

2013 HEALTHY BABIES HEALTHY CHILDREN BUDGET

Recommendation

It is recommended that the Board of Health approve the 2013 Healthy Babies Healthy Children Program Budget in the amount of $2,545,320 as attached as Appendix A to Report No. 080-13.

Key Points

- The 2013 budget for the Healthy Babies Healthy Children program totals $2,545,320 which represents an increase of $162,007over the 2012 base funding, all from increased provincial funding.
- The preliminary grant approval includes an increase of $100,000 in base funding for the new 1.0 FTE public health nursing position which was Board approved in November 2012. (Report No. 134-12)
- The remaining increase of $62,007 comes from one-time resources to ensure the implementation the local screening tool and the development of webinars to assist all program staff across the Province to maintain their competence. Taking into account known and anticipated position gapping and employer paid benefit rate changes, the program requirements can be met within the Ministry's preliminary grant allocation.

Background

The Healthy Babies Healthy Children (HBHC) Program is funded (100%) by the Ministry of Children and Youth Services (MCYS). Over the past year, the MCYS, along with a Provincial Advisory Committee, have developed a new HBHC Screening Tool which has a greater ability to identify vulnerable families. In addition, a new protocol for all aspects of the program was written and is now being implemented. Improved health information packages along with a new provincial website are being given to all families with newborns.

In order to assist in the implementation of the enhanced program, additional 100% provincial funding is being provided to Ontario public health units. This Health Unit will receive a $100,000 increase in base funding for one new full-time equivalent Public Health Nurse position. This new position will support the delivery of the enhanced HBHC Program in particular work with hospitals and primary care practitioners to ensure services meet our most vulnerable families.

2013 Budget

As in past practice, the MCYS requests public health units across the province to submit a Request for Funding Schedule for the HBHC Program based on a "preliminary" allocation. The completed Request for Funding Schedule is attached as Appendix A.

The Health Unit's 2013 preliminary allocation has been increased by $100,000 from the previous year which represents the province's support for a strengthened HBHC program. Report No. 134-12 provided the Board of Health with background information for the program changes and rational for the increased funding for a new 1.0 FTE public health nursing position. The 2013 grant also includes $62,007 in one-time funding to assist with the implementation of the revised HBHC Protocol and to support the province with the development and delivery of orientation materials for Partners in Parenting Education (PIPE) and the development and testing of a standard webinar to support the Nursing Child Assessment Satellite Training (NCAST) Parent-Child Interaction (PCI). The Health Unit has taken a leadership role in this training initiative and assists the province in training HBHC staff across the province.

Meeting the Preliminary Budget

In order to meet the grant allocation, a number of budget adjustments have been made. The staff complement budget has been refined to include all known and anticipated position gapping as well as estimated changes in employer paid health benefit premiums. The anticipated staffing complement for 2013 is as follows: 12.5 Public Health Nurses, 11.5 Family Home Visitors, 2.5 Program Assistants, 1.0 Social Worker and 2.5 Program Managers. The marginal increases in other operating costs such as program travel, professional development, office supplies, and program resources were required to perform the additional work described above. Although the additional one-time funding will offset the existing and new program requirements for 2013 this program continues to experience ongoing budget challenges in order to meet program demands.

Summary

The 2013 budget for the Healthy Babies Healthy Children program totals $2,545,320 which represents an increase of $162,007 over 2012, all from increased provincial funding. The budget includes funding for the new 1.0FTE public health nursing position. Taking into account known and anticipated position gapping and employer paid benefit rate changes, the program requirements can be met within the Ministry's preliminary grant allocation.

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

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

Healthy Babies Healthy Children
Child and Youth Development Branch
Strategic Policy and Planning Division
Ministry of Children and Youth Services
2013 Request for Funding Schedule
January 1, 2013 - December 31, 2013

Public Health Unit: Middlesex-London Health Unit

	Previous Year Approved FTE	Previous Year Approved Budget	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
Salaries & Wages: Staff	28.9	1,814,340	28.1	1,773,127	30.0	1,878,303	
Employee Benefits		448,945		437,763		473,908	
Employee Benefits as % of S&W Staff		24.7%		24.7%		25.2%	
Contracted Services	-	12,000	-	11,636	-	12,000	
Operating Costs		108,028		111,217		119,102	
TOTAL REQUEST FROM MCYS	28.9	2,383,313	28.1	2,333,743	30.0	2,483,313	
Adjustments	-	-	-	-	-	10,000.0	
One-Time Grant Request	-	372,714	-	341,860	-	52,007	
GRAND TOTAL	28.9	2,756,027	28.1	2,675,603	30.0	2,545,320	

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

Signature:

Name: Dr. Christopher Mackie, Medical Officer of Health and CEO

Date: May 15, 2013

Public Health Unit: Middlesex-London Health Unit

	Previous Year Approved FTE	Previous Year Approved Request	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
1a. Salaries & Wages - Unionized							
Management							
Public Health Nurses	11.5	845,361	11.3	832,394	12.5	951,361	
Lay Home Visitors	11.5	568,662	10.9	538,117	11.5	524,312	
Social Workers	1.0	65,782	1.0	66,037	1.0	67,715	
Administration: Program Support	1.5	67,810	1.5	68,154	1.5	69,802	
Administration: ISCIS Data Entry Support	1.0	45,206	1.0	45,206	1.0	46,535	
Administration: ISCIS Release Support							
Other Professional (specify)							
Other Non-Professional (specify)							
Total Salaries & Wages - Unionized	26.5	1,592,821.0	25.7	1,549,907.4	27.5	1,659,725.0	
Employee Benefits - Unionized		398,587		387,782		422,538	
1b. Salaries & Wages - Non unionized							
Management	2.4	221,519	2.4	223,220	2.5	218,578	
Public Health Nurses							
Lay Home Visitors							
Social Workers							
Administration: Program Support							
Administration: ISCIS Data Entry Support							
Administration: ISCIS Release Support							
Other Professional (specify)							
Other Non-Professional (specify)							
Total Salaries & Wages - Non unionized	2.4	221,519.0	2.4	223,220.0	2.5	218,578.0	
Employee Benefits - Non unionized		50,358		49,981		51,370	
Total Salaries & Wages	28.9	1,814,340.0	28.1	1,773,127.4	30.0	1,878,303.0	
Employee Benefits		448,945		437,763		473,908	
2. Contract Services							
Other Professional (specify)							
Other Non-Professional -Translation		12,000		11,636		12,000	
Lay Home Visitors							
Administration: ISCIS Release Support							
Total Contract Services	-	12,000	-	11,636	-	12,000	
3. Operating Costs							
Office Supplies		11,754		11,176		12,300	
Office Equipment		200				200	
Professional Development &Training		9,150		6,536		9,150	
Travel		50,498		53,411		55,026	
Public Awareness/Promotion		2,000		817		2,000	
Program Resources		4,500		7,852		8,000	
Computer costs for ISCIS		25,000		25,000		25,000	
Audit		2,426		1,961		2,426	
Other - Client Travel		2,500		4,464		5,000	
Other (specify)							
Total Operating Costs		108,028		111,217		119,102	
Total Request from MCYS (1+2+3)	28.9	2,383,313	28.1	2,333,743	30.0	2,483,313	
4. Adjustments							
Smart Start For Babies Contribution						10,000	
Gapping							
Total (1+2+3+4)	28.9	2,383,313	28.1	2,333,743	30.0	2,493,313	
5. One-Time Grant Request		372,714		341,860	-	52,007	
Grand Total	28.9	2,756,027	28.1	2,675,603	30	2,545,320	

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 081-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

INCREASED ACCESS TO NICOTINE REPLACEMENT THERAPY (NRT) THROUGH PUBLIC HEALTH UNITS

Recommendations

It is recommended:

1) ***That the Board of Health endorse Report No. 081-13 re Increased Access to Nicotine Replacement Therapy (NRT) Through Public Health Units; and further***

2) ***That the Board of Health send a letter, attached as Appendix A, to the Honourable Deb Matthews, Minister of Health and Long Term Care and local Members of Provincial Parliament (MPPs) to commend the Ontario Government for their ongoing commitment to a Smoke-Free Ontario and to request funding to support free nicotine replacement therapy (NRT) within smoking cessation programs offered by Boards of Health.***

Key Points

- The Province of Ontario has renewed and strengthened its commitment to a Smoke-Free Ontario, and aims to achieve the lowest smoking rates in Canada.
- In recent years, there has been no significant change in adult smoking prevalence rates and population level intentions to quit.
- The Ministry of Health and Long-Term Care pays for free nicotine replacement therapy in Family Health Teams, Community Health Centres and Aboriginal Health Access Centres, but not health units.
- The provision of funding to public health units to support free nicotine replacement therapy within smoking cessation programs would enable the Health Unit to target and tailor cessation services to meet the needs of priority populations within the Middlesex-London community.

Background

Tobacco cessation is essential to reduce the morbidity and mortality associated with tobacco use. It is unclear that a tobacco control strategy that does not include considerable investments in cessation can attain the reduction in the health burden or health care costs that is desired. According to the 2010 Canadian Community Health Survey, twenty-two percent (22%) of Ontarians aged 12 or over reported using some form of tobacco (cigarettes, pipes, cigars, dip or chewing tobacco) in the last 30 days. Even if the uptake of tobacco use was immediately halted, this means that 2.47 million tobacco users in Ontario will still experience the health consequences of tobacco use. According to two reports commissioned by the Ministry of Health Promotion and Sport in 2009/2010 to compile advice and recommendations from the scientific and tobacco control community, "*Building on our Gains, Taking Action Now: Ontario's Tobacco Strategy for 2011-2016"* and the "*Evidence to Guide Action: Comprehensive Tobacco Control in Ontario"*, the provision of evidence-based cessation interventions must be part of Ontario's renewed tobacco control strategy. Specifically, the reports recommend:

1. creating a tobacco user system that encompasses a "no wrong door" approach with clients being asked about smoking at every point in the healthcare system;
2. providing free smoking cessation medication and counseling to tobacco users; and,

3. targeting tobacco users that are considered to be at high-risk for tobacco-related disease and have limited access to cessation services.

Cessation Service and Medication Accessibility

Since implementing the renewed Smoke-Free Ontario Strategy in 2011, there has been progress made toward implementing a comprehensive tobacco control approach which is vital to achieve the Government's commitment to attain the lowest smoking rates in Canada. Ontario Drug Benefit recipients now have access to free smoking cessation medications (Champix and Zyban) and free counseling from pharmacists through the Pharmacy Smoking Cessation Program. In addition, the Ministry of Health and Long-Term Care provides free nicotine replacement therapy (NRT) and counseling to clients of Family Health Teams, Community Health Centres and Aboriginal Health Access Centres.

NRT is also available to public health units through the Centre for Addiction and Mental Health in the form of Smoking Treatment for Ontario Patients (STOP) workshops. Through these workshops, clients who meet the eligibility criteria have been able to access five weeks of free NRT at one time within a span of six months. Although this partnership has been helpful in filling a gap within local communities, it does not provide regular, consistent access to NRT on an ongoing basis throughout the year and does not provide the smoking cessation specialist with the flexibility to tailor the amount of required NRT to meet client needs. Since 2011, the Health Unit has accessed NRT through the Center for Addiction and Mental Health to offer STOP workshops, and has offered a total of eight workshops. Between workshops, that are scheduled sporadically due to the uncertainty of the availability of NRT, individuals, community organizations, workplaces and physicians' offices continue to call and inquire about available STOP workshops. These individuals, at the very time they are motivated to quit, must be placed on a waiting list and are consequently falling between the cracks in our cessation system in Ontario.

According to the Ontario Tobacco Research Unit's "*Smoke-Free Ontario Strategy Evaluation Report*" released in November 2012, there have been no significant changes in recent years to either adult smoking prevalence or population level quit intentions. The report also noted that smoking cessation programs available for the 2011/ 2012 year reached a total of 5% of Ontarian smokers and only 1.3% successfully quit for one year.

Public Health Investment to Reach Priority Populations with Tobacco Cessation

Ministry funding for public health units to support the purchase and provision of free nicotine replacement therapy within smoking cessation programs would enable the Health Unit to target and tailor cessation services to meet the needs of hard to reach, priority populations within the Middlesex-London community. Including public health units in the provision free nicotine replacement therapy on an ongoing basis, like Family Health Teams, Community Health Centres and Aboriginal Health Access Centres could help close cessation service delivery gaps that currently exist. In order to make significant changes to the number of individuals smoking in Ontario, a comprehensive tobacco control strategy that includes a cessation support system that encompasses the "no wrong door" approach and facilitates access to cessation services is required.

This report was prepared by Ms. Sarah Neil, Public Health Nurse and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundations: Principles 1, 2; Comprehensive Tobacco Control: 1, 6, 7, and 9

June 20, 2013

Honourable Minister Deb Matthews
Ministry of Health and Long Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

RE: Ministry Funding for Public Health Units for Nicotine Replacement Therapy

Dear Honourable Minister Matthews,

The Middlesex-London Board of Health wishes to commend the Ministry of Health and Long-Term Care and the Government of Ontario for its ongoing commitment to a Smoke-Free Ontario. At its June 20, 2013 meeting Report No. 081-13 re **Increased Access to Nicotine Replacement Therapy (NRT) Through Public Health Units** was considered and it was moved:

1. *That the Board of Health endorse report No. 081-13 re: "Increased Access to Nicotine Replacement Therapy (NRT) Through Public Health Units"; and,*

2. *That the Board of Health send a letter, attached as Appendix A, to the Honourable Deb Matthews, Minister of Health and Long Term Care and local Members of Provincial Parliament (MPPs) to commend the Ontario Government for their ongoing commitment to a Smoke-Free Ontario and to request funding to support free nicotine replacement therapy (NRT) within smoking cessation programs offered by Boards of Health.*

A copy of Report No. 081-13 has been attached for your information.

Ministry funding for public health units to support the purchase and provision of free nicotine replacement therapy (NRT) within smoking cessation programs would enable the Health Unit to target and tailor cessation services to meet the needs of hard to reach, priority populations within the Middlesex-London community. Including public health units in the provision of funding for free NRT on an ongoing basis, like Family Health Teams, Community Health Centres and Aboriginal Health Access Centres, could help close cessation service delivery gaps that currently exist.

In order to make significant changes to the number of individuals smoking in Ontario, a comprehensive tobacco control strategy that includes a cessation support system that encompasses the "no wrong door" approach and facilitates access to cessation services is required. The Middlesex-London Board of Health looks forward to continuing to work with you to achieve the lowest smoking rates in Canada.

Sincerely,

Christopher Mackie
Secretary-Treasurer
Middlesex-London Board of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 082-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

VOLUNTEER RESOURCES

Recommendation

It is recommended that Report No. 082-13 re Volunteer Resources be received for information.

Key Points

- Health Unit Volunteers logged 4,747 hours of service from September 2012 to June 2013
- Health Unit staff celebrated Volunteers during National Volunteer Week (April 21-27)
- The Hutton House Access Volunteer Program was recently awarded the June Callwood Community Volunteer Service Award. MLHU partners with Hutton House to provide volunteer opportunities for people with disabilities.

Background

A volunteer is 'a person who performs or offers to perform a service voluntarily, to do charitable or helpful work without pay.' They have a spirit of service, a sensitivity for humanity, strong moral values and a social conscience. For over 36 years, the Health Unit has had the benefit of tapping into people who call themselves volunteers.

Year-End Summary

The last two years have been challenging for the volunteer program. Through evidence-informed practices, the Reproductive Health Team identified more effective and constructive ways of promoting eye health for children and for promoting pre-natal health care. This resulted in the cancellation of the vision screening program (Board Report 013-11) and pre-natal health fairs (September 2012) and eliminated the need for approximately 50 volunteers in these areas.

Health Unit volunteers still managed to log 4,747 hours of service from September 2012 to June 2013. They worked with the following Teams: Vaccine Preventable Disease, Reproductive Health and Early Years, Chronic Disease and Injury Prevention, Emergency Preparedness, and Environmental Health. One new Community Emergency Response Volunteer (CERV) team of 44 members was brought on in February 2013. The addition of this new team brings the total number of CERV teams to seven, with approximately 100 CERV volunteers.

The Volunteer Development Committee has not been together since the Volunteer Appreciation Reception in May 2012. To show appreciation to Health Unit volunteers this year, a more personal approach was taken. During National Volunteer Week, (April 21 – 27), volunteers were celebrated in various ways and personally thanked by the people who directly work with them. The Health Unit also

placed an advertisement in the London Free Press - Volunteer Supplement and on the newly developed volunteer webpage of the new website, thanking them for their support.

The Health Unit is proud to have a long-standing relationship with Hutton House through their Access Volunteer Program. Volunteers from this program attend the Health Unit every Friday morning to collate thousands of documents for the Vaccine Preventable Disease Team. This year alone, they completed 1,762 hours of service. The Access Volunteer Program was recently awarded the June Callwood Community Volunteer Service Award. Health Unit staff members played a part in the nomination process. Hutton House and the Volunteers should be congratulated on this accomplishment that recognizes individuals and groups for superlative volunteer contributions to their communities and to the Province of Ontario.

Ms. Gayle Riedl, Human Resources Officer, continues to be an active member of the London and Area Association of Volunteer Administration (LAVA) and the Ontario Public Health Volunteer Resource Management Network.

This report was prepared by Ms. Gayle Riedl, Human Resources Officer.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 083-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

ORAL HEALTH MONTH APRIL 2013

Recommendation

It is recommended that Report No. 083-13 re Oral Health Month 2013 be received for information.

Key Points

- In April 2013, the Health Unit collaborated with the London & District Dental Society to deliver an Oral Health Month campaign aimed at raising awareness about the importance of children having their first dental visit by their first birthday. Only 18% of parents surveyed were aware of this recommendation.
- Local physicians and a total of 195 partner agencies received posters recommending the first dental visit by the first birthday. All dentist members of the London & District Dental Society received information pamphlets to guide and assist them in working with infants and toddlers.

Background

April 2013 was National Oral Health Month. This event is celebrated annually by the health care community to promote good oral hygiene practices and to educate the public on the importance of good oral health. The London & District Dental Society (LDDS), a component society of the Ontario Dental Association, focused on preventing early childhood tooth decay through introducing young children to dental providers by their first birthday. The purpose of this Report is to inform the Board of the Health Unit's joint initiative with the LDDS for Oral Health Month 2013.

Tooth decay is one of the most common diseases of childhood. It is also preventable for the majority of children. Research suggests that education and preventive services targeted to young children and their families are very effective in reducing dental disease among school children. The Canadian Paediatric Society, Canadian Academy of Pediatric Dentistry, Health Canada, and the Canadian Dental Association all recommend that children attend their first dental visit by 12 months of age to establish a "dental home", to educate parents/caregivers about oral health, and to deliver preventive services if necessary.

Oral Health Month Activities

Activities to promote the recommendation that children have their first dental visit by their first birthday were planned in collaboration with the Health Unit's Communication Team and the LDDS. There were three components:

1. ***Research*:** Parents attending the Thames Valley Neighbourhood Early Learning Program ((TVNELP) - a program for families whose children start kindergarten in the fall to connect them to community agencies to increase school readiness) completed surveys related to their children's oral hygiene habits and behaviours, and their own knowledge of the first dental visit by first birthday recommendation.

   Between February 12 and May 22, 2013, 398 parents completed a survey while attending TVNELP sessions. The ages of their children ranged from six months to five years. Only 18% of parents reported that they were aware of the recommendation that children have their first dental visit by their first birthday. Nearly one-third (31%) of parents reported that their preschooler had not yet been seen by a dentist or dental hygienist. Among those whose children had been seen by a dental professional, the average age at the time of the first dental visit was two and a half years. Finally, 11% of parents reported that their child had been turned away from a dental office for being too young to be seen. These findings underscore the importance of continuing to increase awareness of the recommendation for children to have their first dental visit by their first birthday, and to support dental care providers in seeing infants and toddlers.

2. ***Promotion to parents, partners, and other health care providers*:** A poster recommending the first dental visit by first birthday was produced and distributed to 195 Health Unit partner agencies across London and Middlesex County. Agencies were asked to display the posters in high traffic areas where their clients and staff might notice them. An electronic version of the poster was sent to London-area health care workers via an e-mail distribution list. A copy of the poster can be found as Appendix A.

3. ***Promotion to local dental offices*:** The LDDS produced and distributed resources for their member dentists that would guide and assist them in working with infants and toddlers. As part of these resources, copies of the Health Unit's brochure entitled *Preventing early childhood tooth decay* were distributed to the more than 200 dentist members of the LDDS.

Conclusion

Oral Health Month is an annual event to promote oral health and to educate the public and health care providers about important oral health issues. This year, the Health Unit collaborated with the London & District Dental Society to deliver a multi-facetted campaign to raise awareness about the importance of children having their first dental visit by their first birthday, and to support dental care providers in delivering services to young clients. These efforts will continue through the year.

This report was prepared by Dr. Maria van Harten, Dental Consultant; Dr. Chimere Okoronkwo, Manager, Oral Health Team; and Ms. Alison Locker, Epidemiologist, Oral Health, Communicable Disease and Sexual Health (OHCDSH).

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

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

ORAL HEALTH MATTERS

Schedule your children's first dental visit by their first birthday

Health Canada, the Canadian Dental Association and the Canadian Pediatric Society recommend children be seen by a dentist by the time they're 12 months of age.

Photo adapted and used with permission from the University of North Carolina

For more information call:
519-663-5317 x2231

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 084-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

HEALTH UNIT ENGAGEMENT WITH RETHINK LONDON

Recommendation

It is recommended that the Report No. 084-13 re Health Unit Engagement with Rethink London be received for information.

Key Points

- The Official Plan is a comprehensive plan created by municipalities which dictates public policy in terms of transportation, recreation, use and management of land and infrastructure, protection of the environment and resources; and opportunities for employment and residential development.
- Healthy communities fundamentally contribute to the health and wellbeing of the residents in the community.
- Middlesex London Health Unit (MLHU) continues to be actively engaged in the ReThink community conversation and to make recommendations that support a healthier City of London.

Background

In January 2012, the City of London began a review of its Official Plan (OP) through ReThink London, the largest community engagement program in the City's history. In Canada, an official plan is a comprehensive plan created by a municipality which dictates public policy in terms of transportation, recreation, use and management of land and infrastructure, protection of the environment and resources; and ensuring appropriate opportunities for employment and residential development. ReThink London was launched on May 3, 2012 at the London Convention Centre, where approximately 1,300 people attended to hear *The National's* Peter Mansbridge speak about the importance of citizen engagement.

Following the public call to action, the City hosted "Discover your City", an evening organized around five ReThink London themes: How we Live; How we Grow; How we Green; How we Move; and How we Prosper. This event shared with Londoners the many City projects and initiatives that were recently approved or currently underway, and how they fit into ReThink London. These projects originated from the Community Services, Environmental and Engineering Services, Planning and Development Services, and Culture Office of the City of London, as well as from the Health Unit and London Transit Commission.

A Healthier Community

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease. WHO has defined healthy city/community as one that continually creates and improves its physical and social environments and expands the community resources that enable people to mutually support each other in performing all the functions of life and developing to their maximum potential. Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders - where every person is free to make choices when provided a variety of healthy, available, accessible, and affordable options.

The promotion of healthier communities has been one of the historical underpinnings of public health, and is reflected in such key documents as the 1986 Ottawa Charter of Health Promotion and the current Ontario Public Health Standards. The ReThink London process offers Health Unit staff an opportunity to provide evidence-informed recommendations that support a healthier community through the built environment including: active transportation; land use; recreation; complete streets; environmental health matters; social cohesion; and food security.

MLHU's Contribution to ReThink London

- November 2011, letter sent to City Manager expressing Health Unit's interest in being involved in OP Review;
- January 2012, OP Terms of Reference staff recommended enhancement of health, air quality and land use; Healthy Communities Partnership Middlesex-London, recommended physical activity (PA) opportunities be enhanced;
- June 2012, presented at the *How We Move*, focusing on active transportation (AT) and PA ;
- June 2012, staff attended *Your Vision, Your Future* to provide input into developing goals and strategies to help achieve vision recommendations on health, complete streets and AT;
- August 2012, media launch of evidence-based *Healthy City-Active London* position paper and video providing 19 recommendations on Active Transportation to ReThink London,
- October 2012, ReThink event *How to Make a City Awesome* attended by several staff and many other staff completed the online Virtual Preference Survey;
- December 2012, staff attended ReThink event *Building an Exciting, Exceptional, Connected City;*
- December 2012, submission of 15 evidence-based environmental health recommendations to ReThink London addressing natural and manmade hazards;
- March 2013, evidence-based internal Health Assessment process to assist with the review of land use planning and official plan amendment applications; and
- Ongoing, increased involvement in the evaluation of land use applications.

Next Steps

From the consultations and submission of recommendations, the City of London has aggregated the information to develop eight key directions. These eight directions will be the basis for the policies in the new Official Plan. Each key direction is linked with the release of a discussion paper to which the community is invited to provide feedback by June 28, 2013. Health Unit staff from the Environmental Health and Chronic Disease Prevention Services will be examining each discussion paper. With the support of literature/research and previously submitted position paper/recommendations, staff will formulate an evidence-informed response to each of the eight discussion papers

This report was prepared by Ms. Marylou Albanese, Manager; Ms. Bernadette McCall, Public Health Nurse, Healthy Communities and Injury Prevention Team; Mr. Iqbal Kalsi, Manager; and Mr. Andrew Powell, Public Health Inspector, Environmental Health Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Diseases and Injuries Program Standards; Health Hazard Prevention and Management standards under the Environmental Health Program Standards; and the 2011 MLHU Strategic Direction: Healthy Eating and Physical Activity for all.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 085-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

SMOKING NEAR RECREATION AMENITIES AND ENTRANCES BYLAW

Recommendation

It is recommended that Report No. 085-13 re Smoking Near Recreation Amenities and Entrances Bylaw be received for information.

Key Points

- The City of London's Smoking Near Recreation Amenities and Entrances bylaw came into effect May 1, 2013.
- The Health Unit has led the development and implementation of an external/general public communication strategy to promote the new outdoor smoking restrictions.
- Health Unit and the City of London staff continue to work together cooperatively to promote the new outdoor smoking restrictions, resulting in increased awareness, significant media attention and inquiries from the general public to clarify smoking restrictions.

Background

In September 2011, Middlesex-London Board of Health endorsed the *Smoke-Free Outdoor Spaces Position Statement* and directed Health Unit staff to prepare a report summarizing existing municipal bylaw amendment options for establishing smoke-free outdoor public spaces. Based on the review of "*Building the Case for Smoke-Free Public Outdoor Spaces: Technical Report*," the Board of Health directed staff at their November 2011 meeting to petition London City Council and Middlesex County Council to establish smoke-free public outdoor spaces by amending their smoking bylaws to include the provisions of Policy Option 3: a complete ban on smoking in all outdoor areas used for public enjoyment and children recreation areas; 100% smoke-free municipally-owned and/or operated recreational properties; smoke-free outdoor seating areas including bar and restaurant patios; a smoking ban within 9 m of all public places and workplaces entrances/doorways; and, an option for hospital, university and college campuses to be named within the bylaw for either designated smoking areas (DSAs) or for 100% smoke-free campuses. In January 2012, Health Unit staff began to work closely with City of London staff to support them in preparing reports and formulating advice for Council's consideration.

On March 5, 2013, London City Council reviewed a proposed outdoor smoking bylaw that encompassed recommendations from the *Smoking Restrictions in Municipal Outdoor Spaces* report (attached as Appendix A) and feedback from the public participation meeting held October 1, 2012. "*Smoking Near Recreation Amenities and Entrances Bylaw",* attached as Appendix B was approved by City Council, with an effective date of May 1, 2013, to prohibit smoking within 9 metres of recreation amenities in city parks and within 9 metres of entrances to municipally-owned buildings.

Summary of the *Smoking Near Recreation Amenities and Entrances Bylaw*

This bylaw provides positive role modeling for children and youth, supports those who are attempting to quit and protects people from the harmful effects of second-hand smoke outdoors. Under the London outdoor smoking bylaw, a recreation amenity is defined as any part of an outdoor area established for recreation or sport activity, including but not limited to playground equipment, wading pools and splash pads, outdoor rinks, sports fields, spectator areas, food concessions, and Storybook Gardens, but does not include any golf course. A municipally-owned building is one that is owned by the City. Any person who is convicted of an offence under this bylaw may be fined $205 to a maximum of $10,000. London City Council committed to reviewing the bylaw in three years to consider transitioning to a comprehensive smoke-free bylaw at that time.

Communication Strategy to Increase Awareness

Other municipalities who have enacted outdoor smoking restrictions have found that these bylaws are primarily self-enforcing if there is adequate signage and a strong communication plan. Signage and the internal communication plan (City of London employees and sport and recreation organizations) are the responsibility of city staff. The Health Unit developed an external communication strategy, with input from our partners at the City, consisting of three phases. In addition, information regarding the new bylaw and several factsheets were profiled as part of the launch of the new Health Unit website in April 2013 in the smoke-free outdoor spaces section.

Phase 1 – April 12-19 "Join Us! Parks and Playground Clean Up – The New Bylaw is Coming"

Led by the Health Unit's *One Life One You* youth group, a park clean-up on April 19th supported the City of London Clean and Green clean-up efforts. Four downtown parks were chosen: Harris Park, Fork of the Thames, Ivey Park and West Lions Park. To recruit volunteers, create awareness about the event and to promote the new bylaw:

- A "Join Us" poster was disseminated to various community partners
- Radio ads aired on 9 stations
- A media release was issued with numerous tweets, and information on the Health Unit website:
    - 3 radio interviews – Free FM, X-FM Fanshawe and Newstalk 1290; 1 television interview – Rogers TV Inside London; 1 newspaper interview – METRO London
- 2 Metro London advertisements (¼ page ads) and 1 ad in The Londoner (¼ page ad)
- *One Life One You* sent out emails to youth groups, and to the Child Health and Young Adult Teams for promotion within the schools

Approximately 30 bags of garbage were collected from all of the parks combined. Despite the cold, wet weather, a total of 31 individuals participated in the clean-up.

Phase 2 – April 26-30 "Thanks For Not Smoking! It's the Only Way to Play – New Bylaw is Coming"

A phase 2 newspaper advertisement was placed in the Metro. Promotional efforts from Phase 2 combined with the approach of May 1st, generated media attention:

- 1 television interview - CTV London; 1 newspaper interview - The Londoner; 2 radio interviews – AM 980 and CHRW Radio Western

Phase 3 – May 1–June 30 "Thanks for Not Smoking! It's the Only Way to Play – New Bylaw Now in Effect"

On May 1, an email bulletin was issued to the Tobacco Cessation Community of Practice and to health unit staff partnership email groups and list servs to further increase awareness and to promote the importance of smoke-free spaces. Paid and earned communication efforts included:

- 1 media release issued with numerous tweets, and information on the website and Facebook page:
    - 1 radio interview – Newstalk 1290; 2 newspaper interviews – London Community News and METRO London
- Radio ads aired on 6 stations

- Outdoor transit shelter ads and billboard ads in targeted locations within the city
- Posters were sent to health and community partners, focusing on places where children and families visit
- One Metro London advertisement (¼ page ad) and 1 ad in The Londoner (¼ page ad)
- Compliance cards have been provided to the City to be used by sport and recreation organizations and city staff to promote the new bylaw to encourage compliance

Enforcement and Inquiries

Tobacco Enforcement Officers with the Health Unit and the City of London Police will enforce the City's outdoor smoking bylaw. As of May 31, 2013, there have been a total of 22 inquiries/questions received through the Tobacco Information Line regarding the new outdoor bylaw. The majority of inquiries received are from members of the general public who are seeking clarification on whether their workplace is included in the 9 metre entrance-way restriction, whether privately-owned recreational facilities and outdoor sport fields are included, and how the bylaw is applied to outdoor festivals.

The focus of the communication strategy has been educational in nature; therefore, no charges have been issued at this time. Educational efforts will continue over the summer and fall, including the promotion of tobacco-free sport and recreation policy development. Sport and recreation organizations will be encouraged and supported by Health Unit staff to implement policies that prohibit anyone taking part in a sport or recreational activity – participants, volunteers, officials, coaches, leaders and spectators – from using cigarettes, dip, chew or cigars while they are participating in the sport or recreational activity.

Next Steps

Tobacco Enforcement officers at the Health Unit will continue to monitor compliance and respond to questions and inquiries, issuing charges when necessary. In the fall of 2013, phase 4 of the communication strategy will be launched, focusing on entrance-ways to city-owned buildings, like arenas, libraries and community centers.

This report was prepared by Ms. Sarah Neil, Public Health Nurse; Ms. Tanya Weishar, Health Promoter; and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundations: Principles 1, 2; Comprehensive Tobacco Control: 1, 6, 7, 11, and 13

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TO:	**CHAIR AND MEMBERS COMMUNITY SERVICES COMMITTEE AUGUST 21, 2012**
FROM:	**WILLIAM C. COXHEAD MANAGING DIRECTOR OF PARKS & RECREATION**
SUBJECT:	**SMOKING RESTRICTIONS IN MUNICIPAL OUTDOOR SPACES**

RECOMMENDATION

That, on the recommendation of the Managing Director of Parks & Recreation, this report **BE FORWARDED** to a public participation meeting on October 1, 2012 before the Community Services Committee to receive comments related to the following options, with respect to smoking restrictions in municipal outdoor spaces:

Municipal Parks

Option 1 – Maintain status quo (no by-law to restrict smoking in parks)

Option 2 – Post signs suggesting people do not smoke in parks (no by-law)

Option 3 – Prohibit smoking within 9 meters of playgrounds and recreation amenities

Option 4 – Prohibit smoking within 30 meters of playgrounds and recreation amenities

Option 5 – Prohibit smoking in all parks except in designated smoking areas

Option 6 – Prohibit smoking in all parks

Entranceways to Municipal Buildings

Option 1 – Maintain status quo (no by-law)

Option 2 - Prohibit smoking within 9 meters (30 feet) of an entrance to a municipally-owned building

PREVIOUS REPORTS PERTINENT TO THIS MATTER

February 13, 2012 Communication dated January 9, 2012 from Dr. G. Pollett, Medical Officer of Health, Middlesex-London Heath Unit

BACKGROUND

On February 13, 2012 the Community Services Committee received a report from Dr. G. Pollett, Chief Medical Officer of Health from the Middlesex London Health Unit (MLHU) building the case for smoke-free public outdoor spaces in London. Emerging evidence and results from public opinion surveys (both in London and across the Province) demonstrates that the current Provincial standard of second-hand smoke protection is not high enough and that municipal by-laws that extend protection beyond that covered by the *Smoke Free Ontario Act* (SFOA) are required. The MLHU identified that reduction in exposure to second hand smoke is good for

everyone, especially children, would provide positive role modelling for youth and help keep our public spaces cleaner (see Appendix A for a summary of impacts on children and youth). In response to this report Council resolved that:

> The Civic Administration BE DIRECTED to report back to the Community Services Committee with respect to current policies and additional steps that may be taken by the City to restrict smoking in public outdoor areas such as: entrance ways to public buildings and work places, playgrounds, playing fields, swimming pools, splash pads and public gardens; it being noted that the CSC reviewed and received a communication dated January 9, 2012 from Dr. G. Pollett, Medical Office of Health, Middlesex-London Health Unit, with respect to this matter.

This report provides a review of possible options for outdoor smoking restrictions in municipal outdoor areas (parks and entrances to municipally-owned buildings) for Committee and Council to consider.

Current Smoking Regulations

Ontario has a history of progressive legislation providing protection from second-hand smoke. Numerous municipalities, including the City of London (2003), enacted by-laws to ensure that smoking is restricted indoors at public places and workplaces. The *Smoke-Free Ontario Act (SFOA)* came into effect May 31, 2006, prohibiting smoking in enclosed workplaces and public places. The law provided greater protection from second-hand smoke and includes a ban on smoking within 9 metres of entrances and exits at healthcare and long-term care facilities; common areas of multi-unit dwellings; restaurant and bar patios that are partially covered by a roof; inside transit shelters; and on school property. The Provincial legislation helped create a more level playing field for proprietors across Ontario, and a standard level of protection from second-hand smoke exposure.

The City of London's Smoke-Free Public Places By-Law (PH-10) prohibits smoking indoors at public places and the Smoke-Free Workplaces By-Law (PH-11) prohibits smoking in workplaces within the City. The MLHU carries out inspections and are responsible for enforcement of these by-laws and the Smoke Free Ontarians Act (SFOA).

In addition to the restrictions legislated by Provincial law and our Municipal by-laws, the City of London has implemented policies to restrict smoking at outdoor pools, Storybook Gardens and Labatt Park. There are currently no further smoking restrictions on municipally owned outdoor public spaces.

Municipal Scan

Over 50 Ontario municipalities have enacted by-laws regulating smoking in outdoor public spaces. These by-laws range from outright bans on all municipally owned property to varuiys setbacks (9 to 30 meters) from playgrounds and/or recreational amenities (spray pads, sports fields, courts, bleachers). A full list of Ontario municipalities with smoking restrictions in parks is found in Appendix B.

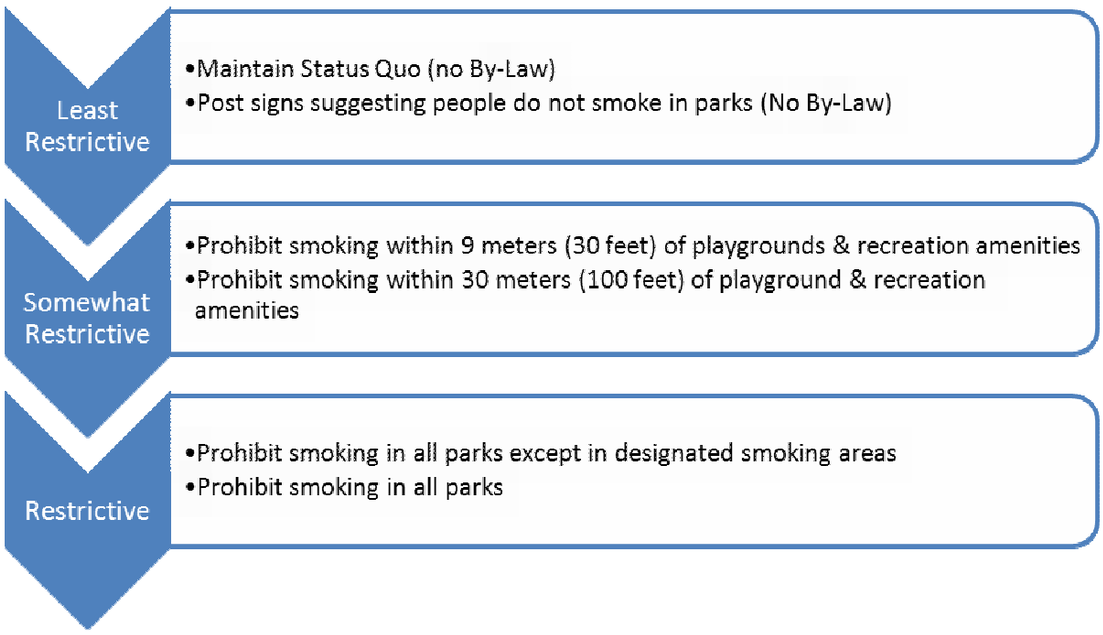
Over 30 municipalities in Ontario have enacted by-laws prohibiting smoking or the holding of lighted tobacco within a 9 meter radius of any entrance to a municipal building.

In communities that have imposed smoking restrictions there have been no negative impacts reported on the use of facilities and a vast majority think the by-laws are good for their resident's health.

OPTIONS FOR CONSIDERATION

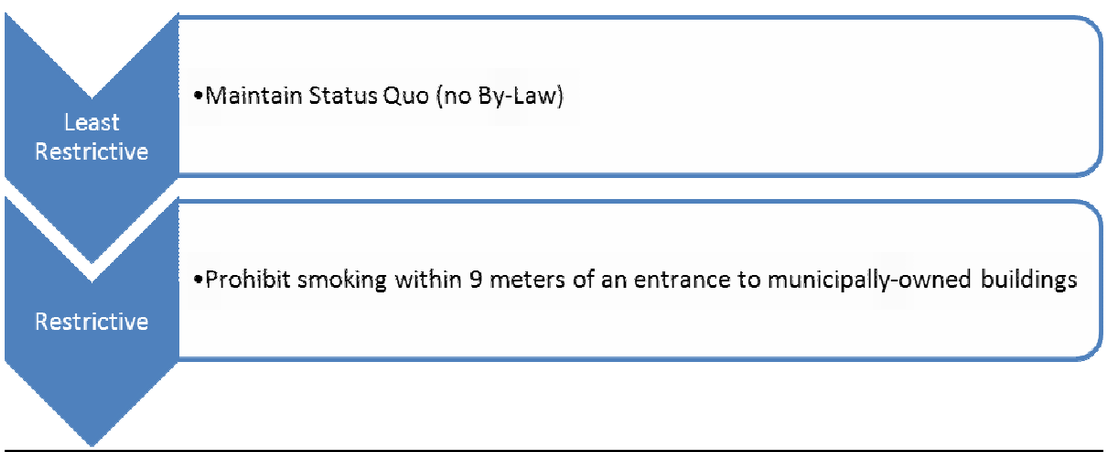
Options for Municipal Parks

The table in Appendix C outlines in detail the pros, cons and financial implications of six (6) potential options for smoking restrictions in parks. These options range from maintaining the status quo to establishing setbacks from park amenities to an outright ban in all parks. Briefly, they are:



Options for Entranceways to Municipally-Owned Buildings

Enacting a by-law to prohibit smoking within 9 meters (30 feet) of an entrance to a municipally-owned building will provide protection to children and youth from the harmful effects of second hand smoke as they enter community centres, arenas, City Hall and other municipal buildings across the city. Such restrictions will provide additional protection for everyone entering these buildings and aligns with current levels of public support. These restrictions are also consistent with Provincial legislation that restricts smoking within 9 meters of entrances to hospitals, longterm care homes and other health care facilities. The estimated cost of signage at entrances to the 200 municipal buildings is approximately $20,000.



Enforcement, Education and Awareness

If Council chooses to proceed with developing a by-law to restrict smoking in outdoor spaces a comprehensive strategy involving three components: education and community partner engagement; signage; and appropriate enforcement will be required (see Appendix E for further details on MLHU's potential campaign and enforcement). The MLHU currently enforces and promotes the *Smoke-Free Ontario Act* and the City of London Smoke-Free Public Places and Workplaces By-laws. If Council chooses to enact a new by-law, for those areas that require additional enforcement support due to congregation of children and youth and/or ongoing non-compliance, enforcement support would be provided by the MLHU's Tobacco Enforcement Officers.

The MLHU has also agreed to continue to promote awareness of rules and will lead any media campaigns to raise awareness of potential new rules in parks and at municipal buildings.

Summary

Outdoor recreation facilities and parks are established to promote healthy activities and restricting smoking in these locations fits with this idea. Introducing smoke-free parks is a move towards reducing the burden of tobacco-related illness and mortality by removing smoking role-models from children and will have a lasting impact on the health of all London residents. Given Council's interest in limiting exposure of children and youth to tobacco use (second hand smoke, role models), option six (6) (Prohibiting smoking in all parks) satisfies this objective to the greatest degree by completely removing smoking from the public parks in which they play. This option is the easiest to understand, easiest to enforce and the most cost effective to implement. Enacting a by-law prohibiting smoking at entrances to municipally-owned buildings will further protect residents when they visit City facilities.

It is expected that such clear and concise by-laws would become self enforcing over time.

NEXT STEPS

If Council chooses, Civic Administration will schedule a public participation meeting on October 1, 2012 to gather input on all or some of the proposed options presented in this report.

Civic Administration, at the direction of Council, will then draft a by-law based on Council's final preference. If necessary, other relevant agreements, policies and procedures or by-laws (Facility Rental Agreements, Special Events Policies and Procedures, Parks By-Law etc.) will be amended as appropriate.

Any new or amended by-laws could be phased-in by May 1, 2013.

MLHU recommends Council also consider enhancing the ability for privately-owned workplaces, recreational properties, hospitals and post-secondary institutions to limit smoking on their properties. For a cost, the City of London may be able to provide the opportunity to these workplaces to be registered and named within a schedule of a by-law so that they could be provided with enforcement support to expand the level of protection provided. Further details regarding consistency with the Municipal Act, fees and enforcement obligations would need be investigated by Civic Administration. Appendix F outlines these opt-in opportunities in greater detail.

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Acknowledgements
This report was prepared with input by the Middlesex London Health Unit (Linda Stobo, Wally Adams), Orest Katolyk, Andrew Macpherson, Scott Stafford and Lynn Marshall.

PREPARED BY:	RECOMMENDED BY:
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c Graham Pollett, Middlesex-London Board of Health
Mr. Wally Adams, Director, Environmental Health & Chronic Disease & Injury Prevention
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Scott Stafford, Division Manager, Parks & Community Sports
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APPENDIX A
Middlesex London Health Unit
Summary of Public Support for Improved Smoking Restrictions &
Impacts of Exposure to Smoking/Second-hand Smoke on Children and Youth

Public support is an important factor to consider when implementing smoking restrictions, and when looking at the City of London, public support for banning smoking in many outdoor public spaces is very high: doorways to public places (90%) and workplaces (89%); playgrounds (87%); and sports fields (81%).

Second-hand Smoke as a Health Hazard
Second had smoke, also referred to as "environmental tobacco smoke or passive smoking", is a mix of smoke that is exhaled and smoke that is emitted when a cigarette, cigar, cigarillo or water pipe is burned. Recent research indicates that outdoor levels of tobacco smoke within one to two meters of a lit cigarette can be as high as indoors. If there is no wind, the tobacco smoke will rise and fall, and then saturate the local area with second-hand smoke; if there is a breeze tobacco smoke will spread and will expose non-smokers downwind. Depending upon weather conditions and air flow, tobacco smoke can be detected at distances greater than 25 – 30 feet away. The closer an individual is to tobacco smoke, and the greater the number of lit cigarettes (like the congestion of smokers at an entrance), the greater the amount of tobacco smoke, and consequently, the greater the harm. For example, if the number of lit cigarettes increases, the concentration of tobacco smoke can increase 2.5-3 times and be detected 9m away. There is no safe level of exposure to second-hand smoke. For every eight smokers who die from smoking, one non-smoker will die from second-hand smoke.

ADVERSE LONG-TERM HEALTH EFFECTS OF SECOND-HAND SMOKE (SHS) EXPOSURE ON CHILDREN AND PREGNANT WOMEN

SHS Exposure & Children	SHS Exposure & Pregnant Women
• Exacerbations of asthma • Decreased lung function • Lower respiratory illness • Middle ear infections • Sudden Infant Death Syndrome (SIDS) • Low birth weight • Adverse impact on cognition, behaviour and brain development	• Spontaneous abortion/miscarriage • Premature birth • Congenital anomalies and smaller head circumference

Some of the adverse health effects are more severe for infants and young children because their bodies, lungs and brains are still in development and they have higher respiratory rates than adults. In addition, children are less likely to leave a smoke filled place outdoors or even complain about the level of smoke, given the difference in power between an adult and a child, putting children at risk for greater exposure. There are places that are nearly impossible to avoid exposure to second-hand smoke, including entrance-ways, and there is often repeated exposure if that place is visited frequently, like a doorway to a workplace, a library or an arena. In 2009, it was estimated the 54% of Ontarians were exposed to SHS at an entrance in the last month.

Exposure to Tobacco Use and Role Modelling to Children and Youth
Children and youth model their own behaviour after the people they look up to – athlete role models, coaches, parents, friends' parents and siblings and fans in the stands; policies that restrict where people smoke sends a consistent message to young people that tobacco use is a harmful addiction and not part of a healthy, active lifestyle. The less tobacco use they see, the less likely children and youth are to smoke. Tobacco waste is also a health concern; discarded cigarette butts in parks and playgrounds are picked up and eaten by small children and pets. It only takes two to three cigarette butts to harm or kill a small animal.

Impact of Smoking Bans on Helping Tobacco Users to Quit
Just over 22% of Middlesex-London adults aged 19 and over smoke, and most smokers want to quit, with 15% committed to quitting in the next 30 days and 53% considering quitting sometime

in the future (2009/2010 CCHS). Stronger restrictions on smoking in outdoor public places support those who are currently addicted to tobacco trying to quit.

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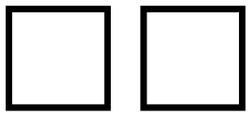


APPENDIX B
Municipal Scan of Outdoor Smoking Restrictions

A review of a database (www.nsra-adnf.ca/cms/smoke-free-laws-database.html) of smoke-free laws across Canada, revealed that over 50 Ontario municipalities have enacted bylaws regulating smoking in outdoor public spaces. Dozens of other municipalities are currently engaged in the development/community consultation phase of smoke-free outdoor public spaces bylaws.

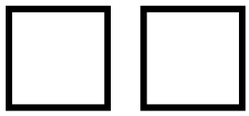
Almost all of these Ontario municipalities have enacted by-laws regulating smoking within 9 meters of entrances to municipally owned buildings. Many of them also have bylaws regulating smoking in parks. In summary, 22 municipalities recognize a 9 or 10 meter zone around playgrounds and/or sports fields, 6 prohibit smoking within 15 meters and a further 6 municipalities prohibit smoking within 25 meters (or more) from. Thirteen municipalities enforce an outright ban in parks, three of which have designated smoking areas in larger parks.

The City of Ottawa has just moved to an outright ban of smoking in parks after a setback ban of 9 meter proved to be unenforceable and confusing.

Three municipalities, Cobalt, North Bay and Woodstock have opt in clauses in the by-law whereby workplaces and/or apartment building owners may request the municipalities to recognize their entranceway be designated as smoke-free and enforce the by-law.

Smoking prohibited within 1-10 meters of play or recreation amenity in parks	
Chatham Kent	Smoking prohibited within 9 m of entrances to municipal buildings and playground equipment excluding sports fields.
Cobourg	Smoking prohibited within 9 m of the edge of the playing surfaces of all children's playground areas in parks.
Cornwall	Smoking prohibited within 9 m of City-owned facilities including playground structures, pools, splash pads, fixed seating or bleachers, tennis courts, basketball courts, etc.
Georgina	Smoking or use of any tobacco product is prohibited within 10 metres of any Town owned and/or operated playground, splash pad, skateboard park and sports field. Designated smoking areas are allowed.
Huntsville	Smoking prohibited within 9 m from any entrance, exit, building opening of any Town facility including but not limited to parkland, playground, sports field, spectator seating area, ice surface whether or not a "No Smoking" sign is posted; on any walkway or pathway set out on or through Town-owned property
Ingersoll	Smoking prohibited on any Town owned sports field, on any walkway set out on or through Town owned and occupied property (but not sidewalks), and within 9 m of any Town facility including but not limited to splash pads, playground equipment, spectator seating areas, ball diamonds, soccer fields, basketball courts, tennis courts.
Midland	Smoking prohibited within 10 m of any Town owned playground or sports field whether or not a "No Smoking" sign is posted.
Napanee	Smoking prohibited "within 6 m of the entrance, exits or boundary of any Municipal Building "Municipal Building" is defined as any building, hall or facility, or part thereof, owned or operated by The Corporation including any sports facility, ball diamond, playground, soccer field or aquatic facility including spectator seating.
New Tecumseth	Smoking prohibited within 10 m of any playground area established and fitted with equipment (slides, swings, etc.). Also prohibited in "the seated observation areas of outdoor sports fields".
Orillia	Smoking prohibited within 10 m of each of: a playground area, sport activity area (including but not limited to ball diamonds, soccer fields, basketball courts, tennis courts, etc.) or beach area.
Parry Sound	Smoking is prohibited within 9 m of any municipally owned or leased park, play-ground, recreational field and beach.
Peterborough	Smoking prohibited within 9 m of any public playground, beach, wading pool, splash pad, sport field or skateboard park. In any City park except in designated areas.
Port Hope	Smoking prohibited within 10 m of the boundary of parks for the purpose of recreational use and shall include any playground equipment, sports field and playground area including but not limited to soccer pitches, baseball diamonds, tennis courts, player's benches, spectators areas, beaches, splash pads, dog parks, skate parks and any children's playground equipment, including but not limited to swing sets and climbing apparatus, including the surrounding playground equipment area owned or leased by

	the Municipality.
Smith-Ennismore-Lakefield	Smoking prohibited within 9 m of any outdoor bleachers and players' benches at 6 named locations, within 9 m surrounding any playground equipment at 5 named locations, and within 9 m surrounding any gazebo, beach or shade shelter at 6 named locations.
Smiths Falls	Smoking prohibited on municipal property, including parks. No person shall smoke within 9 m of any sports facility, playground, splash pad, wading pool or sports field (including spectator areas).
Thunder Bay	Smoking is prohibited within 10 m of any playground equipment located on land owned by the Corporation, within 10 m from the edge of a beach.
Timmins	Smoking prohibited within 10 m of any playground equipment within parks and playgrounds owned by the City, and within 10 m of any municipal park recreational field.
Toronto	Smoking prohibited in parks, but only in the following specific areas: within 9 m of playground equipment and surfaces, wading pools and splash pads, and within zoos and farms.
Uxbridge	Smoking prohibited within 10 m of the boundary of a Municipal playground.
Vaughan	Smoking prohibited on city property except in designated areas. Eight out of eleven of these designated areas are community centre/pool parking lots and the others are marked by signage. Smoking prohibited within 9 m of any City-owned wading pool, splash pad, skating rink, skate park, sportsfield, playground, tennis court or basketball court.
Wasaga Beach	Smoking prohibited within 9 m of playgrounds and playing fields.
Smoking prohibited within 11-30 meters of play or recreation amenity in parks	
Adjala-Tosorontio	Smoking prohibited within 15 m of a playground area and playing field, including but not limited to soccer fields and baseball diamonds.
Blind River	Smoking prohibited within 15 m of playground equipment and recreation fields.
Collingwood	Smoking prohibited within 25 m of any playground equipment, the definition of which includes municipally-owned swimming pools. The definition of playground equipment does not include facilities for baseball, hockey and walking and biking trails.
Elliot Lake	Smoking prohibited within 15 m of playground equipment and recreation fields.
Prince Edward County	All tobacco use prohibited within 25 m of playground structures, sport playing fields, park facilities, tennis courts, outdoor rinks, youth park, skate parks, and within 9 m of recreation facilities owned, operated or leased by the County.
Quinte West	Smoking prohibited within 25 m of playground equipment or playing fields within a playground park owned by the Corporation.
Sault Ste. Marie	Smoking prohibited within 15 m of any playground area, recreation field and while under or within 15 m of the Roberta Bondar Park Tent Pavilion. Smoking is allowed in parking lots adjacent to or near recreation fields.
South Bruce	Smoking prohibited within 30 m of any playground equipment located within a municipal park, within 15 m of any recreational field (including but not limited to baseball diamonds, soccer pitches, tennis courts, horse shoe pits and lawn bowling fields) located within a municipal public park.
St. Thomas	Smoking prohibited within 30 m of any playground equipment, splash pad, swimming pool, tennis court, skateboard facility or player's benches.
Tweed	Smoking is prohibited within 25 m of municipal playgrounds and playing fields.
White River	Smoking is prohibited within 15 m of playground equipment within parks and within 15m of sports and recreational fields.
Woodstock	Smoking prohibited within 30 m of any playground equipment located within a municipal public park (includes swimming pools), within 15 m of any recreational field within a municipal public park (includes baseball diamonds, soccer pitches, player or spectator benches and lawn bowling fields, but not golf courses and during special community events including but not limited to parades, outdoor concerts, sports tournaments, sidewalk sales, Canada Day celebrations and Cowapalooza. Of special note is that private businesses can apply to be added to the schedule to make their doorways smoke-free as well, enforced by the municipality.
Smoking prohibited in all parks – some have designated areas	
Arnprior	Smoking prohibited on any public land which is identified as a public playground or public beach within the limits of the Town.
Barrie	Smoking prohibited outdoors on any property owned and occupied by the City including but not limited to property upon which is located a City facility, parkland, playground, sports field, spectator seating area, ice surface, etc. whether or not a "No Smoking" sign is posted.
Belleville	Smoking prohibited in any park or part thereof designated by signs or markers.
Bonfield	Smoking prohibited on the land surrounding the Township office and on municipal



	parklands, except in designated smoking areas.
Clearview Township	Smoking prohibited on or within 9 m of a playground area or playing field including but not limited to soccer fields, baseball diamonds, football fields, etc., and on municipal property including parks during the period of time when people are assembled and authorized entertainment is provided.
Cobalt	Smoking is prohibited on all municipal property (including parks, beaches, playgrounds and recreational fields) unless a "Designated Smoking Area" is granted by the municipality. A proprietor of a workplace may choose to have the workplace added to the by-law. If a workplace is added to the by-law, smoking is prohibited within a 9 m radius of those entrances and exits.
Hamilton	Smoking prohibited in parks, including playgrounds, recreation centre property, arena and stadium property, sports or playing fields, skateboard parks, beaches, outdoor pools and leash-free dog parks.
Essa, Township of	Smoking is prohibited on municipally owned property. This includes all municipal parks, facilities, spectator seating areas, ice surfaces, outdoor pads, trails, soccer fields, and baseball diamonds. Smoking also prohibited on walkways or paths (except sidewalks) on Township owned and occupied property.
Niagara Falls	Smoking prohibited on all municipal property, including in bus shelters
North Bay	Smoking prohibited on municipal property. Workplace and apartment building owners may request of the City that their entranceway be designated as smoke-free.
Ottawa	Smoking prohibited on all municipal properties, including beaches, playgrounds, parks and sports fields, and restaurants and bar patios. The changes came into effect April 2nd, 2012 after a setback ban of 9 m proved to be unenforceable
Orangeville	Smoking prohibited in parks, trailways, recreational fields, transit environments, municipal parking lots, and Town facilities, including entranceways to libraries, recreation centres, Town Hall, Police Services, fire hall, and the train station.
Welland	Smoking prohibited in parks except in designated areas.

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APPENDIX C - Options to Consider for Prohibiting Smoking in Municipal Parks

Recreation/sport amenities includes: playground equipment, sports fields (soccer fields, football fields, ball diamonds, bleachers, spray pads, wading pools, outdoor pools, skateboard parks, tennis courts, basketball courts etc.

	OPTIONS	PROS	CONS	FINANCIAL IMPACT
Least Restrictive	**1. Status Quo (no by-law)**		Exposure • Will not reduce exposure of children and youth to second hand smoke in parks • Continue to have negative role modelling	Signage - No cost Media/Education Campaign - No cost Enforcement - No cost
Slightly Restrictive	**2. Post signage <u>suggesting</u> people not smoke in parks (no by-law)** 	Exposure • May move some exposure away from areas where signs are posted Enforcement • May encourage more peer enforcement Other benefits • Signage could be temporary (as shown in photo to left, or permanent)	Exposure • "Suggestion" not to smoke may not remove exposure to second hand smoke out of danger zone for children and youth Enforcement • Not enforceable (no by-law) • Vague messaging may imply there is a ban • No direction about where you can smoke	Signage • Cost of permanent signs in all parks approximately $20,000 Media/Education Campaign • May or may not be paid media campaign • Staff time to notify organizations using parks Enforcement cost = $0

Somewhat Restrictive	**3. Prohibit smoking within 9 meters (30 feet) of playground equipment and recreational/ sport amenities in City parks** 	Exposure • Moves exposure to second hand smoke away from immediate areas of play (see Appendix D for maps showing setback in sample parks) Enforcement • Provides a clear rule to enforce • Consistent with proposed entranceway restriction • Peer enforcement goes up where there is a prescriptive law	Exposure • Removes exposure only a minimum distance from activity • Does not address role modelling issue as children/youth will still see adults smoking • Does not limit exposure in areas of parks away from recreation amenities (ex. Parking lots, pathways to playgrounds etc.) Enforcement • Difficult to enforce (Ottawa moved from a setback of 9 m to an outright ban because of onerous nature of messaging and enforcement) Other impacts • Safety concerns – adults attempting to smoke a designated distance from child/setting can no longer actively supervise	Signage • Cost of permanent signs in all parks approximately $20,000 Media/Education Campaign • Paid media campaign partially funded by MLHU • Staff time to notify organizations using parks Enforcement • By MLHU
More restrictive	**4. Prohibit smoking within 30 meters (100 feet) of playground equipment and recreational/ sport amenities in City parks** 	Exposure • Moves exposure to second hand smoke well away from activity areas Enforcement • Peer enforcement goes up where there is a prescriptive law	Exposure • Does not limit exposure in areas of parks away from the identified recreation amenities (ex. Parking lots, pathways to playgrounds etc.) where children will be present upon arrival and departure from park • Does not address role modelling issue as children/youth will still see adults smoking • May increase smoking next to private properties that back onto some parks (see Appendix D) Enforcement • Very difficult to enforce as judging of longer distances is subjective – difficult to visualize 30 meters (according to other Municipalities) • Could create confusion as many smaller parks would have a complete ban (ex. See Appendix D: Capulet Park, Covent Market Plaza) • Confusion may exist in rules of ban ex. Vacant soccer fields Other impacts • Safety concerns – adults attempting to smoke a designated distance from child/setting can no longer actively supervise	Signage • Cost of permanent signs in all parks approximately $20,000 Media/Education Campaign • Paid media campaign partially funded by MLHU • Staff time to notify organizations using parks Enforcement • By MLHU =

Restrictive	**5. Prohibit smoking in all parks except in designated smoking areas** 	Exposure • Ensures exposure to second hand smoke is outside of danger zone for children and youth • Directs smoking to a special area that would reduce exposure to children and youth in parks and away from any adjacent private properties Enforcement • Easy to enforce • Peer enforcement goes up where there is a prescriptive law	Exposure • Does not address role modelling issue as children/youth will still see adults smoking Enforcement • May be difficult for smokers to find Other impacts • Onerous to designate smoking areas in all parks across city • Safety concerns – adults attempting to smoke in a designated area away from child/setting can no longer actively supervise	Signage • Cost of signage showing no smoking areas and designated smoking areas approximately $50,000 Media/Education Campaign • Paid media campaign partially funded by MLHU • Staff time to notify organizations using parks Enforcement • By MLHU Additional Costs • Maintenance of designated smoking areas • Cost of smoking receptacles etc.
Most Restrictive	**6. Prohibit smoking in all parks** 	Exposure • Provides highest level of protection for children and youth from second hand smoke • Provides an additional level of protection for adults • Addresses role modelling issue as children/youth will not longer see adults smoking in parks Enforcement • Easiest option to enforce (according to other municipalities) • Complete ban is easier to understand and obey – clarity of communication • Peer enforcement goes up where there is a prescriptive law that is easy to understand Other benefits • Less litter (cigarette butts) to clean up throughout parks		Signage • Cost of no smoking signs in all parks approximately $20,000 OR • Signs at entrance to municipality (similar to parking by-law notification) Media/Education Campaign • Paid media campaign partially funded by MLHU • Staff time to notify organizations using parks Enforcement • By MLHU Additional Savings • May lead to less cleanup of cigarette litter in parks overall

Exceptions to these options would include all Golf Courses. Special Events where the audience is intended to be mainly adults will designate smoking areas as part of their application (similar to applications for designated smoking areas in outdoor beer gardens).

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Note: Where the 9 or 30 meter buffer extends onto a highway the By-Law will not apply.

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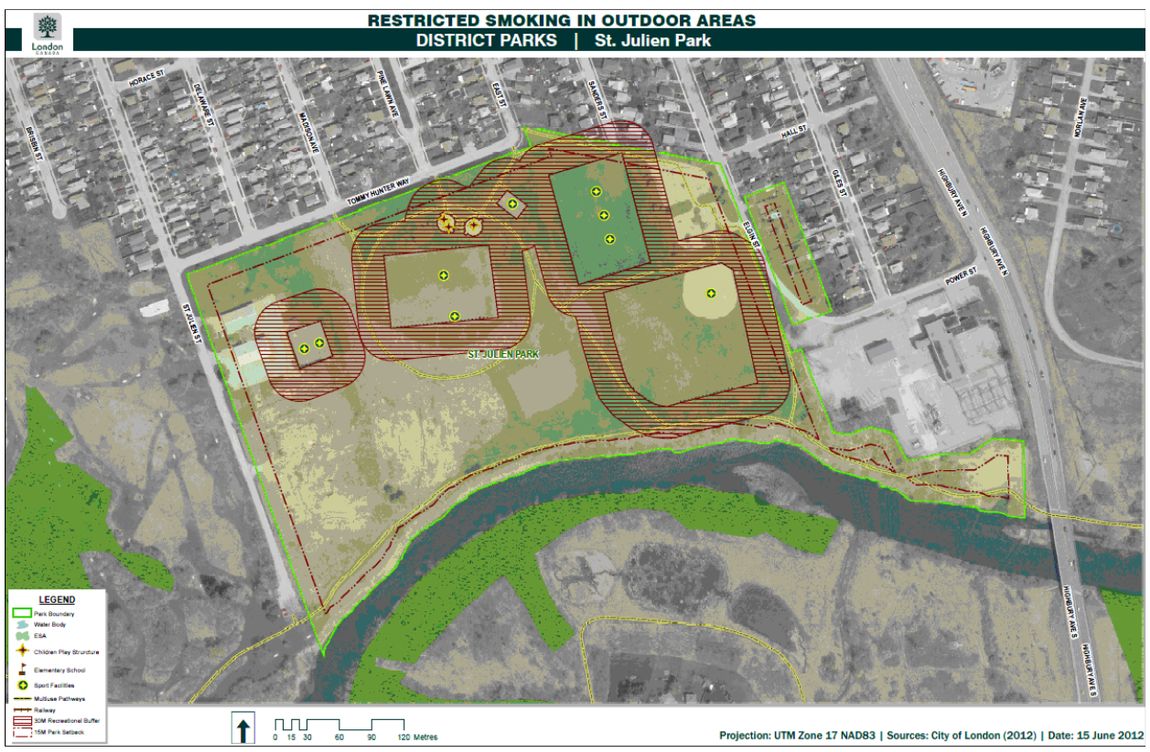
APPENDIX D
Examples of Restricted Smoking Setbacks in Selected Parks

Thirty (30) meter (100 feet) setbacks from playgrounds & recreational amenities in select parks



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Nine (9) meter (30 feet) setbacks from playgrounds & recreational amenities in select parks

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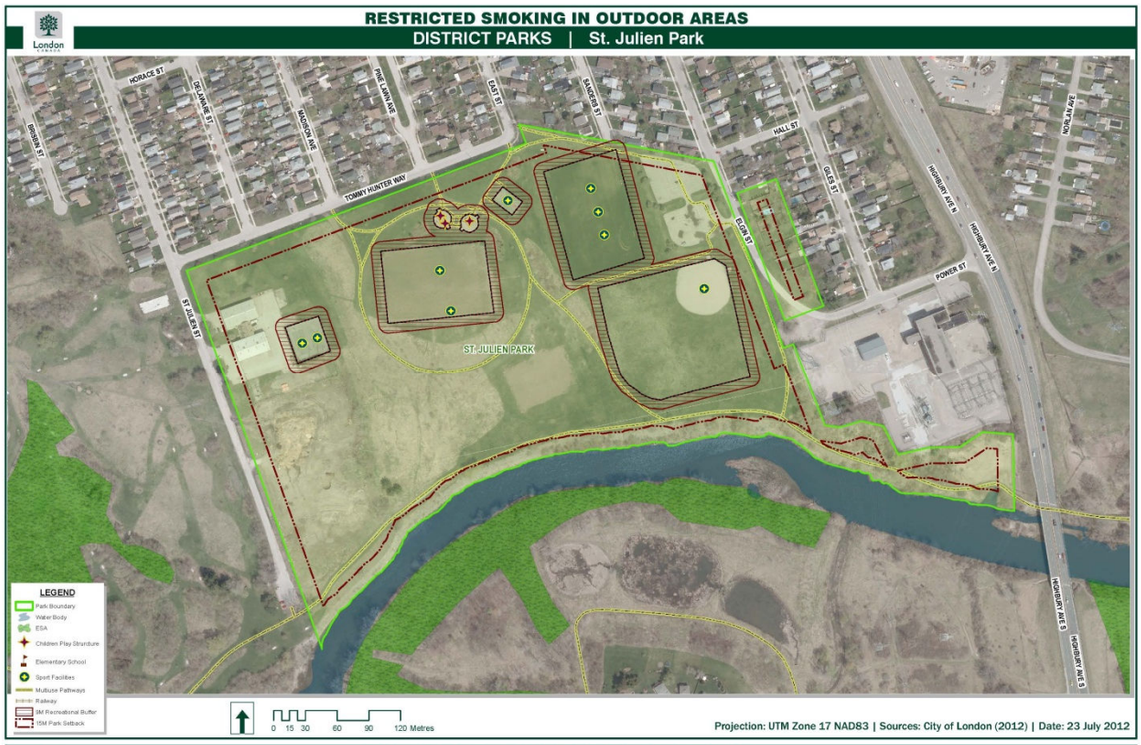

APPENDIX E
Education, Awareness and Enforcement
Middlesex- London Health Unit

The success of any smoking restriction bylaws will be measured by documenting a high compliance rate which relies on a foundation of strong public support. Public support is achieved and maintained through education, awareness, and enforcement. All are necessary to successfully implement and ensure compliance.

i) Education and Community Partner Engagement – A well-planned, comprehensive social marketing and communication strategy will inform everyone about the bylaw and how to comply. This work would be done collaboratively with the Middlesex-London Health Unit. The strategy would include advertising (radio, transit ads, print, etc), a series of media releases and media interviews, presentations and packages to those organizations and community groups that use the facilities, information on the health unit and City of London websites, and the availability of printed resources/packages. To achieve compliance, the public must know about and understand the bylaw. Health Unit and Parks and Recreation staff will have a significant role promoting the bylaw as part of their work in the community.

ii) Signage – Visible (strategically placed) and attractive signage is important for successful smoke-free policy. Signage helps to maximize education and compliance and therefore assist residents to self-enforce the outdoor smoke-free bylaws.

iii) Enforcement – There will be a phased approach to enforcement, with an initial focus on education and promotion. Once the bylaw comes into effect, the first two months will be focused on education and compliance. Following the two months, the first enforcement priority will focus on responding to complaints which may initially be high and decrease over time. Warnings will then be given as part of our education plan and when needed, charges will be issued. It is expected the number of charges will be low because there is a high rate of support for this bylaw and if the bylaw is easy to understand, these types of bylaws are primarily self-enforcing.

The Middlesex-London Health Unit currently employs four (3.1 FTE) Tobacco Enforcement Officers who are trained and highly experienced in enforcing the *Smoke-Free Ontario Act* and the City of London Smoke-Free Public Places and Workplaces By-laws. For those areas that require additional enforcement support due to congregation of children and youth and/or ongoing non-compliance, the Tobacco Enforcement Officers, in partnership with London Police Services would be responsible for providing enforcement support.

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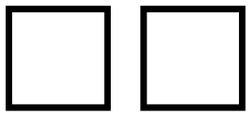

APPENDIX F
OPPORTUNITY TO OPT IN TO ENHANCE PROTECTION

Information Provided by the Middlesex-London Health Unit (July 2012)

The Middlesex-London Health Unit receives a significant number of complaints and requests for assistance from privately-owned workplaces regarding smoking. The owners/proprietors seek greater restrictions on smoking than what currently exists within the *SFOA*.

Smoking Prohibitions within Entrance-Ways of Privately-Owned Workplaces
The Middlesex-London Health Unit receives a significant number of complaints and requests for assistance from privately owned workplaces regarding smoking within a 9-meter radius of the entrance. Owners/proprietors have the option and authority to implement additional policies for the protection of their employees; however, it is the responsibility of the owner/proprietor to enforce these policies, which can be a challenge. Privately-owned workplaces would be provided with the opportunity to register with the City to be named within a schedule of the bylaw so that these workplaces would be provided with enforcement support to expand the level of protection provided. For example, the City of Woodstock enacted the Smoke-Free Workplaces and Public Places Bylaw in June 2008, which not only prohibits smoking within a 9 meter radius of municipally owned and operated buildings, but provided the opportunity for private workplaces to opt into the bylaw; this provision has been very successful.

Smoking Restrictions for Privately-Owned Recreational Properties
There are a variety of privately-owned recreational properties which may choose to register with the City to be named within a schedule of the bylaw so that these properties would be provided with enforcement support to expand the level of protection provided and be consistent with the tobacco-free messages they experience at city-owned and operated recreational facilities.

Smoking Restrictions for Hospital or Post-Secondary Educational Campuses
London Health Sciences Centre (South Street Hospital, University Hospital, Victoria Hospital and Children's Hospital, London Regional Cancer Program, CSTAR and Lawson Health Research Institute) and St. Joseph's Healthcare (St. Joseph's Hospital, Parkwood Hospital, Mount Hope Centre for Long Term Care, Regional Mental Health Care London) have implemented their own policies designating outdoor smoking areas. The Middlesex-London Health Unit regularly inspects hospital grounds to ensure no smoking within nine meters of entrance-ways (*SFOA*), and by request of hospital administration, supports hospital security by encouraging tobacco users to move to the designated areas. Tobacco Enforcement Officers are limited in the support they can provide hospital administration because they can only enforce the 9 meter prohibition, not hospital policy; therefore, hospital administration would be provided with the opportunity to register with the City to be named within a schedule of the bylaw (designated areas or smoke-free grounds) to be provided with greater enforcement support and to expand the level of protection provided. The City of Woodstock enacted the Smoke-Free Workplaces and Public Places Bylaw in June 2008, which provided the opportunity for Woodstock General Hospital to opt into the bylaw. A similar provision could be offered to post-secondary education campuses.

Three municipalities, Cobalt, North Bay and Woodstock have opt in clauses in the bylaw whereby workplaces and/or apartment building owners may request the municipalities to recognize their entranceway be designated as smoke-free and enforce the by-law.

It should be noted that fees for registration are generally established by municipalities to cover some costs of administration.

Bill No. 110
2013

By-law No. A.-6924-85

A By-law to Prohibit Smoking within 9 metres of Recreation Amenities in Municipal Parks, and Entrances to Municipally-owned Buildings.

WHEREAS subsection 5(3) of the *Municipal Act,* S.O. 2001, c.25, as amended, provides that a municipal power shall be exercised by by-law;

AND WHEREAS section 9 of the *Municipal Act, 2001* provides that a municipality has the capacity, rights, powers and privileges of a natural person for the purpose of exercising its authority under this or any other Act;

AND WHEREAS subsection 10(1) of the *Municipal Act, 2001* provides that a municipality may provide any service or thing that the municipality considers necessary or desirable for the public;

AND WHEREAS subsection 10(2) of the *Municipal Act, 2001* provides that a municipality may pass by-laws respecting: in paragraph 4, Public assets of the municipality acquired for the purpose of exercising its authority; in paragraph 5, Economic, social and environmental well-being of the municipality; in paragraph 6, Health, safety and well-being of persons; in paragraph 7, Services and things that the municipality is authorized to provide under subsection (1); in paragraph 8, Protection of persons and property;

AND WHEREAS subsection 115(1) of the *Municipal Act, 2001* provides that a municipality may prohibit or regulate the smoking of tobacco in public places and workplaces;

AND WHEREAS section subsection 115(3) of the *Municipal Act, 2001* provides that section 115 shall not apply to a highway;

AND WHEREAS it has been determined that restrictions on smoking in outdoor public spaces can have a protective effect on smoking uptake among children, youth and young adults, and supports those who are currently addicted to tobacco trying to quit;

AND WHEREAS The Corporation of the City of London considers it desirable for the public to prohibit the smoking of tobacco as set out in this by-law;

AND WHEREAS it is deemed expedient to pass this by-law;

NOW THEREFORE The Council of The Corporation of the City of London hereby enacts as follows:

1.0 DEFINITIONS

1.1 For the purpose of this by-law:

"City" means The Corporation of the City of London;

"City Park" means land and land covered by water and all portions thereof under the control, management, or joint management of the City, that is or hereafter may be established, dedicated, set apart, or made available by the City for recreational purposes, including without limiting the generality of the foregoing, a park, a leash-free dog park and an environmentally significant area, including any buildings, structures, facilities, erections and improvements located in or on such land;

"Enforcement Officer" means a person appointed by the Middlesex-London Board of Health to enforce this by-law or any person appointed by City Municipal Council to enforce this by-law or any police officer of the London Police Service;

"Municipally-owned Building" means a building owned by the City;

"Playground" means any part of an outdoor area fitted with play equipment, including

but not limited to slides, swings, climbing equipment;

"Recreation Amenity" means any part of an outdoor area established for recreation or sport activity, including but not limited to a Playground, pools, wading pools, spray pads, outdoor skating rinks, sports fields (including but not limited to fields for soccer, baseball, football, field hockey, lacrosse, cricket), skateboard parks, bicycle or BMX parks, courts (including but not limited to courts for tennis, basketball), picnic areas, gazebos, outdoor shelters, spectator areas, food and beverage concessions, and Storybook Gardens, but does not include any golf course.

2.0 PROHIBITIONS

2.1 No person shall smoke tobacco or hold lighted tobacco within nine (9) metres of any part of the following public places:
(a) a Recreation Amenity in a City Park; or
(b) an entrance of a Municipally-Owned Building.

2.2 The application of section 2.1 is not affected by the absence or presence of signage with respect to smoking tobacco or holding lighted tobacco.

3.0 EXCEPTIONS

3.1 This by-law does not apply to the smoking of tobacco on a highway.

3.2 This by-law does not prohibit an Aboriginal person from smoking tobacco or holding lighted tobacco, if the activity is carried out for traditional Aboriginal cultural or spiritual purposes.

3.3 This by-law does not prohibit a non-Aboriginal person from smoking tobacco or holding lighted tobacco, if the activity is carried out with an Aboriginal person and for traditional Aboriginal cultural or spiritual purposes.

4.0 ENFORCEMENT

4.1 This by-law may be enforced by an Enforcement Officer.

4.2 No person shall hinder or obstruct, or attempt to hinder or obstruct, any person who is exercising a power or performing a duty under this by-law.

4.3 (a) Where any person contravenes this by-law, such person is subject to the provisions of the *Trespass to Property Act*.

(b) An Enforcement Officer, the Managing Director of Parks and Recreation Services, the Managing Director of Neighbourhood, Children's and Fire Services, or their written designates, or a person designated in writing by the City Manager, may order a person believed to be in contravention of this by-law to:
(i) cease the activity that is in contravention of the by-law; and/or
(ii) leave the premises.

5.0 PENALTY

5.1 Any person who contravenes any provision of this by-law is guilty of an offence and is liable to a minimum fine of $100 and a maximum fine of not more than Ten Thousand Dollars ($10,000).

5.2 If this by-law is contravened and a conviction entered, in addition to any other remedy and to any penalty imposed by the by-law, the court in which the conviction has been entered and any court of competent jurisdiction thereafter may make an order,
(a) prohibiting the continuation or repetition of the offence by the person convicted; and
(b) requiring the person convicted to correct the contravention in the manner and within the period that the court considers appropriate.

6.0 CONFLICTS

6.1 If a provision of this by-law conflicts with an Act or a regulation or another by-law, the provision that is the most restrictive of smoking shall prevail.

7.0 SEVERABILITY

7.1 If any section or sections of this by-law or parts thereof are found in any court of law to be illegal or beyond the power of Council to enact, such section or sections or parts thereof shall be deemed to be severable and all other sections or parts of this by-law shall be deemed to be separate and independent there from and to be enacted as such.

8.0 SHORT TITLE

8.1 This by-law may be referred to as the "Smoking Near Recreation Amenities and Entrances By-law".

8.2 This by-law shall come into force and effect on the 1st. day of May, 2013.

PASSED in Open Council March 5, 2013.

Joe Fontana
Mayor

Catharine Saunders
City Clerk

First reading - March 5, 2013
Second reading – March 5, 2013
Third reading – March 5, 2013

Join Us!
Parks and Playgrounds Clean-Up

Friday April 19th between 1pm and 4pm - Rain or Shine!

Harris Park
West Lions
Forks of the Thames
Ivey Park

~ Student community service hours available
~ Wear the gear (boots, gloves, hat, sunscreen and a smile)

To get involved visit: www.healthunit.com/get-involved-bylaw

THE NEW BYLAW IS COMING!

Effective May 1st, 2013
NO SMOKING within 9 metres of:

- Park Recreational Amenities – playground equipment, splash pads, sport fields
- Entrances to municipal buildings

Middlesex-London Health Unit Tobacco Information Line:
519-663-5317 ext. 2673 or smokefreeinfo@mlhu.on.ca

One Life One You

Canadian Cancer Society / Société canadienne du cancer

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

London CANADA

Thanks for not smoking!

It's the only way to play!

THE NEW BYLAW IS COMING!

Effective May 1st, 2013

NO SMOKING within 9 metres of:

- Park Recreational Amenities – playground equipment, splash pads & sport fields
- Entrances to municipal buildings

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London CANADA

Thanks for not smoking!

It's the only way to play!

THE NEW BYLAW IS NOW IN EFFECT!

NO SMOKING within 9 metres of:

- **Park Recreational Amenities – playground equipment, splash pads & sport fields**
- **Entrances to municipal buildings**

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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London CANADA

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 086-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2103 June 20

BE BRIGHTER WITH BREAKFAST SECONDARY SCHOOL INITIATIVE

Recommendation

It is recommended that Report No. 086-13 re Be Brighter with Breakfast Initiative be received for information.

Key Points

- Children and youth who eat breakfast perform better academically.
- As children get older breakfast consumption declines: by grade 10, 59% of girls and 50% of males do not eat breakfast daily.
- Be Brighter with Breakfast is a comprehensive school health approach aimed at improving breakfast eating patterns among secondary school youth through education, supportive environments, community partnerships and youth engagement strategies.

Background

Education is an important social determinant of health. Children and youth who succeed academically and graduate from secondary school are less likely to live in poverty and more likely to be successful working citizens. Healthy eating patterns in childhood and adolescence promote optimal health, growth and intellectual development. Children and youth who eat breakfast perform better academically. In a 2008 Toronto study, students who ate morning meals at least three days during a school week achieved higher grades and higher ratings on learning skills compared to students who eat morning meals on fewer days or who never eat breakfast. In terms of learning skills, students who ate morning meals were better able to perform independent work, had better initiative, improved problem solving abilities, and improved class participation. School staff and administrators reported that eating morning meals resulted in improvements in student behaviours, attitude, reduced tardiness, less disciplinary problems and a better ability for students to stay on task. This research appears to support that eating breakfast can be linked to student success and academic achievement.

Secondary School Breakfast Initiative

Even though eating breakfast is associated with positive outcomes the literature shows that as children get older breakfast consumption declines: by grade 10, 60% of girls didn't eat breakfast daily. The Young Adult Team launched a breakfast initiative in secondary schools in Middlesex-London called *Be Brighter with Breakfast.* The three main reasons for the development of this program were related to the literature, statistical decline in healthy eating among adolescents and the nurse's assessment of teen behaviours in secondary schools. The initiative was developed to ensure consistent messaging across participating schools. Schools in Middlesex-London were approached regarding their readiness to participate. Of the thirty-three secondary sites nine agreed to participate in the comprehensive initiative that would occur over the next four years.

Be Brighter with Breakfast Strategies and Activities

This initiative applies a comprehensive healthy schools approach to the entire school population with targeted education and skill building aimed at grade 9's in these schools. It is the intent of the team to provide activities in the schools using a youth engagement approach while tracking the knowledge and behavior of the grade nines as they move through this educational process during the next four years.

Public Health Nurses began this initiative by administering a short poll in October 2012 to grade 9's about their breakfast eating habits. The poll will be re-administered before the end of this school year with the same cohort. A comprehensive *Be Brighter with Breakfast* resource guide has been developed and consists of a backgrounder used to engage schools, a standardized presentation to educate about breakfast, curriculum supports for teachers, standardized announcements, posters, a health wall, and a compilation of youth engagement activities that can be adapted and used by various student groups to implement school wide events.

Youth engagement has been a key component of this initiative. This process harnessed youth creativity to develop school wide activities that have promoted the importance of breakfast, activities such as breakfast grams, recipe contests, promoting breakfast programs, and video development. The production of four videos by youth from three local secondary schools with messaging about the importance of eating breakfast will be used in the 2013/2014 school year.

Next Steps

Of the grade 9 students surveyed prior to the implementation of *Be Brighter with Breakfast* strategies and activities, 59% stated they ate a breakfast while 41% stated they did not eat breakfast. However of the 59% that ate breakfast only 42% of them stated they ate 3 of 4 foods groups at breakfast. There is a need to increase the amount of students that eat breakfast and that eat a healthy breakfast.

Statistics and qualitative data have been collected throughout the school year related to this initiative and the analyzing of this data and the results will be important to inform the next phases of this initiative. Additional activities will build on the work of the 2012/2013 school year and it is anticipated that data garnered over the coming year will speak to the effectiveness of the program initiatives.

This report was prepared by Ms. Christine Callaghan, Registered Dietitian, and Ms. Christine Preece, Manager, Young Adult Team.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Foundational Standard - 4, 8; Chronic Disease Prevention - 1, 7, 8, and 11.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 087-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

STUDENT BUS PASS ADVOCACY UPDATE #1

Recommendation

It is recommended that Report No. 087-13 re Student Bus Pass Advocacy Update #1 be received for information.

Key Points

- Delegation was made before the London Transit Commission who motioned to bring this issue forward during the 2014 budget planning; they provided their full support for an equalization grant to be offered by the City of London.
- The youth did not present to the Civic Works Committee and the Community and Protective Services Committee as the request is viewed as a provincial issue and was passed on to the provincial contacts.
- Youth have been invited to present to the Honourable Deb Matthews, MPP when the Civic Administration arrange a meeting to discuss income redistribution.

Initiative Update

Youth Create Healthy Communities (YCHC) has continued their advocacy initiative since being endorsed by the Board of Health at the February 19, 2013 meeting. Following the Board of Health meeting, the youth developed two specifics to continue their initiative.

1) The first was directed towards the City of London Civic Works Committee, asking for their support before continuing on to the London Transit Commission (LTC), to propose the implementation of a youth pass.

2) The second was directed towards the City of London Community and Protective Services Committee to ask for the implementation of an equalization grant similar to that offered to our senior population. This social pricing is based on income redistribution.

YCHC began the second phase of their advocacy by connecting with the Civic Works Committee, and they recommended the youth present their concern to the LTC. Upon discussion with Mr. Larry Ducharme, General Manager of LTC, the youth were granted delegation status for the April 24, 2013 Commission meeting.

At the Commission meeting a motion was approved to bring this issue to administration during their 2014 budget planning. Following this meeting, Mr. Ducharme and his staff met with the youth to discuss the future of this initiative. He provided the youth insight into the history behind social pricing and the full support from the LTC to gain an equalization grant from the City of London.

In May, the youth learned that their request to attend the Community and Protective Services Committee to present and request an equalization grant would not proceed as Committee members felt it was a provincial issue. A letter addressed to both Ms. Michelle Cowin, Public Health Nurse, and Mr. Grant Hopcroft, Director of Intergovernmental and Community Liaison, from the Deputy City Clerk, L. Rowe, stated the municipal council resolved that

> *"the Civic Administration be directed to arrange a meeting with the local members of the Legislative Assembly of Ontario, as soon as possible, in the matter of income redistribution to be further discussed in order to facilitate a program such as the one proposed".*

Mr. Hopcroft connected with Ms. Cowin to discuss the potential of a delegation before the Honourable Deb Matthews, MPP. Additional information was sent to Mr. Hopcroft about the Bus Pass Initiative and the youth are waiting for a scheduled meeting.

The youth have secured a meeting with Ms. Denise Brown, as Chair of the Community and Protective Services Committee, who will explain the decision for passing this issue forward to the province. This meeting will provide an opportunity for the youth to share their perspective and get further details about the committee's decision. This meeting will take place on June 13 after the submission of this report.

Conclusion/Next Steps

The youth are committed to continuing to advocate for this initiative by speaking for the most vulnerable youth that do not often have a voice. The youth also understand that other age groups (adults, seniors, post-secondary and students) have the opportunity to purchase a discounted monthly bus pass. The youth believe that adolescents should be allowed the same opportunity. They believe that they should be classified as a special interest group, an important population of the London community.

The students feel it is important to the health of this community to allow for everyone to have accessible, affordable transportation. They plan to provide a quality presentation to the local MPP when the meeting occurs. It is their intent to have the objectives of the bus advocacy initiative met so all youth can become an integral part of their London community.

This report was prepared by Ms. Michelle Cowin, Public Health Nurse, and Ms. Christine Preece, Manager, Young Adult Team, with input from the student representatives of the Youth Create Healthy Communities.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Disease Prevention Standards 3, 6, Child Health Standard 4 and the Foundational Standard.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 088-13

TO: Chair and Members of the Board of Health

FROM Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

PHYSICIAN OUTREACH INITIATIVE

Recommendation

It is recommended that Report No. 088-13 re Physician Outreach Initiative be received for information.

Key Points

- The physician outreach initiative has been an effective way to strengthen communication and the relationship between physicians and other primary care providers in Middlesex-London and Health Unit staff.
- Physicians and primary care providers are becoming increasingly aware of Health Unit programs, services, and related evidence-based information to help inform their practice.

Background

Families recognize their physicians as a reliable source of health information, and most say they would make behaviour changes recommended by a physician. The Health Unit recognizes the importance of providing local physicians with timely information about programs and services that are available in the community. To assist physicians and other primary health care providers attain current information, the Early Years Team in Family Health Services developed a comprehensive physician outreach initiative.
The first goal of the physician outreach initiative was to increase the number of physicians and primary care providers who were aware of Health Unit programs, services, and related evidence-based information to help inform their practice. The second goal was to strengthen Health Unit communication and relationships with physicians and other primary care providers in London and Middlesex.

Physician Outreach

The Health Unit plays a key role in connecting physicians with the health promotion system and provides current information on local community health issues. Strategies for communicating with physicians to influence public health practice in primary care involve a variety of approaches. Research has shown that there is a greater effect on physician learning when the interventions are interactive, use multiple methods, and are designed for a small group of physicians from a single speciality. Identified strategies for the physician outreach initiative included: print materials; professional updates; referral information; screening and decision-tools; presentations including clinical rounds; workshops and CME events; outreach visits for academic detailing; internet assisted strategies; regular mail outs including evidence-based Health Unit resources; resources for client distribution; the Health Unit Physician Resource Binder; and email updates that contain links embedded into the body of the email. Previous recommendations and literature revealed the need to prioritize and present well organized information by themes to increase physicians' perceptions of relevance. This helps physicians recognize that the information being shared is part of a unified approach to the ongoing physician outreach initiative. All correspondence was coordinated through the physician outreach lead and manager of the program.

Physician Office Visits

There is evidence that supports a shift away from physician outreach interventions of low effectiveness, such as print-only communications, and a move towards physician outreach initiatives that engage more effective

strategies which include educational office visits. In 2009, the Health Unit was selected as one of four pilot sites for the newly released Enhanced 18 Month Well Baby Visit initiative. Educational outreach visits were a recommended strategy which involved a face-to-face visit with physicians, often referred to as physician detailing, to discuss the importance of the enhanced visit for early identification of developmental concerns in young children and to provide information regarding the new fee code associated with conducting the enhanced visit. The Early Years Team incorporated this initiative into the plans for the physician office visits as physicians indicated receptiveness to this information.

Planning

The planning process included three key components:

- A review of recommendations from the two previous physician outreach summary reports;
- Physician mapping to develop an accurate, up-to-date list of local family physicians and paediatricians in relation to Well Baby/Child & Breastfeeding Clinics;
- Resource development including the Health Unit Physician Resource Binder, the Enhanced 18 Month Well Baby Visit Resource Package, Physician Survey, Scripts and Documentation.

Implementation

There were 297 physician names representing 155 primary care offices identified for outreach visits in 2010/2011. 89% of the physician practices consented to an office visit (264/297) and over 80% of the primary care offices were visited by a PHN (129/155). In total, 343 office staff participated in the office visits by PHNs. By 2011, 93% of physicians on the list had access to the Physician Resource Binder. An additional 20 physicians outreach office visits were conducted in 2012. Since 2010, 365 Physician Resource Binders have been distributed and discussed in physician and nurse practitioner offices.

Opportunities/Linkages

Networking and relationship building related to the physician office visits lead to numerous opportunities to provide additional presentations and workshops to primary health care professionals regarding services provided by the Health Unit and the Enhanced 18 Month Well Baby Visit initiative. Highlights include presentations and displays at the Annual Clinical day for Family Physicians in 2011, 2012 and 2013; articles printed in the St. Joseph's Health Care Centre Partnership and Academy of Medicine newsletters; annual presentations at hospital grand rounds and to local nurse practitioners; hosting annual interactive, educational workshops for physicians with MainPro C accreditation; and ongoing physician mail outs resulting in 12,500 requests for resources from physician offices to date. A total of 31 presentations have been given to over 850 health care professionals since the physician outreach initiative began.

Conclusion/Next Steps

This physician outreach initiative has been an effective way to strengthen the partnership between the Health Unit and the local physician practices. It has resulted in increased interdisciplinary awareness among service providers and health professionals within the London and Middlesex Community. The foundation for the physician office visits has been established and physician detailing and continuing to implement multi-strategy approaches to keep primary health care providers informed remains a priority. In order to increase capacity to expand the breadth of services, this collaborative initiative will now include preconception and prenatal health topics and will fall under the leadership of the reproductive health team

This report was prepared by Mrs. Ruby Brewer, Manager, Early Years Team.

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

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 089-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

IMPLEMENTING THE SHARED SERVICES REVIEW RECOMMENDATIONS

Recommendation

It is recommended that Report No. 089-13 re Implementing the Shared Services Review Recommendations – Update #1 be received for information.

Key Points

- Staff have begun assessing the PricewaterhouseCoopers (PwC) report recommendations and will report on progress at the September Board of Health meeting.
- Engagement with PwC on Phase III has begun. The first component of this is identifying for further analysis those recommendations which will be likely to represent the highest value for money, such as revising the MLHU budget process.

Background

PricewaterhouseCoopers (PwC) presented the "Efficiency and Shared Services Review, Interim Report for Phases I and II" (see Appendix B of Report No. 063-13), at the May 9 Board of Health meeting. This report completed the initial phases of the review of Health Unit administrative functions, and identified eight recommendations across four areas to improve the efficiency of the Health Unit's administrative functions (see Appendix A). At the May 16 Board of Health meeting, the Board passed the following resolution:

1. *That Health Unit staff meet with PricewaterhouseCoopers (PwC) to discuss the next steps and report back to the Board of Health in September; and further*

2. *That the Board of Health supports staff identifying opportunities to move forward, and beginning implementation of the PricewaterhouseCoopers recommendations in the interim, including using PwC as consultants where appropriate.*

Addressing the Recommendations

The implementation process will involve identifying actionable items within the PwC recommendations and categorizing them as ready for implementation, requiring significant further analysis, and/or requiring further direction from the Board of Health. Priority will be given to items which are likely to offer greater value for money.

For those items that are ready for implementation, staff will begin work immediately. This will involve assigning a lead, developing an action plan including timelines, staff and other resources required, and measureable objectives. Items requiring further analysis and/or input from the governance level will be examined over the coming months. The report in September will update the Board on progress across all areas and seek further input on next steps.

PwC Phase III

Staff will prioritize which activities would most benefit from PwC involvement. PwC will play a key role in determining which activities offer the highest value for money and opportunity for revenue-generation/cost-savings. It is anticipated that PwC could be particular valuable supporting MLHU with recommendations such as 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" (p. 18). It is anticipated that funds currently allocated for the PwC review will be exhausted by September.

This report was prepared by Mr. Ross Graham, Manager, Special Projects, and Dr. Chris Mackie, Medical Officer of Health.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 090-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 June 20

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – JUNE

Recommendation

It is recommended that Report No. 090-13 re Medical Officer of Health Activity Report – June be received for information.

The following report highlights activities of the Medical Officer of Health since the May Medical Officer of Health Activity Report (Report No. 075-13) to June 12, 2013.

The Medical Officer of Health (MOH) was introduced to the Middlesex County Council on May 14 and spoke about the importance of the Health Unit partnering with municipalities.

The MOH presented opening remarks at the Creating Healthy Active Communities – the Power of Partnerships Forum at the Civic Gardens Complex on May 21. This event was also attended by Board Members: Ms. Denise Brown, Mr. Al Edmondson, Mr. Ian Peer and Ms. Nancy Poole.

The MOH attended the seventh Annual Father's Day Breakfast at the Marconi Club on May 27 with Mr. Dan Flaherty and Mr. John Millson. More than 300 students, athletes, coaches and teachers attended the breakfast that is organized by the Thames Valley District School Board and the London District Catholic School Board. Attendees were asked to become ambassadors in the fight to end violence against women.

The MOH participated in Baby Friendly Initiative (BFI) training with the other staff members from the Office of the Medical Officer of Health on May 28.

On May 29, the MOH taped a segment for "Inside London" for Rogers TV.

The MOH spoke after the Minister of Health and Long-Term Care at a World No Tobacco Day event at Covent Garden Market on May 31.

The MOH attended the Association of Local Public Health Agencies (alPHa) Conference and Annual General Meeting June 2 – 4, 2013 in Toronto and presented the Canadian Public Health Association (CPHA) Conference in Ottawa on June 10 and 11.

On June 5 and 6, the Medical Officer of Health, accompanied by Mr. Dan Flaherty, Communications Manager, visited the newsrooms at London radio stations, television stations and newspapers to become acquainted with the media in the City. These newsrooms included:

- Astral Radio
- CBC London
- Corus Radio
- CTV
- Free-FM
- London Community News
- Metro London

- The London Free Press
- The Londoner

The Medical Officer of Health also participated in the following teleconferences and events:

May 15 -teleconference Ministry of the Environment Updated Soil Framework
May 16 - teleconference Canadian Public Health Association Panel Discussion
May 22 - CEO/CAO Dinner Meeting at the London Convention Centre
May 27 - celebration for Health Unit's student placement program participants
May 30 - teleconference with Dr. Farhan Asrar re Impacting Public Perceptions using Water Fluoridation as a case study
May 31 - event Southwest Tobacco Control Network (TCAN) World No Tobacco Day at the Convent Garden Market.

Analysis and implementation of the PwC recommendations remains a priority for the MOH. In addition to several planning and analysis meetings with staff, the MOH participated on May 30 in a teleconference with Mr. Maurice Chang of PricewaterhouseCoopers, Mr. John Millson and Dr. Bryna Warshawsky regarding next steps in the Shared Services Review.

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

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health