AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2015 September 17

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

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

MEMBERS OF THE BOARD OF HEALTH

Ms. Patricia Fulton
Mr. Jesse Helmer (Vice Chair)
Dr. Trevor Hunter
Mr. Marcel Meyer
Mr. Ian Peer (Chair)
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Mark Studenny
Mr. Stephen Turner
Ms. Joanne Vanderheyden

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:05 – 7:20 p.m.	Dr. Paul Kershaw, Associate Professor, University of British Columbia School of Population & Public Health re Generation Squeeze Community Forum
7:20 – 7:35 p.m.	Dr. Jason Gilliland, Associate Professor, Department of Geography, Western University re Item #4 – Active and Safe Routes to School
7:35 – 7:50 p.m.	Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item #1 - Finance and Facilities Committee Meeting
7:50 – 8:05 p.m.	Committee Member, Governance Committee re Item #2 – Governance Committee Meeting

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meeting September (49-15) 2015 Budget - MOHLTC Approved Grants (49b-15)	Appendix A Work Plan Monthly Tasks Appendix A Appendix B Appendix C	x	x		To receive information and consider recommendations from the September FFC meeting
2	Governance Committee (Verbal)		x	x		To receive information and consider recommendation from the September GC meeting
Delegations and Recommendation Reports						
3	2015 Nutritious Food Basket Survey Results and Implications for Government Public Policy (50-15)	Appendix A Appendix B		x		To report NFB results for Middlesex-London and recommend the Board advocate for an increase in social assistance rates
Information Reports						
4	Active and Safe Routes to School (51-15)		x		x	To provide an update about the Active & Safe Routes to School (ASRTS) community partnership for the improvement of children's health, safety and the environment
5	Working Towards the Vision of a Healthy and Sustainable Local Food System (52-15)	Appendix A			x	To provide information about a program that will address issues across the food system of Middlesex-London
6	Regulatory Compliance Update: Workplace Violence Prevention (53-15)	Appendix A Appendix B			x	To provide the Board of Health with an update regarding the Health Unit's progress towards OHSA requirements with respect to workplace violence, domestic violence in the workplace and harassment
7	2014 Year End Performance on Accountability Indicators (54-15)	Appendix A Appendix B			x	To report that the Health Unit has demonstrated strong performance on the 2014 Year-End Accountability Agreement performance indicators
8	Summary Information Report for September 2015 (55-15)	Appendix A Appendix B Appendix C Appendix D			x	To provide a summary of information from Health Unit programs
9	Medical Officer of Health Activity Report – September (56-15)				x	To provide an update on the activities of the MOH for September 201

CONFIDENTIAL

The Board of Health will move in camera to discuss matters concerning an identifiable individual.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, October 1, 2015
- Next Board of Health Meeting: Thursday, October 15, 2015

CORRESPONDENCE

a) Date: 2015 June 25 (Received 2015 July 3)
Topic: National Alcohol Strategy Advisory Committee
From: Ms. D. Bowen, Regional Clerk/Director of Legislative Services, Regional Municipality of Durham
To: The Right Honourable Stephen Harper, Prime Minister of Canada

Background:
Canada's National Alcohol Strategy Advisory Committee (NASAC) was formed in 2008 to: 1) lead the implementation, monitoring and evaluation of the national alcohol strategy; 2) increase awareness of Canadians on matter relating to alcohol abuse; and 3) to reduce the harm associated with alcohol abuse.

Recommendation:
Receive.

b) Date: 2015 June 30 (Received 2015 July 7)
Topic: Healthy Babies Healthy Children Program
From: Dr. Penny Sutcliffe, MOH & CEO, Sudbury and District Health Unit
To: The Honourable Tracy MacCharles, Minister of Children and Youth Services

Background:
The Healthy Babies Healthy Children Program helps children get a healthy start in life by providing screening, assessment and referral to community programs and services, supporting new parents and helping to find community resources for breastfeeding, nutrition, health services, parenting programs and family literacy programs.

Dr. Sutcliffe outlined the challenges the health unit faces in meeting the HBHC service expectations within the 100% funding envelope and the Sudbury & District Board of Health passed a resolution advocating for the Ministry of Child and Youth Services to fully fund all program costs related to HBHC.

Recommendation:
Endorse.

c) Date: 2015 June 30 (Received 2015 July 7)
Topic: Northern Ontario Evacuations of First Nations Communities
From: Dr. Penny Sutcliffe, MOH & CEO, Sudbury and District Health Unit
To: The Honourable Kathleen Wynne, Premier of Ontario

Background:
First Nations communities in Northwestern Ontario and the James Bay coast require seasonal evacuation and relocation on a nearly annual basis. This is done in a reactionary manner without a proactive strategy to resource and maintain evacuation centres in host municipalities.

Recommendation:
Receive.

d) Date: 2015 June 30 (Received 2015 July 7)
Topic: Enforcement of the Immunization of School Pupil's Act (ISPA)
From: Dr. Penny Sutcliffe, MOH & CEO, Sudbury and District Health Unit
To: The Honourable Eric Hoskins, Minister of Health and Long-Term Care

Background:
SDHU is asking that the Minister of Health and Long-Term Care require all health care providers who give immunizations to submit information directly to health units electronically. Currently, parents are required to submit this information to health units.

Recommendation:
Endorse.

e) Date: 2015 July 6 (Received 2015 July 7)
Topic: Increasing Alcohol Availability in Ontario
From: Ms. Lesley Parnell, Chair, Board of Health, Peterborough County-City Health Unit
To: The Honourable Kathleen Wynne, Premier of Ontario

Background:
An increase in alcohol availability is expected as a result of the Liquor Modernization Project in Ontario. The Board of Health received a report from Mary Lou Albanese (Report 032-15) at the May meeting outlined additional regulations that Health Unit could consider to deal with the sale of beer in grocery stores.

The Middlesex-London Board of Health previously endorsed correspondence from the Sudbury & District Health Unit relating to this matter and forwarded correspondence to the Premier of Ontario.

Recommendation:
Receive.

f) Date: 2015 July 30 (Received 2015 August 5)
Topic: Increasing Alcohol Availability in Ontario
From: The Honourable Kathleen Wynne, Premier of Ontario
To: Mr. Ian Peer, Chair, Middlesex-London Board of Health

Background:
This letter from Premier Wynne to the Chair of the MLHU Board of Health thanks the Health Unit for writing about alcohol policy and commits the Provincial Government to developing initiatives to support safe consumption of alcohol in light of expansion of sales.

Recommendation:
Receive.

g) Date: 2015 August 6 (Received 2015 August 11)
Topic: Smoke-Free Multi-Unit Housing
From: Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care

Background:
The Smoke-Free Ontario Act prohibits smoking in common areas and ensures that signage is posted in appropriate locations. However, people who live in multi-unit housing are at risk of being negatively affected by second-hand smoke from adjacent units. Few buildings designate their units to be smoke-free and tenants can have very little choice in their housing arrangements.

Public health units and organizations like the Non-Smokers Rights Association and Smoke-Free Housing Ontario advocate for tenant protection in these multi-unit dwelling through voluntary no-smoking policies and future development of governmental policy to facilitate the provision of smoke-free housing.

Correspondence from the Perth District Health Unit was previously endorsed at the May Board of Health meeting.

Recommendation:
Receive.

h) Date: 2015 August 6 (Received 2015 August 11)
Topic: Northern Ontario Evacuation of First Nations Communities
From: Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Kathleen Wynne, Premier of Ontario

Background:
See item (c) above.

Recommendation:
Receive.

i) Date: 2015 August 6 (Received 2015 August 11)
Topic: Healthy Babies Healthy Children Program
From: Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Tracy MacCharles, Minister of Children and Youth Services

Background:
See item (b) above.

Recommendation:
Receive.

j) Date: 2015 August 11 (Received 2015 August 13)
Topic: Endorsement of the Bruce Grey Food Charter
From: Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: Ms. Kelley Coulter, CAO, the County of Bruce and Ms. Sharon Voakes, Acting CAO, Corporation of the County of Grey

Background:
Building a healthy community food system is essential for chronic disease prevention, community vitality and healthy growth and development. A food charter outlines a community's vision for a food system.

Recommendation:
Receive.

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

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2015 July 16

MEMBERS PRESENT:	Mr. Ian Peer (Chair) Ms. Trish Fulton Mr. Jesse Helmer (Vice Chair) Dr. Trevor Hunter Mr. Marcel Meyer Ms. Viola Poletes Montgomery Ms. Nancy Poole Mr. Kurtis Smith Mr. Stephen Turner Ms. Joanne Vanderheyden
REGRETS:	Mr. Mark Studenny
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health & CEO (Secretary Treasurer of the Board) Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder) Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Mary Lou Albanese, Manager, Healthy Communities and Injury Prevention Ms. Vanessa Bell, Manager, Privacy and Occupational Health and Safety Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy Dr. Gayane Hovhannisyan, Associate Medical Officer of Health Mr. John Millson, Director, Finance and Operations Ms. Marlene Price, Manager, Vaccine Preventable Disease Mr. Alex Tyml, Online Communications Coordinator Ms. Suzanne Vandervoort, Acting Director, Family Health Services
MEDIA OUTLETS:	Mr. Dan Brown, London Free Press

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

DISCLOSURES OF CONFLICT(S) OF INTEREST

Mr. Peer inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Vanderheyden, seconded by Mr. Turner *that the **AGENDA** for the July 16, 2015 Board of Health meeting be approved.*

Carried

It was noted that Dr. Hunter's name was missing in the Board of Health Member list on the agenda. This will be corrected on the September Agenda.

APPROVAL OF MINUTES

It was moved by Mr. Meyer, seconded by Dr. Hunter *that the* ***MINUTES*** *of the June 18, 2015 Board of Health meeting be approved.*

Carried

BUSINESS ARISING FROM THE MINUTES - none

COMMITTEE REPORTS

1. Finance and Facilities Committee Meeting - July 2nd (Report 044-15)

The Chair of the Finance and Facilities Committee (FFC), Ms. Trish Fulton, reported that the FFC received the following reports:

Financial Update – May 2015 (**Report 18-15FFC**) was received for information.

2016 PBMA Process, Criteria and Weighting (**Report 019-15FFC**)

It was moved by Ms. Fulton, seconded by Ms. Poole *that the Board of Health endorse the criteria presented in Report No. 19-15FFC re Proposed Criteria for 2016 PBMA Process.*

Carried

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden *that the draft minutes of the July 2, 2015 Finance and Facilities Committee be received.*

Carried

DELEGATIONS & RECOMMENDATION REPORTS

2. Generation Squeeze (Report 045-15)

Dr. Christopher Mackie, Medical Officer of Health and CEO, explained Generation Squeeze.

Discussion also ensued about the advocacy role for this issue: local versus federal. It was agreed that a forum would be an excellent way to raise awareness and to learn about the Generation Squeeze approach.

It was clarified that the event would be co-hosted by the Health Unit. Other agencies, such as the London Youth Advisory Council, the United Way and the Child and Youth Network have expressed interested in co-hosting such an event. Ideally the event would be scheduled so that Dr. Kershaw could attend a Board of Health meeting as well.

It was moved by Ms. Poole, seconded by Mr. Helmer *that the Board of Health endorse the invitation of Dr. Paul Kershaw to an organized community forum to share information about Generation Squeeze, serving as strategy to raise awareness and energize community leaders to invest in families.*

Carried

INFORMATION REPORTS

3. Vaccine Preventable Diseases Standard Compliance 2015-2016 (Report 046-15)

Dr. Mackie explained the impact of the changes to the Vaccine Preventable Disease (VPD) program. The Health Unit is in discussion with the Province as to whether to continue with the three dose HPV schedule, or move to two doses. Dr. Mackie reported that British Columbia has adopted the two dose HPV schedule recommended by the National Advisory Committee on Immunization.

It was moved by Ms. Poletes Montgomery, seconded by Mr. Meyer *that the Board of Health receive information about the following Vaccine Preventable Disease program changes:*

1) *Assessment and suspension requirements under the Immunization of School Pupils Act will be prioritized for students 7 years and 17 years of age for the 2015-2016 school year.*

2) *The Health Unit will plan for a two dose Human Papillomavirus Virus vaccine schedule per the recommendation from the National Advisory Committee on Immunization, with a final decision to be made pending guidance from the Ministry of Health and Long-Term Care.*

Carried

It was moved by Mr. Meyer, seconded by Ms. Poletes Montgomery *that Report No. 047-15 re Information Summary Report for July 2015 and the attached Appendix be received for information.*

Carried

4. Medical Officer of Health Activity Report – July (048-15)

It was moved by Ms. Poletes Montgomery, seconded by Mr. Meyer *that Report No. 048-15 re Medical Officer of Health Activity Report – July be received for information.*

Carried

Dr. Mackie reported that he and Mr. Peer attended a County Council meeting to present former Board of Health member, Mr. Al Edmondson, with long-time service plaque.

CORRESPONDENCE

It was moved by Mr. Smith, seconded by Mr. Helmer *that the correspondence be received as presented.*

Carried

It was moved by Mr. Meyer, seconded by Ms. Fulton *that the Board of Health endorse item d) of correspondence re Open Letter to Ask Policy Makers and Political Leaders to Increase Their Investment in Young Children.*

Carried

CONFIDENTIAL

At 7:43 p.m. it was moved by Ms. Fulton, seconded by Mr. Meyer *that the Board of Health move in camera to discuss a matter concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

At 7:48 p.m., it was moved by Mr. Helmer, seconded by Mr. Meyer *that the Board of Health rise and return to public session to report that progress was made in a matter concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

OTHER BUSINESS

Upcoming meetings:

a) Finance and Facilities Committee – Thursday, September 3, 2015 @ 9:00 a.m.
b) Governance Committee – Thursday, September 17, 2015 @ 6:00 p.m.
c) Board of Health – Thursday, September 17, 2015 @ 7:00 p.m.

ADJOURNMENT

At 7:50 p.m., it was moved by Mr. Helmer, seconded by Mr. Smith *that the meeting be adjourned.*

Carried

IAN PEER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 49-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 17

FINANCE AND FACILITIES COMMITTEE MEETING SEPTEMBER 3RD

The Finance and Facilities Committee met at 9:00 a.m. on September 3, 2015 (**Agenda**). The draft public minutes are attached as **Appendix A**. The following items were discussed at the meeting and recommendations made:

Reports	Summary of Discussion	Recommendations for Board of Health's Consideration
Financial Update – June 2015 (Report 020-15FFC)		Received report for information and also received a verbal update from staff.
MLHU – March 31st Draft Financial Statements (Report 021-15FFC)		*That the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31st, 2015 as appended to Report No. 21-15FFC.*
2016 Board of Health Budget - Financial Parameters (Report 022-15FFC)		*That Report No. 022-15FFC be deferred to the September Board of Health meeting.*
50 King Street Re-Zoning Process – Verbal Report	CAO of the County indicated that re-zoning is proceeding, but that the Health Unit is welcome to stay at 50 King for the foreseeable future.	Received for information.
2015-2016 Draft Finance and Facilities Committee Work Plan	Work Plan by Month Work Plan	Received draft work plan for information.

The Finance and Facilities Committee moved in camera to discuss matters concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.

The next meeting of the Finance and Facilities Committee has been scheduled for Thursday, October 1, 2015 at 9:00 am..

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

PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2015 September 3 9:00 a.m.

COMMITTEE MEMBERS PRESENT:	Ms. Trish Fulton (Committee Chair) Mr. Jesse Helmer Mr. Marcel Meyer Mr. Ian Peer Ms. Joanne Vanderheyden
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health and CEO Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy Mr. John Millson, Director, Finance and Operations Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder) Dr. Trevor Hunter, Board of Health Member Mr. Bill Rayburn, Chief Administrative Officer, County of Middlesex

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the meeting.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Ms. Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

2. APPROVAL OF AGENDA

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the* ***AGENDA*** *of the September 3, 2015 Finance and Facilities meeting be approved with the following change: Move item 5.4 . 50 King Street Re-Zoning Process – Verbal Report to the top of the agenda.*

Carried

5.4 50 King Street Re-Zoning Process – Verbal Report

Mr. Bill Rayburn, CAO, County of Middlesex, clarified the County's intentions with the 50 King Street property. His primary message was that the County is happy to have the Health Unit at 50 King Street as long as the Health Unit wishes to stay. The County believes that when the Health Unit no longer needs the 50 King Street property, the answer for the County is not a new lease with a new organization. The County would like to build a new building that combines office space and residential. The planning

process is a long process; therefore, the County is just asking for zoning changes to enable building a tower (beyond 4 floors), to be proactive and to fit with City of London planning cycles. Mr. Rayburn reviewed proposed drawings for the entire site.

In response to a question about timing and interim locations for the Health Unit, Mr. Rayburn explained that the County is not rushing this project, and the need for an interim location would be taken into account. Concern was expressed about the transition period.

Mr. Rayburn left the meeting at 9:30 a.m.

3. APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Meyer *that the **MINUTES** from the July 2, 2015 Finance and Facilities Committee Meeting be approved.*

Carried

4. BUSINESS ARISING FROM MINUTES – none

5. NEW BUSINESS

5.1. Financial Update – June 2015 (Report 020-15FFC)

Discussion ensued about the complications that the current funding situation creates in budgeting and deficit management. Dr. Mackie reported that the report will be revised before it is submitted to the Board of Health on September 17th.

It was moved by Mr. Peer, seconded by Mr. Helmer *that the Finance & Facilities Committee receive Report No. 20-15FFC re Financial Update – June 2015 for information.*

Carried

5.2. MLHU – March 31st Draft Financial Statements (Report 021-15FFC)

Questions were asked about several 'budget' versus 'actual' lines in the draft financial statements. Mr. Millson will investigate the differences in rent (pg. 3) and report back to the Committee.

It was moved by Mr. Meyer, seconded by Mr. Helmer *that the Finance & Facilities Committee recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31st, 2015 as appended to Report No. 21-15FFC.*

Carried

5.3. 2016 Board of Health Budget - Financial Parameters (Report 022-15FFC)

Dr. Mackie recommended that this report be deferred to the September 17th Board of Health meeting so that the report can be revised to reflect the most current information.

Discussion ensued about the reality of 0% anchor budgeting with the municipalities and working toward the 75%/25% cost-shared arrangement with the Province.

It was moved by Ms. Vanderheyden, seconded by Mr. Peer *that the Report No. 022-15FFC be deferred to the September Board of Health meeting.*

Carried

5.5 2015-2016 Draft Finance and Facilities Committee Work Plan – Verbal Report

Ms. Fulton presented a draft annual work plan for the FFC. Dr. Mackie will ensure that the information in the work plan be put in calendar format for easy reference.

Discussion ensued about the Committee's role as an auditing committee. It was agreed that the Finance and Facilities Committee should request Health Unit Management to complete a factual certificate. This certificate process would ensure that the Committee has done its due diligence. It was agreed that members of the Senior Leadership Team review a draft certificate and then bring the certificate to a future Finance and Facilities Committee for Committee approval.

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Draft Annual Work Plan for 2015-2016 be approved by the Finance and Facilities Committee.*

Carried

6. CONFIDENTIAL

At 11:45 a.m., it was moved by Mr. Helmer, seconded by Mr. Peer *that the Finance and Facilities Committee move in camera to discuss matters concerning a proposed or pending acquisition of land by the Middlesex-London Health Unit.*

Carried

At 11:48 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Helmer *that the Finance and Facilities Committee return to public form and report that matters were discussed concerning a proposed or pending acquisition of land by the Middlesex-London Health Unit.*

Carried

7. OTHER BUSINESS

The next scheduled meeting of the FFC is Thursday, October 1, 2015 at 9:00 a.m. in Room 3A.

8. ADJOURNMENT

At 11:50 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Helmer *that the meeting be adjourned.*

Carried

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TRISH FULTON CHRISTOPHER MACKIE

Committee Chair

Secretary-Treasurer

Middlesex London Board of Health- Finance and Facilities Committee
Annual Work Plan by Month

- The draft work plan is designed to ensure that the Finance and Facilities Committee (FFC) meets its mandate to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer, and the Director of Finance & Operations in the administration and risk management of matters related to the finances and facilities of the organization.

- The draft work plan is organized around the requirements to uphold public accountability over the use of resources, to manage the budget process efficiently, to communicate and report on the status of the budget, and to align the budget to the strategic priorities of the Board of health.

- Review refers to activity by the Finance and Facilities Committee

- Recommendations for approval are made to the Board of Health.

JANUARY (2 meetings)
- Review and recommend budget for the year (Budget Process Planning and Budget Templates)

FEBRUARY
- Review and recommend budget for the year (Budget Process Planning and Budget Templates)
- Review quarterly budget variance report (Q4)
- Public Sector Salary Disclosure and BOH Remuneration

MARCH
- Review and recommend strategic direction and key budget planning assumptions for next year's budget
- Vendor Payments
- 100% Funded Program Ministry Funding Announcements

APRIL

MAY
- Recommend guidelines for City budget targets
- Review quarterly budget variance report (Q1)
- Board of Health Remuneration

JUNE
- Review and recommend the audited (MHLTC) Schedule of Revenues and Expenditures and Reconciliation Report
- Review and recommend the audited Financial Statements for the Middlesex London Health Unit

JULY

AUGUST

SEPTEMBER

- Review and recommend the audited Consolidated Financial Statements for the MLHU for programs operating April 1 to March 31.
- Review Program Budgeting and Marginal Analysis criteria/weights and recommend changes if any
- Review quarterly budget variance report (Q2)
- Review Draft FFC Work Plan

OCTOBER

NOVEMBER

- Review quarterly budget variance report (Q3)

DECEMBER

AS REQUIRED:

Accountability

- Review and recommend Provincial Grants
- Review compliance reports

Budget Process

- Review and recommend strategic and financial targets (when?)
- Review Reserves and Reserve Funds and recommend as needed (annually)

Facilities, Risk Management, Administration

- Review space needs and recommend (as needed)
- Review and recommend property leases and acquisitions (as needed)
- review of Financial Policies, Insurance, Appointment of Auditors, and recommend as appropriate

Middlesex London Board of Health
Finance and Facilities Committee

Draft Annual Work Plan: review refers to activity by the Finance and Facilities Committee; recommendations for approval are made to the Board of Health. The draft work plan is designed to ensure that the Finance and Facilities Committee meets its mandate to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer, and the Director of Finance & Operations in the administration and risk management of matters related to the finances and facilities of the organization. The draft work plan is organized around the requirements to uphold public accountability over the use of resources, to manage the budget process efficiently, to communicate and report on the status of the budget, and to align the budget to the strategic priorities of the Board of health.

Accountability

- Review and recommend the audited Consolidated Financial Statements for the MLHU for programs operating April 1 to March 31. (September)
- Review and recommend Provincial Grants
- Review and recommend the audited Financial Statements for the Middlesex London Health Unit (June)
- Review and recommend the audited (MHLTC) Schedule of Revenues and Expenditures and Reconciliation Report (June)
- Review compliance reports

Communication

- Review quarterly budget variance report

Budget Process

- Review Program Budgeting and Marginal analysis criteria and recommend changes if any (July - September)
- Review and recommend budget for the year (January/February)
- Review and recommend strategic direction and key budget planning assumptions for next year's budget (March)
- Review and recommend strategic and financial targets (when?)
- Recommend guidelines for City budget targets (May)
- Review Reserves and Reserve Funds and recommend as needed (annually)

Facilities, Risk Management, Administration

- Review space needs and recommend (as needed)
- Review and recommend property leases and acquisitions (as needed)
- Review of Financial Policies, Insurance, Appointment of Auditors, and recommend as appropriate

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 49b-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 17

2015 BUDGET - MOHLTC APPROVED GRANTS

Recommendation

It is recommended:

1) ***That the Board of Health approve the Board Chair to sign the Public Health Funding Accountability Agreement as appended to Report No. 49b -15; and***
2) ***That the Board of Health approve additional investments of $176,000 for 2015 as outlined in Appendix C to Report No. 49b-15; and further***
3) ***That the Board of Health write a letter to the Minister of Health & Long-Term Care expressing the Health Unit's appreciation for implementing a new public health formula for mandatory programs that supports a more equitable approach to public health funding.***

Key Points

- On September 9th the Health Unit received details of provincial grant approvals for 2015, including an increase of $571,394 (3.6%) in provincial funding to Mandatory (cost-shared) Programs.
- Also included was approval of several grants for one-time funding, totaling $102,600.
- This funding will be sufficient to alleviate budget pressures and fund unique emerging opportunities.
- Recommendations are made for allocation of a portion of this funding. Further analysis and recommendations will come to the Finance and Facilities Committee in October.

2015 Provincial Grant Approval

The Health Unit's 2015 grant request to the Province was made in March 2015 (see Report No. 005-15FFC). On September 9th, 2015 the Health Unit received details of the approved Ministry of Health and Long-Term Care (MOHLTC) grants for 2015 (see funding letter, Appendix A). Table 1 (Appendix B) compares the ministry approved grants with the Board of Heath requests for base and 2015/16 one-time Funding.

Mandatory Programs Funding

For 2015, the Board of Health budget anticipated a $157,093 or 1% increase in provincial grants for Mandatory Programs, and planned for a 0% increase to obligated municipalities. Since then, provincial officials provided guidance to health units to expect no increase in provincial funds for Mandatory Programs. As such, management provided financial updates to the Board of Health which projected a deficit for 2015 (see Report No. 020-15FFC). Funding letters have now arrived indicating that the Health Unit will indeed receive an increase in provincial funding for these programs.

Per Appendix B, the Health Unit received $571,394 or 3.6% more for the delivery of the Mandatory Programs than in 2014. This increase is related to Ministry implementation of recommendations of the recently released report of the Funding Review Working Group, available here. The report recommends allocating funding based on population and equity measures. It identifies Middlesex-London Health Unit as one of the lowest provincially funded public health units per capita in regards to Mandatory Programs.

The additional provincial grant will allow for completion of purchasing, maintenance and other projects that had been put on hold to mitigate the previously projected deficit, and also provides a unique opportunity to address some emerging issues for the remainder of the 2015 operating year. Appendix C details a total of $176,000 in expenditures for immediate consideration by the Board of Health. Further analysis and recommendations will be brought to the Finance & Facilities Committee at its October meeting.

100% Ministry Funded Programs

Several 100% funded programs continue to experience funding pressures as provincial grant increases have not kept pace with inflationary pressures. This is true for the 100% funded Public Health Nursing positions, the 100% Infectious Disease Control initiative, and the core Smoke-Free Ontario initiatives. These programs have received no substantive increases for the current year.

Healthy Smiles Ontario

The Healthy Smiles Ontario grant has been increased $157,676 over the amount approved in 2014. This reflects the increase in claims (demand driven) experienced in 2014 and anticipated dental claims in 2015.

Needle Exchange Program (NEP)

This 100% funding is available to public health units for the costs of providing needles and syringes as well as for disposal costs. Over the past few years the costs of providing these materials have increased substantially and have been accommodated in the Mandatory Programs funding. Other costs associated with delivering the NEP continue to be part of the Mandatory Programs funding or provided directly or indirectly from the Regional HIV/AIDS Connection. The 2015 approved grant of $363,700 reflects the total expected costs of supplying needles and syringes as well as disposal costs. This represents an increase of $128,709 and has been included in the Board of Health approved budget.

Electronic Cigarettes Act – Protection & Enforcement

This 100% funded program is new and relates to the additional enforcement costs associated implementation of the new Act. For 2015, the Health Unit has received base funding of $39,500 (pro-rated for 9 months in 2015) and an additional $39,500 in one-time funding for start-up costs.

One-time Funding

The Health Unit submitted seven business cases, totaling $540,433, for one-time 100% MOHLTC funding. The Health Unit received approval for four cases in the amount of $102,600 to be allocated over the April 1, 2015 to March 31, 2016 period. The Board-approved budget did not include 100% Ministry One-time funding requests. These initiatives generally start only when grants have been approved.

Amending Agreement to the Public Health Funding Accountability Agreement

To accept the 2015 MOHLTC grants, the Board of Health must sign the Amending Agreement to the Public Health Funding Accountability Agreement attached as Appendix D. The amending agreement provides the relevant changes to terms and conditions of the Agreement signed in 2014.

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

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

Ministry of Health and Long-Term Care

Executive Director's Office

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Ministère de la Santé et des Soins de longue durée

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Ontario

iApprove-2015-00949

SEP 0 9 2015

Dr. Christopher Mackie
Medical Officer of Health
Middlesex-London Health Unit
50 King Street
London ON N6A 5L7

Dear Dr. Mackie:

Re: Ministry of Health and Long-Term Care Public Health Funding and Accountability Agreement with the Board of Health for the Middlesex-London Health Unit (the "Board of Health") as amended, dated January 1, 2014 (the "Accountability Agreement")

This letter is further to the recent letter from the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, in which he informed your organization that the Ministry of Health and Long-Term Care (the "ministry") will provide the Board of Health with up to $897,635 in additional base funding and up to $102,600 in one-time funding for the 2015-16 funding year to support the provision of mandatory and related public health programs and services in your community. This will bring the total maximum funding available under the Accountability Agreement for the 2015-16 funding year up to $20,965,300 ($20,862,700 in base funding and $102,600 in one-time funding).

The ministry entered into an Accountability Agreement with the Board of Health dated January 1, 2014, as amended. We are pleased to provide you with two (2) copies of the Amending Agreement that contains the terms and conditions governing the funding referred to in the Minister's letter.

We appreciate your cooperation with the ministry in managing your funding as effectively as possible. You are expected to adhere to our reporting requirements, particularly for in-year service and financial reporting, which is expected to be timely and accurate. Based on our monitoring and assessment of your in-year service and financial reporting, your cash flow may be adjusted appropriately to match actual services provided.

The government remains committed to eliminating the deficit by 2017-18 and therefore it is critical that you continue to manage costs within your approved budget.

.../2

Dr. Christopher Mackie

Please review the Amending Agreement carefully, sign both copies enclosed and return both copies to:

Brent Feeney
Manager, Funding and Accountability Unit
Public Health Standards, Practice and Accountability Branch
Public Health Division, Ministry of Health and Long-Term Care
393 University Avenue, Suite 2100
Toronto ON M7A 2S1

When all the parties have signed the Amending Agreement, the ministry will return one (1) copy to you and will begin to flow the funds reflected in Schedule A of the Amending Agreement.

Should you require any further information or clarification, please contact Mr. Feeney at 416-212-6397 or by email at Brent.Feeney@ontario.ca.

Yours truly,

Roselle Martino
Executive Director
Public Health Division

Martha Greenberg
Assistant Deputy Minister (A)
Health Promotion Division

Enclosure

c: John Millson, Director, Finance and Operations, Middlesex-London Health Unit
Pier Falotico, Director, Financial Management Branch
Michael Parzei, Director, Fiscal Oversight & Performance Branch

Appendix B

Middlesex-London Health Unit
2015 Approved MOHLTC Grants by Program

Program	2015 BOH Request Grant	2015 Anticipated Grant	2015 MOHLTC Approved	2014 MOHLTC Approved	Increase / (Decrease)
Base Funding:					
Cost Shared Programs					
Mandatory Programs[1]	$ 17,255,161	$ 15,866,299	$ 16,280,600	$ 15,709,206	$ 571,394
Children in Need of Treatment (CINOT) Expansion Program[2]	39,375	39,375	67,500	67,500	0
Small Drinking Water Systems Program[3]	34,537	23,900	23,900	23,900	0
Vector-Borne Diseases Program[3]	461,967	461,967	462,000	461,967	33
100% Funded Programs/Initiatives					
Chief Nursing Officer Initiative (1.0 FTE)[3]	126,439	121,414	121,500	121,414	86
Enhanced Food Safety – Haines Initiative[3]	80,000	80,000	80,000	80,000	0
Enhanced Safe Water Initiative[3]	35,627	35,627	35,700	35,627	73
Healthy Smiles Ontario Program[3]	941,532	783,924	941,600	783,924	157,676
Infection Prevention & Control Nurses Initiative (1.0 FTE)[3]	97,688	90,066	90,100	90,066	34
Infectious Disease Control Initiative (10.5 FTE)[3]	1,197,877	1,166,722	1,166,800	1,166,722	78
Needle Exchange Program Initiative	363,684	363,684	363,700	234,991	128,709
Smoke-Free Ontario Strategy Initiatives[3]	1,009,300	1,009,300	1,009,300	1,009,300	0
Electronic Cigarettes Act – Protection & Enforcement[4]	0	0	39,500	0	39,500
Social Determinants of Health Nurses Initiative[3]	196,679	180,448	180,500	180,448	52
Base Funding Sub-Total	**$ 21,839,866**	**$ 20,222,726**	**$ 20,862,700**	**$ 19,965,065**	**$ 897,635**

Notes

(1) The 2015 Board of Health approved budget anticipated a 1% ($157,093) increase.
(2) The 2015 anticipated grant represents 7 months of costs as the CINOT program was intended to be 100% MOHLTC as of August 1, 2015
(3) The 2015 Board of Health approved budget anticipated a 0% increase for these programs.
(4) This is a new 100% Ministry initiative commencing in 2015 and was not anticipated when developing the 2015 Board of Heath budget.

Middlesex-London Health Unit
Table 1 – 2015 Approved MOHLTC Grants by Program (Cont'd)

Program	2015 BOH Request Grant	2015 Anticipated Grant[5]	2015 MOHLTC Approved[6]	2014 MOHLTC Approved	Increase / (Decrease)
One-Time Funding:					
New Purpose-Built Vaccine Refrigerators (100%)	$ 22,667		$ 22,700		
Public Health Inspector Practicum Program (100%)	20,000		10,000		
Smoke-Free Ontario Strategy: Expanded Smoking Cessation Programming for Priority Populations (100%)	27,000		20,300		
Sexual Health: Contraceptives – Competitive Purchasing (100%)	10,100		10,100		
Electronic Cigarettes Act – Protection and Enforcement (100%)	0		39,500		
Immunization of School Pupils Act Regulatory Amendments implementation (100%)	70,510		0		
TCAN – YCMIH.ca provincial campaign (100%)	300,000		0		
Smoke Free Ontario – regulatory amendments (100%)	90,156				
One-Time Funding Sub-Total	**$ 540,433**		**$ 102,600**		
TOTAL	**$ 21,642,446**		**$ 20,965,300**		

Notes (cont'd)

(5) The 2015 Board of Health approved budget did not include 100% Ministry One-time funding requests. Generally these initiatives are started only when grants have been approved.
(6) The approved one-time grants are for April 1, 2015 to March 31, 2016

Appendix C

Middlesex-London Health Unit
2015 Board of Health Budget – Additional Investments

Description	Amount
1) Panorama post-implementation – resolving duplicates	$ 49,000
2) Additional laptop replacements (were proposed to be delayed due to forecasted deficit)	42,000
3) OMERS – remainder of past service adjustment[1]	64,000
4) Legal fees[2]	15,000
5) Deferred building maintenance	6,000
6) Screening Assessment Intervention (SAI) team – to clear data entry backlog and meet Ministry guidelines.[3]	0
Total 2015 Additional Investments	**$ 176,000**

Notes:

(1) This would eliminate the need for a drawdown from the Dental Treatment Reserve in 2015 to fund a past service adjustment. (Report No. 017-15FFC)

(2) Higher than normal requirements for legal assistance. 2015 budget is $60,000

(3) No budget impact, however significant staff turnover in this program has resulted in a 3-4 month backlog of data entry and requirements under the service agreement are not currently being met. It is proposed that a 0.5 FTE Program Assistant from the Mandatory Programs budget (Reproductive Health Team) be reassigned to the SAI team (a 100% Ministry of Children & Youth Services program) for the remainder of 2015.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 50-15

MIDDLESEX-LONDON HEALTH UNIT

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2015 September 17

2015 NUTRITIOUS FOOD BASKET SURVEY RESULTS AND IMPLICATIONS FOR GOVERNMENT PUBLIC POLICY

Recommendations

It is recommended that the Board of Health:

1. ***Send a letter to the Prime Minister of Canada, the Premier of Ontario and the Ontario Minister Responsible for the Poverty Reduction Strategy requesting they prioritize consideration and investigation into a joint federal-provincial basic income guarantee.***
2. ***Send a letter to the Premier of Ontario requesting the province increase social assistance rates to reflect the rising cost of nutritious food & safe housing.***
3. ***Send a letter to all London and Middlesex County federal election candidates requesting they take Food Secure Canada's Eat Think Vote candidate pledge.***
4. ***Forward Report No. 50-15 re 2015 Nutritious Food Basket Survey Results and Implications for Government Public Policy to the City of London, Middlesex County & appropriate community agencies***.

Key Points

- The Nutritious Food Basket survey is conducted annually by all public health units in Ontario to measure the cost of basic, healthy eating.
- The annual survey results repeatedly demonstrate that incomes are not adequate for our most vulnerable Middlesex-London residents to afford basic needs.
- Social determinants of health such as food access, income, housing and employment explain part of the health inequities that exist within and across societies. These determinants are strongly influenced by public policy decisions.

Background

Annually during the month of May, all Ontario public health units conduct the Nutritious Food Basket (NFB) survey in accordance with the requirements under the Ontario Public Health Standards. The survey provides a measure of the cost of basic healthy eating taking into consideration current nutrition recommendations and average food purchasing patterns of Canadians. The NFB results can be used to: estimate the basic cost for an individual or household to eat healthy; compare the basic cost of healthy eating with income and other basic living expenses; and inform policy decisions. In 2015, 12 grocery stores in Middlesex-London were surveyed, including areas of variable economic status.

Survey Results

In May 2015, the estimated local monthly cost to feed a family of four was $860.67. This is a $56.03 or 7.0% increase from the estimated cost in May 2014.

Table 1 highlights some real life situations for Middlesex-London residents utilizing 2015 income rates, rental costs and food costs. The NFB annual survey repeatedly demonstrates that people with low incomes cannot afford to eat healthy after meeting other essential needs for basic living. Appendix A, "***The Cost of Healthy Eating 2015***", provides an overview of the affordability of food costs in relation to basic needs and profiles opportunities for community action.

Table 1 – Monthly Income and Cost of Living Scenarios for 2015

	Single Man on Ontario Works (OW)	Single Man on ODSP	Single Woman over 70 (Old Age Security / Guaranteed Income Security)	Family of 4 Ontario Works	Family of 4 Minimum Wage Earner	Family of 4 Median Income (after tax)
Income (Including Benefits & Credits)	$740	$1193	$1544	$2196	$2882	$6952
Estimated Rent**	$616	$788	$788	$1175	$1175	$1175
Food (Nutritious Food Basket)	$290.09	$290.09	$210.02	$860.67	$860.67	$860.67
WHAT'S LEFT?*	**-$166.09**	**$114.91**	**$545.98**	**$160.33**	**$846.33**	**$4916.33**

* People still need funds for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gifts, entertainment, internet, school supplies, medical and dental costs and other costs.

**Rental estimates are from *Canadian Mortgage and Housing Corporation Rental Market Statistics, Spring 2015*. Utility costs may or may not be included in the rental estimates.

Opportunities for Action

Social determinants of health such as food access, income, housing and employment help explain the health disparities existing within and across societies. These determinants are strongly influenced by government public policy decisions. Poor nutrition can lead to increased risk for chronic and infectious diseases, increased risk of low birth weight pregnancies, and negative impacts on the growth and development of children.

At the 2015 Annual General Meeting, the Association of Local Public Health Agencies (alPHa) passed a resolution prioritizing government consideration and investigation into a basic income guarantee (BIG). The Canadian Medical Association's General Council also passed a resolution supporting BIG last month. A BIG provides a basic minimum income for everyone and ensures an income sufficient to meet basic needs. It is recommended that the Board of Health send a letter of support to the provincial and federal government about prioritizing a BIG. A BIG would replace social assistance when implemented; however, in the meantime, it is recommended that the Board of Health urge the Ontario Government to increase social assistance rates to a level that reflects the rising cost of nutritious food and safe housing.

Eat Think Vote is a campaign led by Food Secure Canada. The long-term goal is to ensure all Canadians have access to healthy, affordable food. Food Secure Canada is advocating for a national food policy that addresses healthy school food, hunger, support for new farmers and affordable food in the North. The campaign includes a candidate pledge and a petition. The campaign's recommendations align with public health priorities, available evidence and public health messaging (Appendix B). It is recommended that the Board of Health send a letter to all London and Middlesex County federal election candidates requesting they take Food Secure Canada's *Eat Think Vote* candidate pledge.

This report was prepared by Ms. Kim Leacy, Registered Dietitian, Ms. Melissa McCann, Program Evaluator, and Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Team.

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

This report addresses the following requirements of the Ontario Public Health Standards (2014): Foundational Standard 3, 4, 5, 8, 9, 10; Chronic Disease Prevention 2, 7, 11, 12

the Cost of Healthy Eating

2015

Each year, Middlesex-London Health Unit tracks the cost of food from local grocery stores using the Nutritious Food Basket survey.

Food Affordability

When money is tight, people cut food budgets to pay for other expenses.

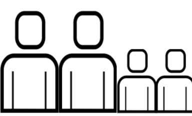
They buy cheaper, less nutritious foods or skip meals.

Poor diets increase risk of infectious & chronic diseases (e.g. diabetes, heart disease and cancer).

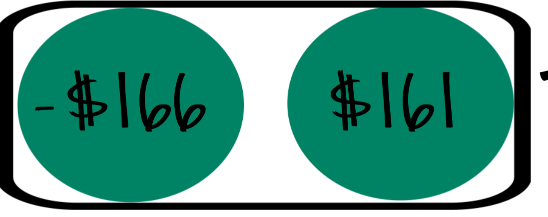
Children in low income households are more likely to get sick and struggle in school.

Income is one of the best predictors of health.

What is left after monthly rent & food costs?



Income (from Ontario Works and all benefits and credits, such as Child Tax Benefit)	$740	$2196
Rent	$616	$1175
Food	$290	$860
REMAINING	-$166	$161



In 2014, about 19,611 local residents received Ontario Works benefits each month.

About 6,800 children under the age of 18 lived in households receiving Ontario Works.

AND

People still need to pay for: heat and hydro, transportation, child care, phone/internet, clothing, medical costs, school supplies, personal care items, household cleaners, etc.

THEREFORE

Our most vulnerable residents do not have adequate funds to meet their basic needs.

All Middlesex-London residents should have access to a nutritious, adequate & culturally acceptable diet.

Last year, over **27,000** people visited the London Food Bank, including about **10,500** children.

What can you do to help?

Be active in the federal election

- Vote on October 19th
- Sign Food Secure Canada's **Eat Think Vote petition**
- Ask your local candidates to take Food Secure Canada's **Eat Think Vote pledge**
- Ask your local candidates about their views on affordable housing, child care, guaranteed annual income and a universal school food program

Learn more about hunger & poverty

- Could you afford your basic needs on social assistance? Try **dothemath.thestop.org**
- Could you make a low income wage last the month? Try **playspent.org**
- Visit **www.vibrantcommunities.ca** to learn about cities reducing poverty

Support the local economy

- Buy local products from local farmers and merchants
- Download the Get Fresh … Eat Local map for Middlesex-London market locations **www.healthunit.com/eating-local**

Volunteer

- Apply to be a Bridges out of Poverty|Circles ally, child minder, meal provider or coalition member. For more info, e-mail:

  sclarke@goodwillindustries.ca (London)

  crystal@wrrcsa.org (Strathroy)
- Share gardening skills or donate growing space to local groups
- Donate time, food or money to support local organizations that increase access to healthy food (e.g. community cooking classes, community kitchens, emergency food donations)

For more information visit: www.healthunit.com/cost-of-healthy-eating

Appendix B

Food Secure Canada's "Eat Think Vote" Campaign

Eat Think Vote is a campaign led by Food Secure Canada and other partners to make food security an election issue. The long-term campaign goal is to ensure all Canadians have access to sufficient, safe, healthy, culturally appropriate and affordable food.

Food Secure Canada is advocating for a national food policy that addresses:

- Healthy school food;
    - Universal school food program
- Zero hunger in Canada;
    - Feasibility study of establishing a basic income floor
    - Increasing the National Child Benefit
    - Developing a national housing strategy
    - Instituting a national Pharmacare program
    - Developing a publicly funded childcare system
    - Increasing the Working Income Tax Benefit
- Support for new farmers; and
    - Programs to help new farmers gain access to land
    - Legislation to prohibit foreign ownership, and limit acquisition of land by private investment funds
    - Low interest loan and small grants for new and aspiring farmers
    - Affordable farmer-to-farmer training, mentoring and apprenticeship programs
- Affordable food in the North.
    - National food policy that includes the northern context
    - Sustainable funding for Community Food Coordinators in all northern communities
    - Basic income floor adjusted to reflect northern costs
    - Changes to *Nutrition North Canada* (e.g., include non-profit food markets and the transportation of traditional foods, reinstate subsidies for necessary non-food items such as gardening supplies and equipment)

The campaign encourages candidates to take a candidate pledge and electorate to sign a petition.

"As a candidate running for office in the 2015 Federal Election, I pledge that if I am elected, I will work with stakeholders and citizens across Canada to develop and implement a national food policy that will lead to a more just, healthy and sustainable food system."

"The Government elected in 2015 should work with others to ensure that all kids in Canada's schools have access to healthy food every day, the right to food becomes a reality for the 4 million Canadians who are now food insecure, the next generation of farmers gets the public support they need to thrive, and good food is affordable and accessible in Canada's remote and northern communities."

Support for Campaign Recommendations

The campaign program and policy recommendations align with public health priorities, available evidence and public health messaging.

Healthy School Food

A universal school food program was recommended by the Healthy Kids Panel, as part of "No Time to Wait: The Healthy Kids Strategy". "Make No Little Plans: Ontario's Public Health Sector Strategic Plan" references moving forward with the Healthy Kids Panel recommendations as a proposed action to meet the strategic goal of improving health by reducing preventable disease and injuries.

Zero Hunger in Canada

The Association of Local Public Health Agencies (alPHa) supports income-related policy recommendations for improving health and addressing food insecurity. At the 2015 Annual General Meeting, alPHa passed Resolutions supporting a basic income guarantee and a national, universal pharmacare program.

The Healthy Kids Strategy also supports the need to address income security to reduce food insecurity. The Healthy Kids Strategy recommends speeding implementation of the Ontario Poverty Reduction Strategy (2014-2019) to ensure Ontario families have enough money to afford their basic needs, including healthy food and housing. Although the Ontario Poverty Reduction Strategy makes provincial, not federal, recommendations, addressing income security and affording basic needs is a prominent theme (e.g., Ontario Child Benefit, social assistance reform, updating Ontario's Long-Term Affordable Housing Strategy, modernization of child care).

Support for New Farmers

In early 2015, the Health Unit Board of Health approved a proposal to increase the Health Unit's capacity for food systems work by hiring a 1.0 FTE Public Health Dietitian (0.5 FTE permanent + 0.5 FTE temporary). Part of this work includes a community food assessment to provide an overview of the local food system and determine priorities for future action to help build a stronger and sustainable local food system. Data is currently being collected, and a report will be completed later this year; however, emerging issues include the increasing average age of local farm operators and barriers for new farmers. Given that agriculture is the predominant land use in Middlesex County and a major contributor to its employment sector, supporting new and future farmers is essential for the long-term vitality of Middlesex County.

Affordable Food in the North

The rate of food insecurity is highest in northern Canada. In 2012, 45.2% of the population of Nunavut and the Northwest Territories experienced food insecurity, compared to 15.2% of Ontario.[1] Within Ontario, the annual Nutritious Food Basket costing consistently shows an increased cost of food in Northern Ontario, as compared to Southern Ontario. In 2013, the average monthly cost for a family of four for the Northern Health Unit regions was $864.92, compared to $796.55 in the Southern Health Unit regions. This is an additional cost of $68.37 or 8.6% per week for residents living in Northern Ontario. Food affordability in the north is essential for resident's food security and overall health.

[1] http://www.nutritionalsciences.lamp.utoronto.ca/wp-content/uploads/2014/05/Household_Food_Insecurity_in_Canada-2012_ENG.pdf

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 51-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 17

ACTIVE AND SAFE ROUTES TO SCHOOL

Recommendation

It is recommended that Report No. 51-15 re Active and Safe Routes to School be received for information.

Key Points

- Active & Safe Routes to School (ASRTS) is a community partnership working together to encourage children and families to choose active transportation (AT) for the improvement of children's health, safety and the environment.
- Wednesday, October 7th, 2015 is International Walk to School Day (iWalk), where schools across the region will be celebrating and raising awareness about the benefits of walking to school.

Only 7% of Canadian children (9% of boys and 4% of girls) achieve the recommended 60 minutes of moderate to vigorous daily physical activity necessary to prevent obesity and the related health concerns.

On Wednesday, October 7th, 2015, schools across the region will be celebrating International Walk to School Day (iWalk), an event that takes place every October to raise awareness about walking to school. Active & Safe Routes to School (ASRTS) is a community partnership to encourage children and families to choose active transportation. For schools involved in ASRTS's overarching program, School Travel Planning (STP), iWalk is an opportunity to run fun events and activities to inspire more children and parents to walk to school.

ASRTS is made up of community partners from the Counties of Middlesex, Elgin, and Oxford, and the cities of London and St. Thomas, including municipal planning and transportation departments, police, non-profits, school board trustees and staff members, school communities, and three local health units. Data collection and evaluation through a partnership with the Human Environments Analysis Laboratory (HEAL) of Western University provides local evidence to support policy making.

Active Transportation

Active Transportation (AT), defined as any form of human-powered travel such as walking or biking, to and from school, provides an ideal way for children to increase their physical activity levels. Increased active travel also provides the additional benefits of improving children's mental health, improving traffic and safety around schools, improving air quality and the environment, helping students arrive to school alert and ready to learn, and allowing children to feel more connected to their community.

The number of Canadian children using AT to school has decreased nearly 50% in the last 20 years. Local data collected through STP found an average of 52% of children using AT to travel to school and 48% using passive modes, such as a car or bus. Of those using passive modes, 54% are being driven in a personal vehicle, which can lead to traffic congestion, poor air quality, and makes the school environment less safe

for children. ASRTS is working to identify and target the barriers preventing families from choosing AT or taking the bus in order to increase the benefits to local students.

School Travel Planning

School Travel Planning (STP) is the overarching program implemented by ASRTS and encourages AT to and from school by developing an action plan to build upon strengths and to remove barriers around the school. STP is a comprehensive process that requires school ownership, supportive partnerships, identification of school-specific concerns (not one-approach-fits-all), and ongoing action plans.

Outcomes

In 2011/2012, seven local schools participated in a pilot STP study funded and coordinated by Green Communities Canada. In 2013, the study process was adapted by ASRTS in partnership with the HEALab to gather better-quality information through a more rigorous data collection phase. Sixteen additional tri-County schools have since participated in the revised STP process over the past 2 school years.

Results of the data collection phase, which includes parent and youth surveys, traffic counts, and school walkabouts, have identified barriers to using AT under the following categories: traffic, infrastructure, weather, and personal factors. Schools involved in the action plan implementation phase address barriers through the 5 E's: Engineering (e.g. new or improved sidewalk renovation); Education (e.g. safety education or bike skills training); Encouragement (e.g. Walk & Wheel promotion days with incentives); Enforcement (e.g. parking or anti-idling blitz); and Evaluation.

Moving Forward

In Fall 2015, we will start conducting the second round of data collection for schools entering the evaluation phase. Data from STPs are being used to provide policy recommendations to government and educational entities for sustainable and long-term change. To date, opportunities have included:

- Presentations to TVDSB and LDCSB;
- Participation on London's Community Safety and Crime Prevention Advisory Committee;
- Meetings with key decision makers; and
- Input into policies, such as, reduced-speed school zones and #CycleON through the Ministry of Transportation of Ontario.

Evidence shows that children require 60 minutes of physical activity per day. STP and AT to and from school enhance children's levels of physical activity, which is good for the health of our children and the community.

This report was prepared by Ms. Emily Van Kesteren, Public Health Nurse.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 52-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2015 September 17

WORKING TOWARDS THE VISION OF A HEALTHY AND SUSTAINABLE LOCAL FOOD SYSTEM

Recommendation

It is recommended that Report 52-15 re Working Towards the Vision of a Healthy and Sustainable Local Food System be received for information.

Key Points

- The food system is the complex set of activities and relationships related to every aspect of the food cycle, including production, processing, distribution, retail, preparation, consumption and disposal.
- Building a healthy, sustainable local food system is an essential component of a healthy community.
- Many residents and organizations across Middlesex-London have shown active interest in developing a more sustainable local food system.
- A comprehensive Community Food Assessment encourages engagement of diverse stakeholders, including the general public, and will help to inform potential actions of a future Middlesex-London Food Policy Council to achieve a healthier and more sustainable food system.

Background

The food system is commonly defined as the complex set of activities and relationships related to every aspect of the food cycle, including production, processing, distribution, retail, preparation, consumption and disposal. According to the American Public Health Association, a sustainable food system provides healthy food to meet current need, while at the same time, keeping the ecosystem and environment healthy so that food can be provided to future generations. A sustainable food system promotes local food production and distribution and ensures that healthy food is available, accessible and affordable to all. Building a healthy local food system is an essential component of a vibrant and healthy community, which is integral for chronic disease prevention and healthy childhood growth and development.

The Vision of a Healthy and Sustainable Local Food System

Momentum towards the development of a healthy and sustainable local food system in Middlesex-London has been growing for the past few years. In 2011, London City Council endorsed London's Food Charter, which establishes a vision of London as a food secure community. The Charter guides and informs all levels of government, businesses, non-profit and faith organizations, communities, families and individuals by linking sustainable food security policies to community action. In 2013, the Local Food Act was enacted to help support the growth of successful and resilient local food economies and systems throughout Ontario.

Several recent actions on the part of the City of London and the County of Middlesex demonstrate their commitment to a sustainable and healthy local food system:

- The Middlesex County Economic Development Strategic Plan was released with recommendations to build and support a sustainable local economy, with a strong emphasis on the agricultural sector (May 2014).

- The County of Middlesex Agriculture Strategy Report and Recommendations was released with the guiding principle of increasing employment, investment and production in a sustainable manner (April 2015).
- The London Plan, second draft, specifically addressed strategies for building a sustainable and strengthened local food system under "City Building Policies" (May 2015).
- The London Community Garden Program Strategic Plan (2015-2019), attached as Appendix A was endorsed by the City of London's Community and Protective Services Committee (August 2015).
- City of London's Community and Protective Services Committee passed a motion to direct Civic Administration to consult with stakeholders on the feasibility of an urban agriculture policy (August 2015).

Many community stakeholders have identified the need for a sustainable, coordinated, viable and health-promoting food system in Middlesex-London. In February 2014, attendees at a stakeholder forum, hosted in part by the Health Unit, expressed unanimous support for a future Middlesex-London Food Policy Council (FPC) to help move this vision forward. A volunteer task group, representing stakeholders across the food system including the Health Unit, was formed to research and make recommendations on the best structure for a FPC. In October 2014, attendees at a second forum unanimously expressed support for a partnership model for a future FPC co-led by two community organizations. In order to inform strategies for action for a future FPC, the group recommended a community food assessment (CFA) be completed as the next step. A second volunteer task group was formed to assist with the CFA.

In 2015, the Health Unit increased its capacity by 0.5 FTE Registered Dietitian to better position the Health Unit to address the environmental, economic, social and nutritional factors connected to the increasing number of local food-related problems including food insecurity, increased consumption of nutrient-poor foods and rising rates of unhealthy weights and related chronic diseases.

Opportunities for Action

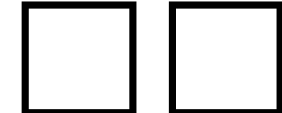
The food system is complex and involves many varied stakeholders. Ultimately, the consumer is the target; therefore, public input and engagement is critical to making meaningful change. The Community Food Assessment (CFA) community survey, launched as part of the CFA, provides community members with an opportunity to share concerns related to the local food system and to gauge support for potential solutions to the most prevalent challenges. The CFA also includes an environmental scan of existing resources and assets, stakeholder interviews and focus groups. The CFA addresses issues across the food system including food production, distribution, purchasing and consumption, food literacy, waste management, and food policy.

Understanding the challenges within our local food system will help the community move toward workable solutions. The results of the CFA, expected by the end of 2015, will inform recommendations and strategies for action to help support the development of a healthy and sustainable local food system and provide insight into the required membership and mandate of the future Middlesex-London Food Policy Council.

This report was prepared by Ms. Ellen Lakusiak and Ms. Kim Leacy, Registered Dietitians, and Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Team.

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

This report addresses the following requirements of the Ontario Public Health Standards (2014): Foundational Standards 1, 2,3,4, 5, 8, 9, 10; Chronic Disease Prevention 3,5,6, 7,8, 11, 12



TO:	CHAIR AND MEMBERS COMMUNITY AND PROTECTIVE SERVICES COMMITTEE AUGUST 25,2015
FROM:	WILLIAM C. COXHEAD, MANAGING DIRECTOR, PARKS & RECREATION LYNNE LIVINGSTONE, MANAGING DIRECTOR, NEIGHBOURHOOD, CHILDREN AND FIRE SERVICES
SUBJECT:	LONDON COMMUNITY GARDENS PROGRAM STRATEGIC PLAN (2015 – 2019) AND YEAR ONE IMPLEMENTATION PLAN

RECOMMENDATION

That, on the recommendation of the Managing Directors of Neighbourhood, Children and Fire Services and Parks and Recreation, the London Community Gardens Program Strategic Plan (2015 – 2019) and the year one implementation plan identifying actions to be undertaken by Civic Administration in 2015/2016 **BE ENDORSED** (attached as Schedule A).

It is noted that:

- London Community Gardens Program Strategic Plan is directly linked to the City's Strategic Plan in 2 strategic areas of focus: *Strengthening Our Community* (invest in new parks and recreation facilities and pursue innovative models for programs and service delivery; support neighbourhood driven activities and decision making) and *Building a Sustainable City* (invest in parks and recreation facilities and amenities). The city's role is to maximize the use of municipal land to act as gathering places in neighbourhoods, bringing residents of all ages together to promote healthy, vibrant, and engaged communities around a common focal point: food; and,

- Funding to meet the current needs of London Community Gardens Program Strategic Plan was approved in the 2015 budget as part of the base budgets for Neighbourhood, Children & Fire Services and Parks and Recreation.

PREVIOUS REPORTS PERTINENT TO THIS MATTER

- London Community Gardens Program Review (March 29, 2011)

BACKGROUND

The community gardens strategic plan provides the overall vision and direction for community gardens across London. This includes gardens both on municipal and private land.

The purpose of this report is to:

- seek endorsement of the London Community Gardens Program Strategic Plan
- provide an overview of the role of the municipality in supporting the implementation of this plan, notably:
    - acting as a resource for the community through information sharing and providing capacity building opportunities to current and future community gardens and gardeners;
    - supporting the community to develop new community gardens on private land through sharing best practices and funding opportunities such as the City's SPARKS! Neighbourhood Matching Fund; and,
    - providing day-to-day oversight and the development of all community gardens on municipally owned land; and,
- outline the actions to be undertaken by Civic Administration in year one implementation of the Plan.

Background and Context

London is home to 14 neighbourhood gardens (on municipally owned land) encompassing 600 plots where gardeners grow vegetables, fruit and other plants. These neighbourhood gardens are spread across our city and are located in park space. One garden is located both on public and private land. The majority of gardens are at full plot capacity and some have waiting lists due to the growing popularity of community gardening. This number does not include many more community gardens spread across the city on non-city property, from roof tops, to schools and universities, to churches, and other private properties.

In 2011, the City undertook a review of the London Community Gardens Program (community gardens located on municipally owned land), which resulted in eight recommendations. Most of the recommendations have been accomplished, including the development of the London Community Gardens Program (LCGP) Guidelines & Procedures for gardens on municipally owned land. One of the outstanding recommendations identified the need for the City of London to develop a Strategic Action Plan for Community Gardens.

In October 2013, the City of London began a comprehensive strategic planning process in order to identify the overall vision for community gardens and more specifically, the strategic priorities for the London Community Gardens Program for the next five years. The process involved consultations (through focus groups and surveys) with key stakeholder groups, including current community gardeners, community members who are interested in community gardening, and staff from the City of London. A review of community gardens statistics, information, trends, and best practices from around the world was also conducted.

London Community Gardens Program Strategic Plan

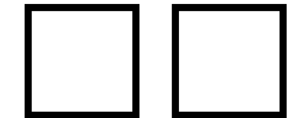
The London Community Gardens Program Strategic Plan was developed with input from the community and provides the overall vision and direction for community gardens across London. This includes gardens both on municipal and private land. The Plan also clearly articulates the City of London's role and how this role aligns with the broader community vision of community gardening. Based on the surveys, which captured the voices of 75 existing community gardeners and 80 Londoners who do not currently participate in community gardening, information was obtained that shaped the strategic plan attached as **Schedule A**.

It is important to note, this plan only focuses on community gardening. It does not address the broader subject of urban agriculture or the broader desire for London food security.

Through the consultation process, stakeholders developed a community vision: *'a community garden in every London neighbourhood'* which assists the City in developing the role community gardens on municipal land play in order to achieve this broader vision.

In addition, the Strategic Plan identifies a range of ideas and opportunities to significantly improve the London Community Gardens Program. The primary opportunities include:

- Improve how London Community Gardens Program is aligned to and linked with other citywide programs and initiatives.
- Broaden the garden governance models identifying opportunities for self-management (managed by local gardeners/volunteers).
- Work towards improving accessibility in all gardens for older adults and people with physical or mobility challenges. Opportunities include, providing raised beds and accessible pathways to and within community gardens.
- Work towards aligning community garden design to the 'Accessibility for Ontarians with Disabilities Act' standards
- Expand the development of community gardens located on municipal/and or private lands into neighbourhoods across the city.
- Support the capacity of local groups and organizations to develop new community gardens on private land through sharing best practices and funding opportunities through grant programs such as the SPARKS! Neighbourhood Matching Fund.
- Explore alternate locations for community gardens on city owned land.
- Increase promotion and communication efforts about community gardens, their benefits and how to start / maintain a community garden.
- Set up a committee comprised of gardeners and city staff to help inform and participate in the implementation of the strategic plan



- Develop a plan to support new gardeners so they can be successful thus reducing the number of abandoned plots.
- Measure, document and report on the outcomes and successes of community gardens for the City of London and its residents.
- Assign a Community Gardens staff person at the City of London to oversee the London Community Gardens Program and act as a liaison between the City of London, gardeners, the coordinating agency (currently London Community Resource Centre) and volunteer led gardening groups.

In order to accomplish these ideas and opportunities, the Strategic Plan identifies the following:

1. **Strategic Roadmap** outlining Civic Administration's role in achieving the community's vision.
2. **Strategic Directions** over the next five years Civic Administration will undertake that identify key areas to continue to invest time and resources, to improve upon, and to develop and implement.

Municipal Role and Year One Implementation

The role of the City of London in supporting the implementation of the London Community Gardens Program Strategic Plan is:

- acting as a resource for the community through information sharing and providing capacity building opportunities to current and future community gardens and gardeners;
- supporting the community to develop new community gardens on private land through sharing best practices and funding opportunities such as the City's SPARKS! Neighbourhood Matching Fund; and,
- providing day-to-day oversight and the development of all community gardens on municipally owned land.

Civic Administration has identified the following priorities to implement in 2015/2016. These include actions that have been implemented over the past couple of years (based on the recommendations identified in 2011) and actions of urgent nature.

2015/2016 Actions to Accomplish:

Action to Implement	Status
• Develop an internal and external communication strategy to be phased in over 2 years	Completed: public signage in all municipally owned gardens – includes contact information
• Create a training and support strategy for new inexperienced gardeners	To be developed
• Improve accessibility at gardens	Completed: portable raised beds that can be moved to a garden based on request
• Comprehensive policies and guidelines manual including code of conduct, conditions of use, composting, and starting a new garden	Completed and in its 3rd year of implementation
• Develop wait list and conflict management processes	To be developed
• Review the current oversight structure	Oversight structure to be in place by January 1, 2016 as current contract expires December 31, 2015
• Engage municipal government and wider community in ongoing development of the London Community Gardens Program	In progress: community consultation process to develop Strategic Plan and ongoing implementation of actions
• Community gardens in city and community plans linked to other priorities in the city	Completed: aligns with City's new Strategic Plan, the draft London Plan, and the Parks and Recreation Master Plan
• Plan to identify and leverage sponsorship	To be developed
• Garden site selection process/ gardens on municipal land	The current process is to be reviewed and revised

In 2016, city staff will meet with key stakeholder groups including interested gardeners (create a committee) to develop and lay out an implementation plan including timelines for 2016 to 2019.

FINANCIAL IMPACT

Funding currently exists in the base budget to meet the current needs of London's Community Gardens Program. There are no additional resources required in 2015 to assist with the implementation of the identified year one actions.

Any growth to the current program could be addressed as resources become available.

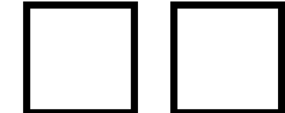
CONCLUSION

Community gardens accomplish many purposes including food production, enhancing healthy living and contributing to active neighbourhoods. Over the years, London residents and City Council have recognized the benefits and significance of community gardens, and have expressed support for their continued development and sustainability.

Gardens are seen as essential to the health and quality of life of London residents and are deemed as important social gathering spaces within neighbourhoods, on par with community centres, cafés and recreational facilities.

SUBMITTED BY:	SUBMITTED BY:
CHERYL SMITH **MANAGER, COMMUNITY DEVELOPMENT & FUNDING** **NEIGHBOURHOOD, CHILDREN AND FIRE SERVICES**	**SCOTT STAFFORD** **DIVISON MANAGER, PARKS & COMMUNITY SPORTS** **PARKS AND RECREATION**
RECOMMENDED BY:	**RECOMMENDED BY:**
LYNNE LIVINGSTONE **MANAGING DIRECTOR** **NEIGHBOURHOOD, CHILDREN AND FIRE SERVICES**	**WILLIAM C. COXHEAD** **MANAGING DIRECTOR** **PARKS AND RECREATION**

C. John Fleming, Managing Director, Planning and City Planner
Andrew Macpherson, Manager, Parks Planning and Design



Schedule A

LONDON COMMUNITY GARDENS PROGRAM STRATEGIC PLAN (2015 – 2019)

INTRODUCTION

Community gardens accomplish many purposes including food production, enhancing healthy living and contributing to active neighbourhoods. Accordingly, the residents of London and City Council have recognized these benefits and the significance of community gardens, and have expressed support for their continued development and sustainability.

Community Gardens flourish because of the commitment and efforts of many groups and individuals. In London, we have 14 community gardens on land owned by the city, but there are many more 'community gardens' on land that is not municipally owned. We can find community driven gardens spread across the city, from roof tops, to schools and universities, to churches and other private properties.

The community gardens strategic plan provides the overall vision and direction for community gardens across London. This includes gardens both on municipal and private land. The plan is the result of the commitment and collective effort of many. We are grateful to over 150 Londoners who participated in the consultative processes to develop our first-ever London Community Gardens Program Vision and Strategic Plan. At this time, the plan does not address the broader subject of urban agriculture or the broader desire for London food security.

OUR ROOTS

Community gardening originated in London in 1993 and was operated by several different organizations over the years, including the Middlesex London Health Unit. In 2002, the London Community Resource Centre (LCRC) took over and has been managing the gardens located on city land ever since. Since 2006, the City of London has provided core funding to support the management of London's Community Gardens Program. The City of London's Parks & Recreation Division also provides in-kind contributions, including assistance with community garden openings, maintenance and seasonal closures, watering and composting services, and ongoing liaison with gardeners and the LCRC related to garden issues in parks. In addition, the City of London's Environmental and Parks Planning works with the community to select sites for newly proposed gardens on public land; and to facilitate consultation and any necessary public processes. In 2013, following extensive public consultation, City staff completed the development of the London Community Gardens Program Operational Guidelines and Procedures which laid the foundation for consistent operations across all gardens.

Today, London is home to 14 gardens (on municipally owned land) encompassing 600 plots where gardeners grow vegetables, fruit and other plants. The gardens are part of the London Community Gardens Program (LCGP), as they sit on city owned land in various London neighbourhoods. The majority of gardens are at full plot capacity and some have waiting lists due to the growing popularity of community gardening.

All gardens are grown organically, which means no chemical pesticides or herbicides are used. Compost, mulching, crop rotation and companion planting are used to obtain maximum yield. The community garden plots are approximately 10' by 10', 10' by 20' or 20' by 20' depending on the needs of the gardeners. Additional space is set aside for a composting area and for storing supplies.

The Benefits of Community Gardening

"Community gardens build and nurture community capacity, which is defined as the sum total of commitment, resources, and skills that a community can mobilize and deploy to address community problems and strengthen community assets. Strong community capacity increases the effectiveness and quality of community health interventions."(1) Research also shows that community gardens promote healthy communities, and if done properly will contribute to food security for low-income families. (2)

For Londoners, the benefits of community gardens are diverse and bountiful.

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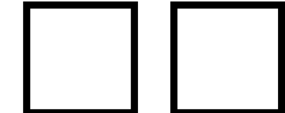
(1) J. Twiss and L. Rilveria, Community Gardens: Lessons Learned From California Healthy Cities and Communities, American Journal of Public Health, September 2003
(2) Kantor, L. S. 2001. Community Food Security Programs Improve Food Access. Food Review 24(1), 20-26.



- Community gardens provide delicious, healthy, culturally appropriate food and can be an important source of fresh produce, increasing dietary quality and food security. This is especially important in low-income neighbourhoods and areas with poor access to healthy foods.
- Community Gardens are vital to the active living of London residents, providing access to a source of recreation and connecting people to nature and the outdoors.
- London's gardens extend beyond a garden's harvest; to community building where neighbours come together around a shared passion and community identity and spirit.
- Community gardens enhance mental health and provide stress relief.
- Community gardens can be a foundation for revitalizing and beautifying areas and environmental stewardship.
- Community gardens contribute to creating an environment for a resilient, diversified and inclusive economy.
- Community gardens are unique sites for skill building and learning for gardeners, including newcomers, the underemployed, and youth.

Over the last two decades, it has been proven that community gardens are **vital to the larger neighbourhood system** within London and are a priority within The London Plan (draft). Gardens are seen as essential to the public health and quality of life of London residents and are deemed as important social gathering spaces within neighbourhoods, on par with community centres, cafés and recreational facilities.

CHARTING A COURSE FOR LONDON'S COMMUNITY GARDENS PROGRAM

In 2011, the City undertook a review of the London Community Gardens Program, which resulted in eight recommendations. Most of the recommendations have been accomplished, including the development of the Community Garden Guidelines & Procedures for gardens on municipally owned land.

In October 2013, the City of London embarked on a comprehensive strategic planning process in order to identify the overall vision for community gardens and more specifically, the strategic priorities for the London Community Gardens Program for the next five years. The process involved consultations (through focus groups and surveys) with key stakeholder groups, including current community gardeners, community members who are interested in community gardening and staff from the City of London and London Community Resource Centre (LCRC). A thorough review of community gardens statistics, information, trends and best practices from around the world was also conducted.

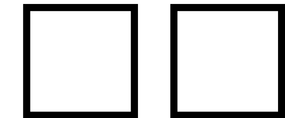
Based on the surveys, which captured the voices of 75 existing community gardeners and 80 Londoners who do not currently participate in community gardening, critical information was obtained that shaped the strategic plan.

Learnings

- 55% of current community gardeners are very satisfied with their London Community Gardens Program experience and 39% are somewhat satisfied.
- Community Gardeners chose to join the program because they wanted to grow their own food (92%) and secondly, because they desire to spend time outdoors doing something they love. Many also enjoy the physical activity that is associated with gardening. Non-community gardeners also identified these same reasons for wanting to join a garden but also felt that community building and healthy eating would be significant benefits.
- 90% of gardeners feel they receive effective support from the City of London and LCRC.
- A majority of gardeners enjoy socializing with one another, however some gardeners prefer the solitude of tending their plot.
- About 32% of gardeners are willing to take on volunteer roles at the local community garden level, however an equal percentage have no interest in volunteering. Similar trends were found with respondents who are not part of the program at the current time.
- The majority of respondents who are not community gardeners but are interested in having a plot feel they would need varying levels of support from the City of London and other gardeners in order to be successful with their garden.

Opportunities

Based on the survey and six focus groups with interested Londoners and City of London staff, a range of ideas and opportunities were identified to significantly improve the London Community Garden Program.



The primary opportunities include:

- Improve how London Community Gardens program is aligned to and linked with other citywide programs and initiatives.
- Broaden the garden governance models at the local level:
  - Established gardens could employ a bottom-up management model whereby a garden is volunteer-managed and maintained, with nominal supports (i.e. maintenance, insurance, resource access) from the City of London.
  - New gardens could employ a top-down model as greater support may be required by the City of London at the outset, and over time the garden may transition to a volunteer-led garden, which would reduce demand for city resources.
  - Hybrid models could be developed by different gardens, based on their needs.
- Work towards improving accessibility in all gardens for older adults and people with physical or mobility challenges. Opportunities include, providing raised beds and accessible pathways to and within community gardens.
- Work towards aligning community garden design to the 'Accessibility for Ontarians with Disabilities Act' standards.
- Expand the development of community gardens located on municipal/and or private lands into neighbourhoods across the city as required/requested.
- Support the capacity of local groups and organizations to develop new community gardens on private land through sharing best practices and funding opportunities through grant programs such as the SPARKS! Neighbourhood Matching Fund.
- Explore alternate locations for community gardens on city owned land.
- Increase promotion and communication efforts about community gardens, their benefits and how to start / maintain a community garden.
- Set up a committee comprised of gardeners and city staff to help inform and participate in the implementation of the strategic plan
- Develop a plan to support new gardeners so they can be successful thus reducing the number of abandoned plots (i.e. peer mentor program; community garden orientation program)
- Measure, document and report on the outcomes and successes of community gardens for the City of London and its residents.
- Assign a Community Gardens staff person at the City of London to oversee the Community Gardens Program and act as a liaison between the City of London, gardeners, the coordinating agency and volunteer led gardening groups.

Moving Forward

Over the next five years, the London Community Gardens Program strengths and the identified opportunities for improvement will serve as a catalyst to build an even stronger and more successful program that is recognized as 'best in class' across Canada.

OUR COMMUNITY VISION FOR LONDON COMMUNITY GARDENS

During our consultation process, participants were asked what their vision was for community gardens. The resounding response was *'a community garden in every London neighbourhood.'* This vision makes perfect sense. However, upon reflection, this vision is not the sole responsibility of the City of London. To achieve this lofty dream will require the efforts of many groups working together in order to establish gardens on both public and private lands in London's neighbourhoods.

The City's Role

The City of London's role in achieving this vision for community gardens sitting on municipally owned land are as follows:

1. Responsible for day-to-day oversight of all community gardens on municipally owned land and the development of new community gardens on public land.
2. Act as a resource for the community through information sharing and providing capacity building opportunities to current and future community gardens and gardeners.
3. Support the community to develop new community gardens on private land through sharing best practices and funding opportunities such as the City's SPARKS! Neighbourhood Matching Fund.

The Community Role

A bold vision and five-year plan for London Community Gardens Program has been crafted ***in support*** of this broad-based vision for community gardens. Some of what is envisioned is already exemplified in London's current community gardens, and these elements will be fostered and strengthened. Other ideas are aspirations for the future.

When crafting the strategic plan for the London Community Gardens program, work was guided by ***five key principles*** that resonated throughout the community consultation process and that were reinforced through experience and research undertaken.

The guiding principles are:
1. Community gardens on municipally-owned land are most viable when they are ***neighbourhood*** initiated, organized and led.
2. Community gardens are successful when gardeners, the City of London, partners and neighbourhoods work together.
3. Community gardens are sustainable when gardeners are empowered and committed.
4. Community gardens are vibrant places when they mirror the diversity and needs of the neighbourhoods they serve.
5. Community gardens are vital to environmental stewardship.

Based on these principles, the London Community Gardens Program **MISSION** is to:

Provide Londoners with the opportunity to enhance their wellness and quality of life through involvement in the community gardens program.

And, the London Community Gardens Program Vision is:

*To support in a **shared effort** with London partners, such as residents, community groups and associations, schools, businesses, faith-based and public sector organizations and more, to establish **"a community garden in every London neighbourhood, initiated and led by local residents."***

WHAT DOES THIS MEAN FOR LONDONERS OVER THE NEXT FIVE YEARS?

Below are the OUTCOMES for London Community Gardens Program (LCGP) gardeners and London residents:

1. ***Healthier lifestyles*** - Londoners connect with the land and the environment through gardening, enhancing their spiritual, mental and physical well-being.
2. ***Stronger neighbourhoods*** – LCGP will foster a sense of neighborhood identity and spirit and build local capacity.
3. ***Enhanced inter-generational and cross-cultural connections*** - Residents of all ages, cultures and backgrounds, speaking many languages, garden alongside one another.
4. ***Beautified urban areas*** – LCGP has the power to enhance urban environments by creating natural, green landscapes.
5. ***Greater access to produce*** - Community gardens provide a source of fresh and healthy food for gardeners, food that may be a critical supplement to a family's resources.

THE PLAN FOR GETTING THERE

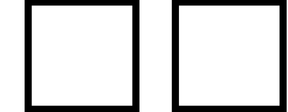
STRATEGIC DIRECTIONS FOR GARDENS ON MUNICIPALLY OWNED LAND

The vision and strategic outcomes are lofty. And, the goals and objectives are equally compelling.

Operational Goals and Supporting Objectives
Over the next five years, the London Community Gardens Program will excel at:

1. Communication and collaboration
- Develop a highly functional LCGP website and digital tools to cultivate learning and collaboration between gardeners, the community and city administrators
- Implement a multi-faceted communication strategy (system-wide / garden level)
- Create a strategy to optimize relationship building between gardeners and key stakeholders

2. Building value-added partnerships
- Develop an inclusive partnership strategy with schools, community agencies, local businesses, seniors' residences, and committees (Accessibility Advisory Committee and Age Friendly London's Outdoor Spaces & Building Working Group, etc.)



- Prioritize expansion into neighbourhoods that feature a high proportion of rental or high density housing
- Implement a strategy to mobilize multi-cultural and diverse groups into community gardening
- Create linkages with food systems

3. Attracting and retaining gardeners

- Create a training / support strategy for new or inexperienced gardeners: buddy system; orientation program and ongoing education curriculum
- Establish a tiered garden plot membership model: demonstration gardens;½ plot; shared plot; own plot
- Create a gardener skills inventory to share expertise
- Improve accessibility at gardens identified by the community, including raised beds, solid surface, wide pathways into gardens, easy water access, available seating nearby, etc. This work is to be accomplished in partnership with gardeners, key stakeholders and possible funders.

4. Engaging neighbourhoods in community garden expansion

- Develop a community awareness / public relations plan, including a common identity for LCGP
- Establish an 'Expansion Blueprint' for Community Gardens, including co-locating gardens with community facilities, parks or services, and rooftop gardens
- Set up an Annual Meeting process for LCGP with reporting protocols
- Conduct ongoing community outreach, including a broad advocacy strategy

5. Administering garden guidelines and processes

- Maintain efficient, coherent policies/guidelines that meet London Community Gardens Program stakeholder needs
- Establish a thorough garden site selection process for gardens on municipally owned lands, design guidelines and 'new garden expansion' process
- Ensure proficient waitlist management process
- Develop effective protocols for collaborative enforcement of LCGP guidelines

Capacity Goals and Supporting Objectives

Over the next five years, the London Community Gardens Program will build capabilities in the following key areas:

1. Effective governance at garden and system level

- Develop a local community garden structure for gardens on **municipally-owned land** that is self-managing and enables leadership and participation among gardeners
- Create governance models that reflect the unique needs of a community garden
    - Top-down approach or bottom-up model
    - Day-to-day management of gardens
    - System oversight
- Establish a LCGP Committee to guide the development of a Garden Management Plan, advocate for the LCGP and support our community gardeners
- Implement conflict management process
- Review the City of London oversight structure for LCGP

2. Strong community gardens leadership

- Generate a comprehensive strategy to attract and retain LCGP volunteers to fill leadership roles at the local garden level
- Engage the municipal government and wider community through inclusiveness in the ongoing development of the London Community Gardens Program
- Set up a formalized community gardening forum with regular contact between all community gardeners to share experiences and ideas

Resourcing Goals and Supporting Objectives

Over the next five years, the London Community Gardens Program will invest and allocate the following resources:

1. Access to natural resources needed for gardening (such as water, fertile soil, etc.)

- Ensure LCGP sites have access to needed natural resources
- Create guidelines that address accountabilities and responsibilities of City of London, London Community Gardens Program Committee, garden leaders, and gardeners

2. Garden plots to meet demand and expansion requirements
- Identify / or designate public lands / co-location lands / surplus lands for LCGP
- Work closely with developers to identify potential land for community gardens
- Support community gardens on private land. For example, through assistance provided through the SPARKS! Neighbourhood Matching fund

3. Municipal support
- Ensure community gardens is weaved into the Strategic Plan for the City of London and the City is committed to providing critical services to support the gardens.
- Assign sufficient staffing to support current and expanded LCGP program including maintenance and administration (noting any growth to the current program could be addressed as resources become available).
- Link LCGP program to city priorities (i.e. The London Plan, Child & Youth Agenda, London Strengthening Neighbourhoods Strategy, Age Friendly London, Parks & Recreation Master Plan)

4. Adequate funding
- Develop a plan to identify and leverage sponsorship opportunities to fund the LCGP
- Create a multi-pronged funding approach, including a LCGP membership pricing model

Strategic Roadmap London Community Gardens Program

Our London Community Gardens Program Strategic Roadmap follows:

Program Strategy Roadmap

Thus, achieving our MISSION & VISION.

London Community Gardens Program Vision

London Community Gardens Program will work with London partners, such as community groups and associations, schools, businesses, faith-based and public sector organizations and more, to support the community's vision of:
"A community garden in every London neighbourhood, initiated and led by local residents."

London Community Gardens Program Mission

Providing Londoners with the opportunity to enhance their wellness and quality of life through involvement in the community garden program.

And, MEET the NEEDS of London Residents and Neighbourhoods.

What Are The Outcomes the London Community Garden Program Will Contribute To?

Healthier lifestyles for individuals and families	Stronger London neighbourhoods	Enhanced inter-generational and cross-cultural connections	Beautified urban areas	Greater access to produce

So we can operate with EFFECTIVENESS & EFFICIENCY,

What Operations & Processes We Must Excel At?

Administering garden guidelines and processes	Communication and collaboration	Building value-added partnerships	Attracting and retaining gardeners	Engaging neighbourhoods in community garden expansion

We will build our CAPACITY,

What Capacity Does the London Community Gardens Program Need?

Effective governance at garden and system level	Strong community gardens leadership

We will use our RESOURCES wisely, and

What Resources Do We Need?

Access to natural resources needed for gardening	Garden plots to meet demand	Municipal support	Adequate funding

We are rooted in the following guiding principles.

OUR GUIDING PRINCIPLES

Our work is rooted in the following principles:
- Community gardens on municipally-owned land are most viable when they are ***neighbourhood*** initiated, organized and led.
- Community gardens are successful when gardeners, the City of London, partners and neighbourhoods work together.
- Community gardens are sustainable when gardeners are empowered and committed.
- Community gardens are vibrant places when they mirror the diversity and needs of the neighbourhoods they serve.
- Community gardens are vital to environmental stewardship.

NEXT STEPS

IMPLEMENTING OUR STRATEGIC PLAN

The thoughtful and bold Strategic Plan provides a renewed direction over the next 5 years, and in the months ahead, the community will shift attention to ***implementation***. At the beginning of each fiscal year, top action priorities will be identified to continue to move the plan forward. Project teams, made up of a diverse group of stakeholders will be assigned to those priorities with the necessary resources to support the work and achieve the desired results.

MEASURING OUR STRATEGIC ROADMAP – OUR SCORECARD

Over the last 21 years, community gardens in our city have demonstrated amazing accomplishments and positive outcomes for gardeners and residents of London. However, this new Strategic Plan raises the bar and inspires our community to do and achieve more.

In 2016, Civic Administration will create a LCGP 'Balanced Scorecard' which will measure, report and communicate LCGP's progress, success and improvement efforts across the four pillars of our Strategic Roadmap. The scorecard will ensure we are on track to accomplish the vision and goals and will allow our community to share performance results with Londoners.

Examples of indicators of success will include:

- Community garden growth and neighbourhood penetration
- Improved gardener satisfaction rates with the program
- Higher neighbourhood interest in implementing a community garden
- Increased rates of consumption of local and organic produce by garden members
- Increased knowledge, skills and behaviours of gardeners
- More community gardens in partnership with schools, associations, agencies, etc.
- Increased physical activity and enjoyment of the outdoors by gardeners
- Improved friendships and connections to the community for garden members
- Increased sense of ownership and examples of leadership among garden members
- Enhanced community awareness about the community gardens program

CLOSING WORDS

Proudly, the strategic plan for the London Community Gardens Program has been shaped by the input, ideas and feedback of gardeners, Londoners and staff associated with the program. We are pleased with the program's accomplishments to date but we will now turn our attention to the next segment of our evolving journey.

Our strategic plan challenges all of us to work together to achieve more and realize even greater benefits for Londoners, neighbourhoods and the city as a whole.

YEAR ONE IMPLEMENTATION PLAN: 2015/2016 Actions to Accomplish:

Civic Administration has identified the following priorities to implement in 2015/2016. These include actions that have been implemented over the past couple of years (based on the recommendations identified in 2011) and actions of urgent nature.

Action to Implement	Status
• Develop an internal and external communication strategy to be phased in over 2 years	Completed: public signage in all municipally owned gardens – includes contact information
• Create a training and support strategy for new inexperienced gardeners	To be developed
• Improve accessibility at gardens	Completed: portable raised beds that can be moved to a garden based on request
• Comprehensive policies and guidelines manual including code of conduct, conditions of use, composting, and starting a new garden	Completed and in its 3rd year of implementation
• Develop wait list and conflict management processes	To be developed
• Review the current oversight structure	Oversight structure to be in place by January 1, 2016 as current contract expires December 31, 2015
• Engage municipal government and wider community in ongoing development of the London Community Gardens Program	In progress: community consultation process to develop Strategic Plan and ongoing implementation of actions
• Community gardens in city and community plans linked to other priorities in the city	Completed: aligns with City's new Strategic Plan, the draft London Plan, and the Parks and Recreation Master Plan
• Plan to identify and leverage sponsorship	To be developed
• Garden site selection process/ gardens on municipal land	The current process is to be reviewed and revised

In 2016, city staff will meet with key stakeholder groups including interested gardeners and lay out an implementation plan including timelines for 2016 to 2019.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 53-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 17

REGULATORY COMPLIANCE UPDATE: WORKPLACE VIOLENCE PREVENTION

Recommendation

It is recommended that Report No. 53-15 re Regulatory Compliance Update: Workplace Violence Prevention be received by the Board of Health for information.

Key Points

- The Board of Health is accountable for ensuring that the Occupational Health and Safety Act (OHSA) requirements with respect to workplace violence, domestic violence in the workplace and harassment are met.
- This report provides the Board of Health with an update regarding the Health Unit's progress towards these requirements.

Background

In 2013, the Health Unit identified gaps in its level of compliance with respect to the *OHSA* requirements that relate to workplace violence and domestic violence in the workplace. The Board of Health subsequently supported recommendations in Report No. **018-14FFC** and Report No. **025-14**, addressing two critical gaps: (1) the identification and assessment of workplace violence risks associated with each public health job category (e.g. Public Health Nurse, Public Health Inspector); and (2) the design and delivery of staff training based on the results of the risk assessment.

1. 2015 Overview of MLHU's Current Level of Compliance with 'Bill 168' Requirements

Attached as **APPENDIX A** to this report is the *2015 Overview of 'Bill 168' Requirements and MLHU's Current Level of Compliance*. This document demonstrates that over the past 2 years, efforts to increase the Health Unit's overall compliance with the Workplace Violence requirements of the *Occupational Health and Safety* Act have been successful. Of the 16 statutory requirements related to workplace and domestic violence, only 3 remain at partial compliance, pending the finalization of the policy development/policy review process.

One of the primary drivers responsible for the Health Unit's increased level of compliance is the completion of a workplace violence risk assessment, conducted by Ted Carroll of Policing and Security Management Services (PSMS).

2. 2015 Workplace Violence Risk Assessment Report

Following Board of Health approval on April 24, 2014, PSMS and the Health Unit undertook a process to assess and analyze the risk of workplace violence associated with the nature, type and conditions of work for all

MLHU job positions. The workplace violence risk assessment concluded at the end of February 2015. The findings have been summarized in a final report entitled: *2015 Workplace Violence (WV) Risk Assessment Report*, attached as **APPENDIX B** to this report.

The assessment took into consideration circumstances that would be common to similar workplaces as well as circumstances that are specific to MLHU. The risk assessment process included the review, collation and analysis of: (1) the MLHU workplace violence policy and program: (2) other relevant policies and procedures; (3) past employee incidents reports; and (4) the completion of a questionnaire by a cross-section of employees.

The Report contains thirteen (13) recommendations for controlling and/or reducing the identified workplace violence risks and exposures. These recommendations cover a range of topics, including:

- Emergency Code System enhancements;
- Increasing staff awareness of the incident reporting process;
- Parking Lot safety;
- Panic Alarm considerations;
- Pre-screening protocols for high-risk individuals or situations;
- Cell Phone Requirements;
- Security Personnel expectations; and
- Staff Training.

On May 5, 2015, the Senior Leadership Team (SLT) conducted a detailed review of the report along with proposed strategies for the implementation of each recommendation. The Health Unit will be moving forward with with all or part of each of the 13 recommendations. Priority was given to the delivery of training for the employee groups that were identified as being at increased risk of workplace violence. To that end, specialized training has been provided to all of the Health Unit's Public Health Inspectors and Tobacco Enforcement Officers. Training for the Health Unit's home visiting team, staffed by Public Health Nurses and Family Home Visitors is scheduled for November of this year. Work towards the adoption and implementation of the remaining recommendations has been initiated and is expected to continue into 2016.

Conclusion

Under the *OHSA*, the Health Unit is required to meet 16 statutory requirements with respect to addressing workplace violence, domestic violence in the workplace and workplace harassment. As of the writing of this report, the Health Unit is in full compliance with 13 of the 16 requirements. It is anticipated that all 16 requirements will be fully met by December 2015.

This report was prepared by Ms. Vanessa Bell, Manager, Privacy and Occupational Health and Safety.

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

2015 Overview of 'Bill 168' Requirements and MLHU's Current Level of Compliance

As presented to the Board of Health: September 17, 2015

○ – No compliance ◐ – Progress Towards Compliance ● – Full Compliance

1. Workplace Violence

	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE SEP 2015	REQUIREMENT	OHSA REFERENCE	PROGRESS NOTES AND/OR RECOMMENDATIONS FOR ONGOING COMPLIANCE
a.	◐	●	Prepare a written policy.	32.0.1(1)	With the Services of Ms. Catherine Birr and following the direction outlined in The Ministry of Labour Guideline entitled: *Workplace Violence and Harassment: Understanding the Law*, MLHU's policy was revised and approved by the SLT on June 5, 2013. The policy incorporates all of the required elements as outlined in the OHSA. **RECOMMENDATION:** No further action is required at this time.
b.	◐	●	Review policy as often as is necessary, but at least annually.	32.0.1(1)	In 2014, the policy was reviewed by: • Ted Carroll, PSMS (September); and • Lisa Kwasek, Hicks Morley (December). As a result of these reviews, there are a number of proposed revisions to the policy. In 2015, the policy was reviewed by: • The JOHSC (March 25 and April 21) • Scheduled for BOH/Governance Committee approval by Q4 of 2015. **RECOMMENDATIONS:** No further action is required at this time.

1. Workplace Violence

	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE SEP 2015	REQUIREMENT	OHSA REFERENCE	PROGRESS NOTES AND/OR RECOMMENDATIONS FOR ONGOING COMPLIANCE
c.	●	◐	Policy to be posted conspicuously in the workplace.	32.0.1 (2)	Current Policy (2013) is posted to: • JOHSC intranet page • e-Administrative Policy Manual; • JOHSC Bulletin Boards at all HU sites. **RECOMMENDATION:** Updated policy to be posted pending BOH/Governance Committee approval.
d.	◐	●	Employer must assess risk of WV that may arise from the: (1) Nature of the workplace* (i.e. the **physical aspects** of the workplace); (2) The type of work* (i.e. the **type of activities** workers perform); or (3) The conditions of the work* (i.e. **other aspects** such as hours worked, the surrounding neighbourhood, etc.) * Explanation of these terms taken for the *MOL Guideline: Workplace Violence and Harassment: Understanding the Law.*	32.0.3(1)	1. Two (2) Nature of Workplace Assessments completed: a. 2008: PSMS conducted a comprehensive review of the physical sites of the 3 Health Unit offices; and b. 2011: PSMS conducts a technical review of the panic alarm system. 2. One (1) Type-of-Work Assessment completed. The *2015 Workplace Violence Risk Assessment Report* includes a detailed analysis of the vulnerabilities and threats that are experienced by MLHU Job Function. 3. One Conditions-of-Work Assessment completed. The *2015 Workplace Violence Risk Assessment Report* includes detailed analysis of some of the other aspects of work that impact on the safety and security of staff, including the *Violent Crime Severity Index* for London Area Neighbourhoods. **RECOMMENDATION:** No further action is required at this time.

1. Workplace Violence

	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE SEP 2015	REQUIREMENT	OHSA REFERENCE	PROGRESS NOTES AND/OR RECOMMENDATIONS FOR ONGOING COMPLIANCE
e.	(a) ◐ (b) ○	(a) ● (b) ●	Assessment must address: (a) circumstances that would be common to similar workplaces (i.e. **other public health units**); and (b) circumstances specific to the workplace (**MLHU**);	32.0.3 (2)	(a) The *2015 Workplace Violence Risk Assessment Report* includes information on circumstances that are common to: • Windsor-Essex County Health Unit • Sudbury District Health Unit • Wellington-Dufferin Guelph Health Unit • Lambton Public Health|County of Lambton (b) The *2015 Workplace Violence Risk Assessment Report* includes information on circumstances that are MLHU-specific. **RECOMMENDATION:** No further action is required at this time.
f.	○	●	Communicate the results of the WV Risk Assessment to the JOHSC	32.0.3 (3)	The results of the Risk Assessment were provided to the JOHSC on March 24, 2015. Also, in 2013, the JOHSC received a number of updates on the Health Unit's progress with respect to the workplace violence initiative. **RECOMMENDATION** No further action is required at this time.

1. Workplace Violence

	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE SEP 2015	REQUIREMENT	OHSA REFERENCE	PROGRESS NOTES AND/OR RECOMMENDATIONS FOR ONGOING COMPLIANCE
g.	○	●	Reassess the risks of WV as often as is necessary to ensure that the policy and program continue to protect workers from WV.	32.0.3 (4)	With the completion of the *2015 Workplace Violence Risk Assessment Report*, all required elements have been examined. *The MOL Guideline: Workplace Violence and Harassment: Understanding the Law* indicates that the employer should review the assessment at least annually. It further outlines the following triggers for commissioning a re-assessment. A re-assessment should be undertaken if: • The workplace moves or the existing workplace is renovated or reconfigured; • There are significant changes in the type of work (for example, new tasks are assigned or a new project is undertaken); • There are significant changes in the conditions of work (for example, making a service or clinic available at a later hour); • There is new information on the risks of workplace violence; or • A violent incident indicates a risk-related to the nature of the workplace, type of work or conditions of work as was not identified during an earlier assessment. **RECOMMENDATIONS:** 1. That the SLT, the NLT and the JOHSC receive regular (at least annually) reminders of the triggers for initiating a workplace violence re-assessment. 2. That the SLT assign the annual review of the Workplace Violence Risk Assessment to the JOHSC. 3. That the JOHSC provide the SLT with a report on the outcomes of the annual review, including a recommendation for whether or not a re-assessment is required as per the triggers for re-assessment as outlined in the *MOL Guideline*.
h.	○	●	Communicate the results of the re-assessment to the JOHSC	32.0.3 (5)	Not applicable. **RECOMMENDATION:** No further action is required at this time.

1. Workplace Violence

	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE SEP 2015	REQUIREMENT	OHSA REFERENCE	PROGRESS NOTES AND/OR RECOMMENDATIONS FOR ONGOING COMPLIANCE
i.	◐	●	Develop and maintain a program to implement the workplace violence policy, inclusive of the following elements: (a) Measures and procedures to control the risks (identified in the risk assessment required under 32.0.3 (1)) that are likely to expose a worker to physical injury. (b) Measures and procedures for summoning immediate assistance when workplace violence occurs or is likely to occur; (c) Measures and procedures for workers to report incidents of workplace violence (d) Set out how the employer will investigate and deal with incidents or complaints of workplace violence	32.0.2 (1) and (2)	All of the required elements of a workplace violence program are delineated in the workplace violence policy. A number of recommendations have been made within the *2015 Workplace Violence Risk Assessment Report* for the strengthening of these measures and controls. **RECOMMENDATION:** That the Manager, Privacy and Occupational Health and Safety, as designated by the SLT continue to coordinate the implementation of the SLT-approved recommendations from the *2015 Workplace Violence Risk Assessment Report*.

1. Workplace Violence

	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE SEP 2015	REQUIREMENT	OHSA REFERENCE	PROGRESS NOTES AND/OR RECOMMENDATIONS FOR ONGOING COMPLIANCE
j.	◐	●	Provide instruction to the worker on the contents of the policy and program with respect to workplace violence.	32.0.5 (2)	In December 2014, 48 staff members were provided with De-escalating Aggressive Behaviour (Level 1) Training. In June 2015, 30+ Public Health Inspectors and Tobacco Enforcement Officers received Evade and Escape (Level 2) workplace violence prevention training. In November 2015, all Public Health Nurses and Family Home Visiting staff from the Health Unit's high-risk home visiting team (Healthy Babies, Healthy Children) will receive a workplace violence prevention training curriculum that has been customized for their work, based on the results from the *2015 Workplace Violence Risk Assessment Report*. **RECOMMENDATIONS**: 1. That the remainder of staff receive the appropriate level of training, based on the results from the *2015 Workplace Violence Risk Assessment Report*. 2. That an online learning module be adopted for inclusion in the catalogue of the Health Unit's new online Learning Management System.

2. Domestic Violence					
	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE 2015	REQUIREMENT	OHSA REFERENCE	CURRENT STATUS and RECOMMENDATIONS FOR ONGOING COMPLIANCE
a.	◐	●	If an employer becomes aware, or ought reasonably to be aware, that domestic violence that would likely expose a worker to physical injury may occur in the workplace, the employer shall take every precaution reasonable in the circumstances for the protection of the worker	32.0.4	In 2014, MLHU launched a new online employee injury/incident reporting tool that includes content to allow for the reporting of domestic violence and its potential impact on the workplace. This tool has been tested in that 4 reports were made in 2014. In each case, the Health Unit launched response protocols and developed safety plans for the protection of all workers. In order to meet the responsibilities within the act that require the employer to become aware or to "ought reasonably to be aware", MLHU was advised that this standard could be met by offering training to managers and staff that increases their capacity to recognize potential signs of domestic violence in the workplace. Therefore, in May 2013, MLHU offered voluntary training entitled: ***Neighbours, Friends and Families at Work.*** This training, funded by the government of Ontario and administered through the Centre for Research on Violence Against Women and Children at Western University consists of a 1-hour curriculum that provides instruction on recognizing the warnings signs of domestic violence and its potential to impact the workplace. Seventy-nine (79) of 336 active staff received that training. Seventeen (17) of 40 managers and directors received the corresponding 3-hour curriculum for managers entitled: ***Make it Our Business***. **RECOMMENDATIONS:** 1. That MLHU incorporate the Neighbours, Friends and Families at Work and Make it Our Business curricula into the Library Catalogue of the soon-to-be launched Learning Management System (LMS); and 2. That all managers and staff be encouraged to complete the training at least once.

3. Harassment					
	LEVEL OF COMPLIANCE JUNE 2013	LEVEL OF COMPLIANCE 2015	REQUIREMENT	OHSA REFERENCE	CURRENT STATUS and RECOMMENDATIONS FOR ONGOING COMPLIANCE
a.	◐	●	Prepare a written policy	32.0.1(b)	Complete.
b.	○	◐	Policy to be posted conspicuously in the workplace	32.0.1 (2)	Pending BOH/Governance Committee approval.
c.	○	●	Develop and maintain a program to implement the workplace harassment policy. Program must include: (a) Measures and procedures for workers to report incidents of workplace harassment; (b) Set out how the employer will investigate and deal with incidents and complaints of workplace harassment.	32.0.6.(1)	Program elements to be included in the revised policy draft.
d.	○	◐	Provide worker with information and instruction to the worker on the contents of the harassment policy and program	32.0.7 (a)	Pending BOH/Governance Committee approval.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. X

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 19

2014 YEAR END PERFORMANCE ON ACCOUNTABILITY INDICATORS

Recommendation

It is recommended that Report No. xx-xx re 2014 Public Health Performance Indicators Year-End Results be received for information.

Key Points

- The Health Unit has demonstrated strong performance on the 2014 Year-End Accountability Agreement performance indicators meeting or exceeding the targets on 7 out of 12 indicators.
- There are limitations to the performance indicator data and some indicators are used for monitoring and baseline purposes only.

Background

Under section 5.2 of the Accountability Agreement between the Middlesex-London Board of Health and the Ministry of Health and Long Term Care (MOHLTC), the Board has agreed to use best efforts to achieve agreed upon Performance Targets for the Indicators specified.

There are currently 28 indicators which are reported to the MOHLTC each year. These indicators reflect the program areas of food safety, water safety, infectious disease control, vaccine preventable disease, tobacco control, injury prevention, substance abuse and child health. For 12 of these indicators, a 2014 target was negotiated and agreed upon by both the Board and MOHLTC.

2014 Year-End Results

In August 2015, the MOHLTC published the Health Unit's 2014 year-end performance on 21 indicators. Of those 21 reported, 12 indicators were performance indicators and nine indicators were monitoring indicators. The 2015 Mid-Year Indicator Summary Table for Health Promotion Indicators and 2014 Year-End Indicator Summary Table for Health Protection Indictors provide a summary of these results (see Appendix A and Appendix B). The reporting period for the indicators is January 1, 2014 – December 31, 2014 unless otherwise noted.

Performance Indicators

Performance indicators include a limited set of indicators which reflect priority areas for performance improvement. These indicators are listed in the Public Health Funding and Accountability Agreement and have performance targets.

Of the 12 performance indicators reported, the Health Unit met or exceeded targets on seven.

Of the remaining five indicators, four were within 1% of their performance targets and the indicator for Baby-Friendly Initiative status was one step below the target due to delays on the part of the accrediting body. No additional compliance reporting was required for any of the 12 performance indicators.

Monitoring Indicators

Monitoring indicators are different from performance indicators and are used:

- to ensure that high levels of achievement are sustained;
- allow time for baseline levels of achievement and methods of measurement to be confirmed; and/or
- to monitor risks related to program delivery.

Monitoring indicators do not have performance targets.

Additional Comments

The data generated for indicators (4.4), (4.5) and (4.6) was collected from Panorama in January 2015. Significant issues which impact the integrity of this data are being addressed, however, have not yet been fully resolved. It is expected that 2015/2016 school year data will be accurate. As a monitoring indicator, it has not been subjected to additional verification by the MOHLTC and caution should be applied when interpreting these results.

Limitation in the Data and One-Time Funding

The indicators presented in this report are an incomplete representation of the work that public health units do to protect and promote the health of Ontario residents but have been chosen to:

- Reflect government priority;
- Describe some of the core business of public health;
- Measure Board of Health level outcomes as per the OPHS, 2008;
- Be responsive to change by action of the Board of Health;
- Provide opportunity for performance improvement;
- Have available data sources; and
- Be sensitive, timely, feasible, valid, reliable, understandable, and comparable.

The report also notes that health units operate under unique local factors and there is variability across health units such as demographics, geographic size, human resources, etc., that impact each health unit differently and caution is advised when comparing health unit performance.

This report was prepared by Mr. Jordan Banninga, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc
Medical Officer of Health

2015 MID-YEAR INDICATOR SUMMARY TABLE: HEALTH PROMOTION INDICATORS

Board of Health for the Middlesex-London Health Unit

August 7, 2015

#	Indicator	Baseline		2014 Year-End			2015					
							Mid-Year				Year-End	
		Reporting Period	Performance	Reporting Period	Performance	Target	Reporting Period	Numerator	Denominator	Performance	Target	Performance/ Compliance Required
1.1	% of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines*	2013 + 2014	TBD								N/A	N/A
1.2	Fall-related emergency visits in older adults aged 65 +	2009	5,826								N/A	N/A
1.3	% of youth (ages 12 - 18) who have never smoked a whole cigarette	2009 + 2010	83.6%								N/A	N/A
1.4	% of tobacco vendors in compliance with youth access legislation at the time of last inspection	2011	96.0%	January 1, 2014 - December 31, 2014	99.1%	≥90%	January 1, 2015- June 30, 2015	310	314	98.7%	≥90%	N/A
1.5	% of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)	2014	100%			N/A					100%	N/A
1.6	% tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA)	2013	92.6%	January 1, 2014 - December 31, 2014	99.7%	100%					100%	N/A
1.7	% tobacco retailers inspected for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA)	2013	97.2%	January 1, 2014 - December 31, 2014	99.7%	100%					100%	N/A
1.8	Oral health Assessment and Surveillance: % of schools screened	July 2013- June 2014	100.0%			N/A	July 1, 2014- June 30, 2015	123	123	100.0%	100%	TBD
	Oral health Assessment and Surveillance: % of all JK, SK and Grade 2 students screened in all publicly funded schools	July 2013- June 2014	92.9%			N/A	July 1, 2014- June 30, 2015	11410	11410	100.0%	100%	
1.9	Implementation status of NutriSTEP® Preschool Screen	2013	Initiation	January 1, 2014 - December 31, 2014	Preliminary	Preliminary	January 1, 2015- June 30, 2015	Intermediate			Intermediate	N/A
1.10	Baby-Friendly Initiative (BFI) Status	2011	Preliminary	January 1, 2014 - December 31, 2014	Advanced	Designated	January 1, 2015- June 30, 2015	Advanced			Designated	N/A

LEGEND:

(grey) No data/ no report required for specified reporting period.

N/A Not applicable for specified reporting period.

* Currently under review

TBD To be determined at a later period.

2014 YEAR-END INDICATOR SUMMARY TABLE: HEALTH PROTECTION INDICATORS

Board of Health for the Middlesex-London Health Unit

July 22, 2015

#	Indicator	2014						2015				
		Reporting Period	Numerator	Denominator	Performance	Target (%)/ Monitoring/ Baseline	Performance/ Compliance Report Required	Reporting Period	Numerator	Denominator	Performance	Target (%)**/ Monitoring/ Baseline
2.1	**% of high-risk food premises inspected once every 4 months while in operation**	January 1, 2014 - December 31, 2014	702	702	100.0%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
2.2	**% of moderate-risk food premises inspected once every 6 months while in operation**	January 1, 2014 - December 31, 2014	858	862	99.5%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
2.3	**% of Class A pools inspected while in operation**	January 1, 2014 - December 31, 2014	37	37	100.0%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
2.4	**% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection**	January 1, 2014 - December 31, 2014	N/A	N/A	N/A	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
2.5	**% of public spas inspected while in operation**	January 1, 2014 - December 31, 2014	49	49	100.0%	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
3.1	**% of personal services settings inspected annually**	January 1, 2014 - December 31, 2014	606	606	100.0%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
3.2	**% of suspected rabies exposures reported with investigation initiated within one day of public health unit notification**	January 1, 2014 - December 31, 2014	953	967	98.6%	Baseline	N/A	January 1, 2015 - December 31, 2015	--	--	--	100.0%
3.3	**% of confirmed gonorrhea cases where initiation of follow-up occurred within two business days**	January 1, 2014 - December 31, 2014	107	107	100.0%	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
3.4	**% of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case**	January 1, 2014 - December 31, 2014	23	24	95.8%	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
3.5	**% of salmonellosis cases where one or more risk factor(s) other than "Unknown" was entered into iPHIS**	January 1, 2014 - December 31, 2014	90	99	90.9%	Baseline	N/A	January 1, 2015 - December 31, 2015	--	--	--	90.0%
3.6	**% of confirmed gonorrhea cases treated according to recommended Ontario treatment guidelines**							January 1, 2015 - December 31, 2015	--	--	--	Baseline
4.1	**% of HPV vaccine wasted that is stored/administered by the public health unit**	September 1, 2014 - August 31, 2015	--	--	--	0.0%	TBD	September 1, 2015 - August 31, 2016	--	--	--	0.0%
4.2	**% of influenza vaccine wasted that is stored/administered by the public health unit**	September 1, 2014 - August 31, 2015	--	--	--	0.2%	TBD	September 1, 2015 - August 31, 2016	--	--	--	0.2%
4.3	**% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection**	January 1, 2014 - December 31, 2014	401	402	99.8%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
4.4	**% of school-aged children who have completed immunizations for hepatitis B**	2013 - 2014	2659	3987	66.7%	Monitoring	NO	2014 - 2015	--	--	--	Monitoring
4.5	**% of school-aged children who have completed immunizations for HPV**	2013 - 2014	1002	1938	51.7%	Monitoring	NO	2014 - 2015	--	--	--	Monitoring
4.6	**% of school-aged children who have completed immunizations for meningococcus**	2013 - 2014	2819	3987	70.7%	Monitoring	NO	2014 - 2015	--	--	--	Monitoring

LEGEND:

N/A Not Applicable
-- Data not yet collected
TBD To be determined
****** Target pending board approval and is subject to change

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. X

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 19

2014 YEAR END PERFORMANCE ON ACCOUNTABILITY INDICATORS

Recommendation

It is recommended that Report No. xx-xx re 2014 Public Health Performance Indicators Year-End Results be received for information.

Key Points

- The Health Unit has demonstrated strong performance on the 2014 Year-End Accountability Agreement performance indicators meeting or exceeding the targets on 7 out of 12 indicators.
- There are limitations to the performance indicator data and some indicators are used for monitoring and baseline purposes only.

Background

Under section 5.2 of the Accountability Agreement between the Middlesex-London Board of Health and the Ministry of Health and Long Term Care (MOHLTC), the Board has agreed to use best efforts to achieve agreed upon Performance Targets for the Indicators specified.

There are currently 28 indicators which are reported to the MOHLTC each year. These indicators reflect the program areas of food safety, water safety, infectious disease control, vaccine preventable disease, tobacco control, injury prevention, substance abuse and child health. For 12 of these indicators, a 2014 target was negotiated and agreed upon by both the Board and MOHLTC.

2014 Year-End Results

In August 2015, the MOHLTC published the Health Unit's 2014 year-end performance on 21 indicators. Of those 21 reported, 12 indicators were performance indicators and nine indicators were monitoring indicators. The 2015 Mid-Year Indicator Summary Table for Health Promotion Indicators and 2014 Year-End Indicator Summary Table for Health Protection Indictors provide a summary of these results (see Appendix A and Appendix B). The reporting period for the indicators is January 1, 2014 – December 31, 2014 unless otherwise noted.

Performance Indicators

Performance indicators include a limited set of indicators which reflect priority areas for performance improvement. These indicators are listed in the Public Health Funding and Accountability Agreement and have performance targets.

Of the 12 performance indicators reported, the Health Unit met or exceeded targets on seven.

Of the remaining five indicators, four were within 1% of their performance targets and the indicator for Baby-Friendly Initiative status was one step below the target due to delays on the part of the accrediting body. No additional compliance reporting was required for any of the 12 performance indicators.

Monitoring Indicators

Monitoring indicators are different from performance indicators and are used:

- to ensure that high levels of achievement are sustained;
- allow time for baseline levels of achievement and methods of measurement to be confirmed; and/or
- to monitor risks related to program delivery.

Monitoring indicators do not have performance targets.

Additional Comments

The data generated for indicators (4.4), (4.5) and (4.6) was collected from Panorama in January 2015. Significant issues which impact the integrity of this data are being addressed, however, have not yet been fully resolved. It is expected that 2015/2016 school year data will be accurate. As a monitoring indicator, it has not been subjected to additional verification by the MOHLTC and caution should be applied when interpreting these results.

Limitation in the Data and One-Time Funding

The indicators presented in this report are an incomplete representation of the work that public health units do to protect and promote the health of Ontario residents but have been chosen to:

- Reflect government priority;
- Describe some of the core business of public health;
- Measure Board of Health level outcomes as per the OPHS, 2008;
- Be responsive to change by action of the Board of Health;
- Provide opportunity for performance improvement;
- Have available data sources; and
- Be sensitive, timely, feasible, valid, reliable, understandable, and comparable.

The report also notes that health units operate under unique local factors and there is variability across health units such as demographics, geographic size, human resources, etc., that impact each health unit differently and caution is advised when comparing health unit performance.

This report was prepared by Mr. Jordan Banninga, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc
Medical Officer of Health

2015 MID-YEAR INDICATOR SUMMARY TABLE: HEALTH PROMOTION INDICATORS

Board of Health for the Middlesex-London Health Unit

August 7, 2015

#	Indicator	Baseline		2014 Year-End			2015					
							Mid-Year				Year-End	
		Reporting Period	Performance	Reporting Period	Performance	Target	Reporting Period	Numerator	Denominator	Performance	Target	Performance/ Compliance Required
1.1	% of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines*	2013 + 2014	TBD								N/A	N/A
1.2	Fall-related emergency visits in older adults aged 65 +	2009	5,826								N/A	N/A
1.3	% of youth (ages 12 - 18) who have never smoked a whole cigarette	2009 + 2010	83.6%								N/A	N/A
1.4	% of tobacco vendors in compliance with youth access legislation at the time of last inspection	2011	96.0%	January 1, 2014 - December 31, 2014	99.1%	≥90%	January 1, 2015- June 30, 2015	310	314	98.7%	≥90%	N/A
1.5	% of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)	2014	100%			N/A					100%	N/A
1.6	% tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA)	2013	92.6%	January 1, 2014 - December 31, 2014	99.7%	100%					100%	N/A
1.7	% tobacco retailers inspected for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA)	2013	97.2%	January 1, 2014 - December 31, 2014	99.7%	100%					100%	N/A
1.8	Oral health Assessment and Surveillance: % of schools screened	July 2013- June 2014	100.0%			N/A	July 1, 2014- June 30, 2015	123	123	100.0%	100%	TBD
	Oral health Assessment and Surveillance: % of all JK, SK and Grade 2 students screened in all publicly funded schools	July 2013- June 2014	92.9%			N/A	July 1, 2014- June 30, 2015	11410	11410	100.0%	100%	
1.9	Implementation status of NutriSTEP® Preschool Screen	2013	Initiation	January 1, 2014 - December 31, 2014	Preliminary	Preliminary	January 1, 2015- June 30, 2015	Intermediate			Intermediate	N/A
1.10	Baby-Friendly Initiative (BFI) Status	2011	Preliminary	January 1, 2014 - December 31, 2014	Advanced	Designated	January 1, 2015- June 30, 2015	Advanced			Designated	N/A

LEGEND:

(grey)	No data/ no report required for specified reporting period.
N/A	Not applicable for specified reporting period.
*	Currently under review
TBD	To be determined at a later period.

2014 YEAR-END INDICATOR SUMMARY TABLE: HEALTH PROTECTION INDICATORS

Board of Health for the Middlesex-London Health Unit

July 22, 2015

#	Indicator	2014						2015				
		Reporting Period	Numerator	Denominator	Performance	Target (%)/ Monitoring/ Baseline	Performance/ Compliance Report Required	Reporting Period	Numerator	Denominator	Performance	Target (%)**/ Monitoring/ Baseline
2.1	% of high-risk food premises inspected once every 4 months while in operation	January 1, 2014 - December 31, 2014	702	702	100.0%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
2.2	% of moderate-risk food premises inspected once every 6 months while in operation	January 1, 2014 - December 31, 2014	858	862	99.5%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
2.3	% of Class A pools inspected while in operation	January 1, 2014 - December 31, 2014	37	37	100.0%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
2.4	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection	January 1, 2014 - December 31, 2014	N/A	N/A	N/A	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
2.5	% of public spas inspected while in operation	January 1, 2014 - December 31, 2014	49	49	100.0%	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
3.1	% of personal services settings inspected annually	January 1, 2014 - December 31, 2014	606	606	100.0%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
3.2	% of suspected rabies exposures reported with investigation initiated within one day of public health unit notification	January 1, 2014 - December 31, 2014	953	967	98.6%	Baseline	N/A	January 1, 2015 - December 31, 2015	--	--	--	100.0%
3.3	% of confirmed gonorrhea cases where initiation of follow-up occurred within two business days	January 1, 2014 - December 31, 2014	107	107	100.0%	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	Monitoring
3.4	% of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case	January 1, 2014 - December 31, 2014	23	24	95.8%	Monitoring	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
3.5	% of salmonellosis cases where one or more risk factor(s) other than "Unknown" was entered into iPHIS	January 1, 2014 - December 31, 2014	90	99	90.9%	Baseline	N/A	January 1, 2015 - December 31, 2015	--	--	--	90.0%
3.6	% of confirmed gonorrhea cases treated according to recommended Ontario treatment guidelines							January 1, 2015 - December 31, 2015	--	--	--	Baseline
4.1	% of HPV vaccine wasted that is stored/administered by the public health unit	September 1, 2014 - August 31, 2015	--	--	--	0.0%	TBD	September 1, 2015 - August 31, 2016	--	--	--	0.0%
4.2	% of influenza vaccine wasted that is stored/administered by the public health unit	September 1, 2014 - August 31, 2015	--	--	--	0.2%	TBD	September 1, 2015 - August 31, 2016	--	--	--	0.2%
4.3	% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection	January 1, 2014 - December 31, 2014	401	402	99.8%	100.0%	NO	January 1, 2015 - December 31, 2015	--	--	--	100.0%
4.4	% of school-aged children who have completed immunizations for hepatitis B	2013 - 2014	2659	3987	66.7%	Monitoring	NO	2014 - 2015	--	--	--	Monitoring
4.5	% of school-aged children who have completed immunizations for HPV	2013 - 2014	1002	1938	51.7%	Monitoring	NO	2014 - 2015	--	--	--	Monitoring
4.6	% of school-aged children who have completed immunizations for meningococcus	2013 - 2014	2819	3987	70.7%	Monitoring	NO	2014 - 2015	--	--	--	Monitoring

LEGEND:

N/A Not Applicable
-- Data not yet collected
TBD To be determined
****** Target pending board approval and is subject to change

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 55-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 17

SUMMARY INFORMATION REPORT FOR SEPTEMBER 2015

Recommendation

It is recommended that Report No. 55-15 re Information Summary Report for September 2015 and the attached Appendices be received for information.

Key Points

- The Naloxone Program is a finalist for the Collaboration Award from the Pillar Nonprofit Network. This program distributes the antidote to opioid overdose to people who participate in our harm reduction programs, and is delivered in partnership with several local agencies.
- The Middlesex-London Health Unit provided input to the Ministry of Health and Long-Term Care (MOHLTC) on the proposed regulations that will be drafted to support the amendments to the *Smoke-Free Ontario Act* *(SFOA)* and the enactment of the *Electronic Cigarette Act* *(ECA)*.
- Harvest Bucks, a farmers' market vegetable and fruit voucher program administered by the Health Unit, had a successful third year and was supported by strong community partnerships. Adding a Middlesex County farmers' market location for 2016 is a program priority.
- Community physical activity challenges can be effective in motivating individuals to become physically active. The inMotion™ Community Challenge, happening October 1 to 31st, 2015 with links to tips, information, the tracker and the app found on www.inmotion4life.ca.
- The Health Unit continues to work collaboratively with local and provincial partners to engage at-risk youth and other priority populations in community-based programs and research designed to increase food literacy and improve healthy food preparation among those at risk for poor health.

Background

This report provides a summary of information from a number of Health Unit programs. Appendices and links will provide further details, and additional information is available on request.

Pillar Award Nomination for Naloxone Program

On September 2nd, The Naloxone Program was announced as a finalist for the 2015 Pillar Community Innovation award in the Community Collaboration category, which recognizes outstanding examples of collaboration within our community. The announcement is a reflection of the dedication, hard work and efforts of the Middlesex London Health Unit, Regional HIV/AIDS Connection, London Intercommunity Health Centre and the London Area Network of Substance Users. The Naloxone Program provides pocket-sized overdose prevention kits and training to people who are at risk of opioid overdose. To date, over 80 people have received training and kits, resulting in at least 6 successful overdose reversals, saving the valuable lives of the recipients. Although several other Ontario communities have implemented naloxone distribution programs, the partnership nature of The Naloxone Program in London and Middlesex is unique. Leveraging

existing resources has maximized capacity and reach of the program and availability of naloxone for people who need it most.
The Pillar Community Innovation Awards will be announced and presented on November 25th at the London Convention Centre.

Input Provided to the MOHLTC on Proposed Regulations for *SFOA* and *ECA*

The passing of the *Making Healthier Choices Act* enabled the enactment of the *Electronic Cigarettes Act (ECA)* and amendments to the *Smoke-Free Ontario Act (SFOA)*. Regulations are now being drafted by the MOHLTC to support the enforcement of the *ECA*, and regulatory amendments are being drafted for Regulation 48/06 under the *SFOA*. The Health Unit provided input to the MOHLTC on the proposed regulations attached to this report as Appendix A (Comments on the Proposed Changes to Ontario Regulation 48/06 re: *Smoke-Free Ontario Act*) and Appendix B (Comments on the Proposed Changes to Ontario Regulation under the Electronic Cigarettes Act).

Harvest Bucks

Based on data collected to develop the *Eating Well with Canada's Food Guide* recommendations, 89% of Middlesex-London residents do not eat enough fruits and vegetables. Harvest Bucks, a farmers' market voucher program administered by the Health Unit, helps to increase local access to and consumption of fruits and vegetables. In 2014, $17,738 Harvest Bucks were distributed by 17 community programs to 536 London households with $13,014 (73%) redeemed. Attached to this report as Appendix C is the Harvest Bucks 2014 infographic. Adding a Middlesex County farmers' market location is a program priority; however, to ensure Harvest Bucks are utilized, participating markets must be located in communities with organizations that have an interest in purchasing or applying for sponsored Harvest Bucks for use within community-based programming. The participating market manager or delegate must also fulfill certain requirements related to vendor education and reimbursement. We have had communication through our community partners with the Strathroy Farmers' Market, given its ideal location, and are hopeful that the Market will commit to participating for the 2016 operating year.

In Motion Community Partnership

In 2013 and 2014, the Middlesex-London *in motion*™ Community Partnership implemented the i*n* motion™ Community Challenge. The Challenge encourages residents to be physically active and provides them the opportunity to track their physical activity minutes while being a part of a larger community initiative. The 2015 in Motion™ Community Challenge will be bigger and better. This year's objective is to increase the number of participants taking part in the Challenge and to encourage sustained physical activity. Multi-sectoral community partners are contributing to a variety of promotional strategies and grassroots mobilization that will enhance the 2015 Challenge message. Physical inactivity continues to be a public health concern in our community. The in Motion™ Community Challenge is one strategy in a comprehensive approach aimed at increasing the awareness of our community about the importance of physical activity in the prevention of disease and promotion of health. Watch a television promotion for the 2015 Challenge.

Food Literacy Programming Remains a Priority within Public Health

The Health Unit continues to work collaboratively with a number of residential group homes for at-risk youth delivering food literacy activities. Notably, ***"My Balanced Plate"*** (attached as Appendix D), a resource to assist group home staff and residents to achieve healthy eating goals, was created with direct input and feedback from youth in care and staff from a local group home. The purpose of this resource is to provide an active daily reminder to youth in care (aged 14-17 years) of the number of servings required from each food group, examples of appropriate serving sizes and healthy snacks, and a gentle prompt to increase physical activity and reduce sedentary activity daily. Provincially, Cycle 4 funding from Public Health Ontario's Locally Driven Collaborative Projects has been directed towards the creation of a reliable and validated measurement tool to assess food literacy among a defined high risk population in Ontario. Twenty-six public health units, including the Middlesex-London Health Unit, are participating in this research project. Dr. Heather Thomas, R.D., Public Health Dietitian, represents the Health Unit on the project and is a member of the core research team directing the development and implementation of this project. Progress will be provided to the Board of Health through future reports.

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

Comments on the Proposed Changes to Ontario Regulation 48/06 re: *Smoke-Free Ontario Act*
Middlesex-London Health Unit

Linda Stobo, Manager Chronic Disease Prevention and Tobacco Control

Date: Wednesday August 26th, 2015

To: Martha Greenburg
Assistant Deputy Minister
Health Promotion Division
Ministry of Health and Long-Term Care

Jackie Wood
Acting Director
Strategic Initiatives Branch
Ministry of Health and Long-Term Care

The following comments are from the Middlesex-London Health Unit concerning the proposed amendments to Regulation 48/06 under the *Smoke-Free Ontario Act.* Our comments are based on the summary information posted in the absence of actual regulatory language.

Re: Definitions

We would recommend that all terms that provide authority and/or that may be used for compliance and enforcement are defined in the regulations to provide clarity.

Comments Related to "Flavouring Agent" and Exemptions

Define ***"flavouring agent"*** in such a way that the prohibition of flavoured tobacco products applies to "a tobacco product that has a flavour or aroma other than that of tobacco". Tobacco products should only taste like tobacco; any flavours or additives like wine, rum, whiskey, cherry, vanilla or any other flavour should not be permitted and the Regulations need to take a comprehensive and prohibitive approach, like the approach embodied in Quebec's Bill 44, *An Act to Bolster Tobacco Control.* Use of the word "distinguishing", as outlined in the summary comments posted, may infer that only characterizing candy, fruit or other such flavours are to be prohibited from sale, creating a loophole for the tobacco industry to create and package tobacco products like "crisp blend" and "rich blend", that tell users that these products are not simply products with a basic tobacco taste. The prohibition of flavoured products needs to apply to "all tobacco products that have a flavour or aroma other than that of tobacco".

The menthol ban exemption should be revoked in January 2016, and menthol should be captured within the definition used for "flavouring agent" as described above. The menthol ban should come into effect at the same time as the ban on other flavours and additives. The most recent Youth Smoking Survey results indicate that of the Ontario youth who use a flavoured tobacco product, approximately 19,400 use menthol products.

Remove the exemption for cigarettes that contain only a flavouring agent that imparts a flavour or aroma of "clove", and "clove" should be captured within the definition used for "flavouring agent", and the prohibition of sale should come into effect January 2016.

Remove the exemption for all flavoured pipe tobacco products from the prohibition on the sale of flavoured tobacco products. New Brunswick took a comprehensive and progressive approach to the ban on the sale of flavoured tobacco products. If the Smoke-Free Ontario strategy is committed to comprehensive tobacco control and intends to be successful in preventing initiation of tobacco use, regardless of age, and promoting cessation attempts by those currently using tobacco, a comprehensive flavour ban on all forms of tobacco products – cigarettes, cigars, pipes, cigarillos and smokeless - is required. Tobacco products should taste like tobacco, and not contain additives or flavourings that mask the taste and aroma of tobacco with wine, port, rum or whiskey flavours.

Remove the exemption from the flavour ban for cigars. The language proposed for the exclusion of cigars from the prohibition on the sale of flavoured tobacco is reminiscent of language that was enacted for the flavour ban on cigarillos in 2010. The challenges that Health Units faced with enforcement, the increased cost of enforcement, and the readiness of the tobacco industry to circumvent the legislation through the manufacturing and distribution of slightly larger, unfiltered "little cigars" provides a prophetic view of the future potential enforcement challenges that Health Units will face if the cigar exemption, as proposed, goes forward. The industry already has 6g+ cigars flavoured with grape and chocolate available for sale. A comprehensive ban on the sale of all flavoured tobacco products would be more cost effective to implement and enforce across the province, with greater likelihood of consistent application of the legislation and lesser likelihood that the tobacco industry will counter the health protective measures that the proposed flavour ban regulations intend to provide.

Flavouring agent and tobacco products should be defined by way of Regulation that prohibits the sale of flavoured hookah or shisha products.

The Middlesex-London Health Unit recommends that Ontario prohibit the use of all flavours and additives for all forms of tobacco products, including hookah/shisha products so that products that contain tobacco taste only like tobacco, without any other aroma, flavour or taste.

Comments Related to the Prohibition of Use of Hookah/Shisha

The Middlesex-London Health Unit strongly recommends that a province-wide prohibition on the use of hookah/shisha waterpipe smoking wherever smoking is banned under the *Smoke- Free Ontario Act*

be considered. This opportunity was adopted by New Brunswick (effective July 1, 2015), Nova Scotia (effective May 31, 2015) and Prince Edward Island (introduced June 9, 2015).

Comments Related to "Owner" and Automatic Prohibitions

"***Owner***" is the terminology used in the legislation under Section 16, and **"owner" or "occupier of a place"** is used in the draft regulation summary under the section titled "**Automatic Prohibition Signs**". Within the regulation, both "owner" and "occupier of a place" should be clearly defined or clarified to limit the number of challenges that Health Units and the Ministry of Health and Long-Term Care face when issuing Automatic Prohibition orders. Those who are selling tobacco products within a place that contravenes the legislation should be held accountable for their actions. In addition, those tobacco retailers that routinely contravene the legislation should be held accountable for their actions, regardless of the location of those offences. Owners of a tobacco retail establishment with multiple registered convictions should not be allowed to circumvent Section 16 of the legislation through relocation to a different address.

The Middlesex-London Health Unit recommends that Ontario enact firm language regarding vendor compliance histories, ownership and those who own, occupy or operate the place where tobacco is sold to prevent tobacco retailers from circumventing obligations and consequences under the *Act*.

Comments Related to Hospital and Provincial Government Buildings

In principle, the Middlesex-London Health Unit supports the Ministry's intention to prohibit smoking on outdoor grounds of public hospitals, private hospitals and psychiatric facilities in Ontario. Within Middlesex-London, St. Joseph's Healthcare (SJHC) has already enacted their own 100% smoke-free grounds policy and London Health Sciences Centre (LHSC) has already enacted their own policy which limits smoking to outdoor designated areas, however, both have had mixed success.

In both cases, there is not enough hospital administration and senior leader oversight reinforcing the smoke-free provisions. Despite their policies that extend protections beyond the current provisions of the *Smoke-Free Ontario Act*, smoking within 9 metres of the entrance ways still occurs on a fairly routine basis and the amount of enforcement and surveillance required to bring the hospital grounds into compliance with the *Smoke-Free Ontario Act* exceeds the Health Unit's enforcement capacity. The smoke-free policies enacted by the hospitals do not have adequate enforcement supports built into the implementation plan. If the province prohibits smoking on hospital grounds, or permits designated smoking areas on hospital grounds as a phased approach to smoke-free, several conditions must be met:

- Provincial leadership is required to work with and promote any new smoking restrictions with hospital administrations across the province. Hospital administration must be directed by the Ministry of Health and Long-Term Care to properly oversee management of either the designated smoking areas or the 100% smoke-free grounds provisions, with accountability agreements, hospital accreditation, and funding model structures tied to hospital administration's obligations to

ensure compliance with the smoke-free provisions.

- The Ministry must convey to Ontario's hospitals that the implementation of a hospital-wide, evidence-based smoking cessation program is mandatory and part of the hospital's provision of healthcare services.

- Non-compliance on the part of hospital staff must be handled internally and swiftly by hospital administration through discipline and codes of conduct policies.

- The designated areas need to be prescribed by Regulation. The current provisions that are prescribed by regulation for the establishment of controlled smoking areas would provide an excellent model, and if the designated smoking areas do not meet the prescribed Regulations, then the hospital would be subject to a charge under the law. Specifically, designated smoking areas on hospital property should:

    - Be set up far enough away from any point in which second-hand smoke can enter the hospital either through doorways, windows or air intake valves.

    - Any approved DSA should only have a roof and no more than 2 walls, and should not be adjacent to an area where food or drink is served, sold or offered for consumption.

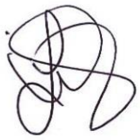
    - The number of designated areas should be limited to one.

    - Any designated smoking area must have extensive health warning and smoking cessation support signage.

    - The use of designated smoking areas should be limited to patients only; use of the designated area by staff and visitors should be a chargeable offence.

    - A detailed enforcement protocol should be submitted to the Ministry including the provision of training to hospital security staff and appropriate security staffing levels to support compliance.

If you wish to discuss further any of the considerations provided, please do not hesitate to contact us.



Linda Stobo, B.Sc., MPH (Candidate)
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Comments on the Proposed Changes to Ontario Regulation under the *Electronic Cigarettes Act*
Middlesex-London Health Unit

Linda Stobo, Manager Chronic Disease Prevention and Tobacco Control

Date: Thursday August 27th, 2015

To: Martha Greenburg
Assistant Deputy Minister
Health Promotion Division
Ministry of Health and Long-Term Care

Jackie Wood
Acting Director
Strategic Initiatives Branch
Ministry of Health and Long-Term Care

The following comments are from the Middlesex-London Health Unit concerning the proposed amendments to Ontario Regulation under the *Electronic Cigarettes Act.* Our comments are based on the summary information posted in the absence of actual regulatory language.

Re: Definitions

We would recommend that all terms that provide authority and/or that may be used for compliance and enforcement are defined in the regulations to provide clarity.

Comments Related to "Flavoured Electronic Cigarette" and Nicotine E-Juice

The inaction of Health Canada in enforcing the illegal marketing and sale of nicotine electronic cigarette (e-cigarette) juice (nicotine e-juice) in stores across Ontario is contributing to a disregard of the federal law by suppliers, distributors and retailers. The subsequent increased availability of these new commercially-branded, marketed and visibly-displayed nicotine e-juice bottles is misleading retailers and their customers regarding the legal status and safety of the products. By Regulation, define "***flavoured electronic cigarette***" to include electronic cigarettes and its component parts that contain nicotine.

Section of the Act:
Section 8. No person shall sell or offer to sell a flavoured electronic cigarette that has been prescribed as prohibited at retail or for subsequent sale at retail or distribute or offer to distribute it for that purpose.

Based on the current definition of electronic cigarette and the opportunity to regulate nicotine e-juice through the definition of "flavoured" or "flavouring agent", the need for active enforcement against the illegal sale of e-cigarette juice containing nicotine will be met, protecting children, youth and adult consumers from a product that lacks appropriate manufacturing and quality standards at the present time.

The Middlesex-London Health Unit recommends that Ontario define "flavoured electronic cigarette" to include electronic cigarettes and its component parts <u>that contain nicotine</u>, and to continue to monitor the evidence regarding the use of flavours within e-juice and how flavourings may impact e-cigarette use by young people.

<u>**Comments Related to Retailer Registration with the Local Medical Officer of Health**</u>

Under Section 5(1)7 of the *E-Cigarette Act,* there exists the opportunity for mandatory registration with the local Medical Officer of Health by those who plan the retail selling of electronic cigarettes and its component parts. The "prescribed place or a place that belongs to a prescribed class" could be defined by Regulation as a place that <u>has not</u> registered with the local Medical Officer of Health as a retail outlet that intends to sell electronic cigarettes and its component parts. Currently, these devices are available for sale in many locations, including convenience stores, specialized vape stores, butcher shops, gift stores, clothing stores and those stores that specialize in the drug culture. Health Units are going to have much difficulty in creating a comprehensive and accurate listing of e-cigarette and e-juice vendors within their jurisdictions. The requirement to register with the local Medical Officer of Health, like the approach taken under the *Skin Cancer Prevention Act* was very helpful to support a smooth implementation of new legislation. By including this requirement, selling electronic cigarettes at retail from a prescribed place would be a chargeable offence; therefore, motivation to register would be high, and enforcement would be more consistent and cost-effective for public health units.

The Middlesex-London Health Unit recommends that Ontario prescribe by way of Regulation that registration with the local Medical Officer of Health as a retail outlet of electronic cigarettes and its components parts become mandatory.

<u>**Comments Related to "Owner" and Automatic Prohibitions**</u>

"***Commercial***" and "***person*"** is the terminology used within the legislation. The Middlesex-London Health Unit would recommend that consideration be given to also define by way of Regulation, the **"owner" or "occupier of a place"** that sells electronic cigarettes and its component parts so that there is operator obligation on the appropriate sale and distribution of these devices. This language would strengthen the mandatory registration process, proposed in the above section. Further, the Middlesex-London Health Unit would recommend that re-consideration be given to the inclusion of language that supports the issuing of automatic prohibition orders for those owners or occupiers of a place that routinely contravene Section 2

and 3 of the *Act*. Those who are selling electronic cigarettes and component parts within a place that contravenes the legislation should be held accountable for their actions.

The Middlesex-London Health Unit recommends that Ontario enact firm language regarding vendor compliance histories, ownership and those who own, occupy or operate the place where electronic cigarettes and component parts are sold to prevent retailers from circumventing obligations and consequences under the *Act*.

Comments Related to Required Signage

The Middlesex-London Health Unit recommends that only one sign be required for posting within retailers regarding the prohibition on selling or supplying electronic cigarettes to minors. The sign must:

- Be 18 centimetres in height and 35 centimetres in width;
- Have a yellow background with black text;
- Read "it is illegal to sell or supply electronic cigarettes to anyone under 19 years of age" in English, or "il est illégal de vendre ou de fournir des cigarettes électroniques a des personne de moins de 19 ans" in French.

The second prescribed sign proposed within the summary comments would act more as a promotional tool or indirect promotion to youth and young people than its intended use as a tool to help minimize sales to minors. It is with these considerations in mind that New Brunswick adopted new regulations on June 30, 2015 to require a single "sales to minors" sign facing the store employee only.

The Middlesex-London Health Unit recommends that the only signage that should be required in retail premises selling e-cigarettes is ID signage located behind the counter that faces the retail clerks, along with the other signage required for prohibition of use of e-cigarettes within enclosed public places, workplaces and other locations as prescribed.

Comments Related to Packaging Requirements

Under Section 7 of the *Electronic Cigarette Act*, "no person shall sell or offer to sell electronic cigarettes at retail or for subsequent sale at retail or distribute or offer to distribute electronic cigarettes for that purpose unless the electronic cigarettes are packaged in accordance with the regulations." Currently, there are no federal manufacturing and packaging requirements for electronic cigarettes and e-juice; therefore, the Middlesex-London Health Unit recommends that Ontario prescribe by way of Regulations packaging requirements. Additional information that supports this recommendation is being provided by way of including Report No. 036-15 "The Need for Enforcement and Mandatory Safety Standards for E-Cigarette Juice Containing Nicotine" that was presented to the Middlesex-London Board of Health in June. After a full

discussion, it was moved by Mr. Studenny, seconded by Ms. Poole, and carried, that the Board of Health:

1. Endorse Report No. 036-15 re The Need For Enforcement And Mandatory Safety Standards For E-Cigarette Juice Containing Nicotine.
2. Recommend that Health Canada actively enforce legislation against the illegal import, advertising and sale of e-cigarette juice containing nicotine, and conduct mandatory inspections of e-cigarette and e-juice manufacturers regarding safety standards, quality controls and packaging requirements, by sending a letter to the Prime Minister of Canada and the federal Minister of Health, copied to local Members of Parliament, and by asking staff to draft a motion to take to the next Association of Local Public Health Agencies Annual General Meeting for consideration, and further
3. Send a letter to the Advisory Committee on Health Delivery and Human Resources (with a copy sent to all local Members of Provincial Parliament) to seek its support in advocating to the federal Government on the E-Cigarette Juice Containing Nicotine.

Given the lack of federal action on this important consumer safety issue, the Middlesex London Health Unit recommends that Ontario prescribe by way of Regulations under the *Electronic Cigarette Act* strict packaging requirements that would currently fill the void that exists for the manufacturing and distribution of electronic cigarettes and component parts.

If you wish to discuss further any of the considerations provided, please do not hesitate to contact us.

Linda Stobo, B.Sc., MPH (Candidate)
Chronic Disease Prevention and Tobacco Control Manager
Email: linda.stobo@mlhu.on.ca
Tel: (519) 663-5317 ext. 2388

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 036-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 June 18

THE NEED FOR ENFORCEMENT AND MANDATORY SAFETY STANDARDS FOR E-CIGARETTE JUICE CONTAINING NICOTINE

Recommendations

It is recommended that the Board of Health:

1. ***Endorse Report No. 036-15 re The Need For Enforcement And Mandatory Safety Standards For E-Cigarette Juice Containing Nicotine.***
2. ***Recommend that Health Canada actively enforce legislation against the illegal import, advertising and sale of e-cigarette juice containing nicotine, and conduct mandatory inspections of e-cigarette and e-juice manufacturers regarding safety standards, quality controls and packaging requirements, by sending a letter to the Prime Minister of Canada and the federal Minister of Health, copied to local Members of Parliament, and by asking staff to draft a motion to take to the next Association of Local Public Health Agencies Annual General Meeting for consideration.***

Key Points

- Nicotine is a highly addictive and toxic substance which has the potential to cause acute adverse health effects and which can be lethally poisonous at high doses.
- Electronic cigarettes ("e-cigarettes") containing nicotine and their accompanying nicotine solutions ("e-juice") fall under the federal *Food and Drugs Act*, requiring authorization prior to importation, advertising and sale.
- To date, no nicotine-containing e-cigarette or e-juice has been approved by Health Canada and therefore persons importing, advertising or selling such products are acting in contravention of the *Food and Drugs Act.*
- Despite the current position of Health Canada, e-juice containing nicotine is increasingly visible and available in the retail market, presenting a number of new public health risks, including nicotine poisoning.

Background

Electronic nicotine delivery devices, known more commonly as e-cigarettes are battery-powered devices that deliver nicotine, flavourings and other chemicals through the inhalation of a vapour. E-cigarette refill liquids, which may or may not contain nicotine, are referred to as "e-juice". A 2011 survey found that 93% of Canadian e-cigarette users use nicotine e-juice with their devices. Long-term studies on the safety of the devices and their efficacy as a cessation aid are not available. Despite the lack of evidence, e-cigarettes are widely available for sale at pharmacies, grocery stores, convenience stores and gas stations; currently, 70% of Middlesex-London tobacco retailers sell the devices and/or the accompanying e-juice. As global e-cigarette sales are forecasted to reach $3 billion by the end of 2015, London has seen an increase in the number of e-cigarette specialty stores ("vape stores") opening for business over the past two years. Such stores exclusively sell electronic smoking equipment and accessories, including e-juice. Worldwide, there are now over 450 brands being marketed in over 7000 flavours.

E-juice is manufactured predominantly in China and bottles are not subject to any legal safety standards for labelling or packaging such as those imposed on the pharmaceutical industry in the production of medication. In 2009, Health Canada issued a Public Notice Advisory to Canadians, attached as Appendix A,

and a notice to stakeholders, attached as Appendix B, instructing persons importing, advertising or selling e-cigarette products in Canada to stop doing so immediately as such activity contravened the *Food and Drugs Act*. The Notice outlined the legal requirement for product market authorization and advised Canadians not to purchase or use the products. Middlesex-London Health Unit Tobacco Enforcement Officers (TEO) distributed this Notice to all tobacco retailers in 2011 due to an increase in calls from tobacco retailers and members of the public. The sale of nicotine e-juice in retail shops in Middlesex-London, primarily flea markets, kiosks in shopping centres and specialty vape stores, were referred by TEOs to Health Canada's Health Products and Food Branch Inspectorate for investigation. A template acknowledgement letter was received by the Health Unit. Every premise reported to Health Canada continues to illegally sell nicotine juice.

Ontario's *Electronic Cigarette Act, 2015* regulates the use of e-cigarettes in places where smoking is prohibited, and imposes sales and advertising restrictions, as described in Report No. 040-15; however, enforcement of the sale of nicotine e-juice lies solely with Health Canada. Failure of Health Canada to actively enforce contraventions of the *Food and Drugs Act* is contributing to the increased availability, marketing and sale of illegal nicotine products.

Public Health Concerns

With an estimated median lethal dose between 1 and 13 mg per kg of body weight, 1 teaspoon (5 ml) of a 1.8% nicotine solution could be lethal to a 90-kg person. A 20ml bottle of e-juice contains on average 360 mg of nicotine, several times the lethal dose. Incidents of nicotine poisoning have risen substantially, especially in the United States. In Canada, the risks associated with unregulated nicotine e-juice compositions include variable concentrations of chemicals and nicotine, dangerous nicotine dose levels or undisclosed ingredients. According to laboratory testing commissioned by Health Canada, approximately one-half of all products labelled as nicotine-free contained nicotine. In addition, unsealed, leaky or non-child proof bottles containing a potent poison is a concern. The rising prevalence of e-cigarette use is also a concern; use is highest among young people with one in five youth (aged 15-19) and young adults (aged 20-24) having ever tried an e-cigarette. Prevalence varies across provinces; among youth aged 15-19, ever use ranged from 15% in Ontario to twice that (31%) in Quebec. The use of flavourings and lifestyle marketing tactics mimic tobacco industry advertising and promotional practices. All main transnational tobacco companies are now selling e-cigarettes, and are investing hundreds of millions of dollars into product development and manufacturing.

Local Concerns

During recent inspections in London, TEOs found that all nine retail shops which mainly sell drug paraphernalia also sell e-cigarettes and nicotine e-juice. The seven known specialty vape stores in London also sell nicotine e-juice. In addition, TEOs are finding that e-cigarette displays have become more visible and elaborate in tobacco retailer premises. Nicotine e-juice is now prominently displayed on point of sale shelving and countertops of many tobacco retailers in Middlesex-London. Although some still appear to be from "independent" distributors, many are Vapur brand. The Vapur brand e-juice bottles on display are labelled to contain nicotine and participating storeowners have been given a document titled "About Vaporizers and E-Juice", attached as Appendix C. The information sheet is issued by Casa Cubana, the umbrella company of Vapur, who is also an importer and distributor of cigars and tobacco accessories. The document's wording encourages retailers to sell their nicotine juice to customers. The TEOs expressed concern that tobacco retailers may have difficulty understanding the high-literacy language used in the communication, especially for those whom English is a second language. The Casa Cubana document advises retailers that e-cigarettes containing nicotine are "a political and regulatory grey area in Canada" with an "arguable legal status," and retailers are advised to not comply with Health Canada's Advisory Notice.

Next Steps

The inaction of Health Canada in enforcing legislation banning marketing and sale of nicotine juice in stores is contributing to a disregard of the federal law by suppliers, distributors and retailers. The subsequent increased availability of these new commercially-branded, marketed and visibly-displayed nicotine e-juice bottles is misleading retailers and their customers regarding the legal status and safety of the products. There is a need for active enforcement against the illegal import, advertising and sale of e-cigarette juice containing nicotine, and manufacturers need to be subjected to mandatory inspections regarding safety standards, quality controls and packaging requirements to protect children, youth and adult consumers.

This report was prepared by Ms. Leila Davis, Tobacco Enforcement Officer and Ms. Linda Stobo, Chronic Disease Prevention and Tobacco Control Manager.

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, 9, 11 and 13

Canadä

Health Canada Advises Canadians Not to Use Electronic Cigarettes

Advisory
2009-53
March 27, 2009
For immediate release

OTTAWA - Health Canada is advising Canadians not to purchase or use electronic smoking products, as these products may pose health risks and have not been fully evaluated for safety, quality and efficacy by Health Canada.

These products come as electronic cigarettes, cigars, cigarillos and pipes, as well as cartridges of nicotine solutions and related products. These products fall within the scope of the *Food and Drugs Act*, and under the *Act*, require market authorization before they can be imported, advertised or sold. The sale of these health products is currently not compliant with the *Food and Drugs Act* since no electronic smoking products have been granted a market authorization in Canada.

In recent months, a number of electronic cigarettes, cigars and pipes as well as cartridges of nicotine solutions and related products have been marketed in Canada, and through the Internet. Most of these products are shaped and look like their conventional counterparts. They produce a vapour that resembles smoke and a glow that resembles the tip of a cigarette. They consist of a battery-powered delivery system that vapourizes and delivers a liquid chemical mixture that may be composed of various amounts of nicotine, propylene glycol, and other chemicals.

Nicotine is a highly addictive and toxic substance, and the inhalation of propylene glycol is a known irritant. Although these electronic smoking products may be marketed as a safer alternative to conventional tobacco products and, in some cases, as an aid to quitting smoking, electronic smoking products may pose risks such as nicotine poisoning and addiction. Please visit the Health Canada website for further information about nicotine and addiction.

*…..**cont'd on reverse)***

While no electronic smoking product has yet been authorized for sale in Canada, Health Canada has authorized the sale of a number of smoking cessation aids, including nicotine gum, nicotine patches, nicotine inhaler, and nicotine lozenges.

Electronic smoking products, including their nicotine cartridges, must be kept out of the reach of children at all times, given the risk of choking or nicotine poisoning. Nicotine is hazardous to the health and safety of certain segments of the population such as children, youth, pregnant women, nursing mothers, people with heart conditions, and the elderly.

Persons importing, advertising or selling electronic cigarette products in Canada must stop doing so immediately. Health Canada is providing information to interested stakeholders on how to apply for the appropriate market authorizations and establishment licences.

Canadians who have used e-cigarette products and are concerned about their health should consult with a health care practitioner.

Complaints involving electronic smoking products can be reported to the Health Products and Food Branch Inspectorate by calling the toll-free hotline at 1-800-267-9675, or by writing to:

Health Products and Food Branch Inspectorate
Health Canada
Address Locator: 2003C
Ottawa, Ontario K1A 0K9

You can also contact a Health Products and Food Branch Inspectorate Regional Operational Centre:

ONTARIO OPERATIONAL CENTRE
Health Products and Food Branch Inspectorate
2301 Midland Avenue
Scarborough, Ontario
M1P 4R7
Tel: (416) 973-1600
Fax: (416) 973-1954
E-mail: insp_onoc-coon@hc-sc.gc.ca

Please see the attached Health Canada Notice to Stakeholders regarding E-Cigarettes.

March 27, 2009

NOTICE

Our file number: 09-108446-55

To All Persons Interested in Importing, Advertising or Selling Electronic Smoking Products in Canada

Electronic smoking products (i.e., electronic products for the vaporization and administration of inhaled doses of nicotine including electronic cigarettes, cigars, cigarillos and pipes, as well as cartridges of nicotine solutions and related products) fall within the scope of the *Food and Drugs Act*. All of these products require market authorization prior to being imported, advertised or sold in Canada. Market authorization is granted by Health Canada following successful review of scientific evidence demonstrating safety, quality and efficacy with respect to the intended purpose of the health product. This evidence is provided by the sponsor seeking market authorization. To date, no electronic smoking product has been authorized for sale by Health Canada.

In the absence of evidence provided by the sponsor establishing otherwise, an electronic smoking product delivering nicotine is regulated as a New Drug under Division 8, Part C of the *Food and Drug Regulations*. In addition, the delivery system within an electronic smoking kit that contains nicotine must meet the requirements of the *Medical Devices Regulations*. Appropriate establishment licences issued by Health Canada are also needed prior to importing, and manufacturing electronic cigarettes.

Health Canada is aware that some electronic smoking products have been advertised and sold in Canada without market authorization from Health Canada. Persons who may be importing, advertising or selling electronic smoking products without the appropriate authorizations are asked to stop doing so immediately. Products that are found to pose a risk to health and/or are in violation of the *Food and Drugs Act* and related *Regulations* may be subject to compliance and enforcement actions in accordance with the Health Products and Food Branch Inspectorate's Compliance and Enforcement Policy (POL-0001).

If you wish to submit a complaint about the advertising or sale of a health product without market authorization, please contact the Health Products and Food Branch Inspectorate.

…/2

The following Web links are provided for your information:

"How to Submit a Trade Complaint":
http://www.hc-sc.gc.ca/dhp-mps/compli-conform/prob-report-rapport/gui_38_trade-industrie_cp-pc-eng.php

For information pertaining to applications and submissions for drugs and health products:
http://www.hc-sc.gc.ca/dhp-mps/prodpharma/applic-demande/index-eng.php

Information about establishment licensing requirements may be found at:
http://www.hc-sc.gc.ca/dhp-mps/compli-conform/licences/index-eng.php

Sponsors interested in seeking market authorisation for electronic smoking products may contact Health Canada's Therapeutic Products Directorate for information about the drug submission process at: SIPDMail@hc-sc.gc.ca.

April 2015

ABOUT VAPORIZERS & E-JUICE

What is the current situation?

The vaping market in Canada has evolved over the last several years – from standard disposable E-cigarettes, to now include vape tanks and liquids (with/without nicotine).

In Canada, most e-cigarettes users are smokers aiming to cut back on cigarettes (or quit them altogether) and searching for alternative nicotine free and nicotine delivery products. Consequently, thousands of vape shops have opened up across the country in the last several years – all offering e-cigarette/liquids consumers a nicotine alternative.

Through its established VAPUR® brand, Casa Cubana has decided to introduce a range of nicotine delivering liquids specifically designed for the Convenience & Gas Channel.

Are liquids with nicotine legal in Canada?

Health Canada has long stated that all products containing nicotine are regulated under Canada's Food and Drugs Act (FDA) – effectively requiring subsequent approval or certification before being sold in Canada. But everyone knows that tobacco products, as one example, although containing much larger amounts of nicotine than typical E-juices found in our marketplace – are not regulated under the FDA.

Despite some general public positioning and subsequent Cease and Desist letters since issued to shop owners across the country, Health Canada has yet to seize any product or stop any retail outlet from selling any branded E-Juices (with nicotine) in Canada over the last 3 years.

Because the nicotine ingredient in VAPUR® liquids is dispensed in/at such low levels – it is the longstanding position of the E-Juice industry in Canada that this type of product is effectively exempted from regulation (as a drug) under Canada's Food and Drugs Act.

Because the VAPUR® liquids (with or without nicotine) are not marketed as health products (i.e. for medicinal use) or sold as healthier alternatives to smoking or as smoking cessation devices – the product is also not regulated as a Natural Health Product under the Federal Government's Natural Products Regulations.

Consequently, it remains the industry's position that no specific government approval or certification (at this time) is required for selling these (low-level nicotine) products in Canada.

CASA CUBANA 275, rue Stinson, Montréal (Québec) H4N 2E1
T 514-737-0066 1-877-606-1806 F 514-737-5211 1-877-228-2262

Are Casa Cubana clients doing anything illegal by distributing VAPUR® liquids with nicotine?

Casa Cubana takes its commitments and responsibilities to its commercial partners quite seriously. We are confident that if ever challenged in any way, our activities and products would be well argued and defended.

That being said, Governments and government inspectors have the authority to interpret legislation (or review their interpretations) whenever and however they see fit – and on any consumer product.

Know that Casa Cubana stands 100% behind the quality and legality of all of our products.

Are electronic cigarettes containing nicotine still illegal in Canada?

Electronic cigarettes containing nicotine remain a political and regulatory grey area in Canada. While the devices do not make any health claims and deliver (exempted) low-levels of nicotine to consumers – existing Canadian laws should arguably not impact these products.

Despite the arguable legal status of these products, Health Canada remains steadfast in its position that they do require market authorization before being imported and sold in Canada. Their enforcement activities to date have led to the continued refusal of imported product into Canada (refusal at Customs). Because no E-cigarette product is actually manufactured in Canada, these products are consequently seldom found in the marketplace.

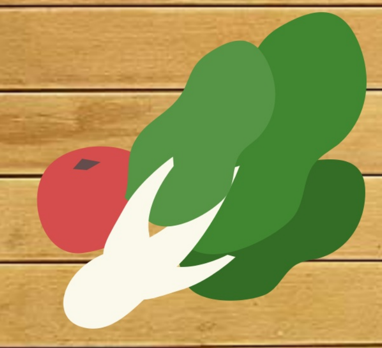
Does Casa Cubana guarantee its products?

We stand behind everything that we sell. Period.

Should any issue ever arise as to the quality or legality of any of our VAPUR® products or for more information regarding the content of this document, please do not hesitate in contacting us.

CASA CUBANA 275, rue Stinson, Montréal (Québec) H4N 2E1
T 514-737-0066 1-877-606-1806 **F** 514-737-5211 1-877-228-2262

HARVEST BUCKS 2014



Vegetable & fruit farmers' market voucher program started in 2012

HARVEST BUCKS
Redeemable for vegetables and fruit at participating market vendors
Expires December 31, 2014
$2

89%

of Middlesex-London residents did NOT meet their vegetable & fruit requirement based on Canada's Food Guide[1]

Did you know?

Eating enough vegetables & fruit is important for healthy living, healthy weights & prevention of chronic diseases.

$17,738 *Harvest Bucks distributed*

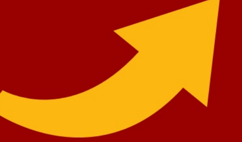
6 *Funded programs [2]*

+

11 *Direct purchase programs [3]*

536 *London households received Bucks*

5 *Participating farmers' markets [4]*



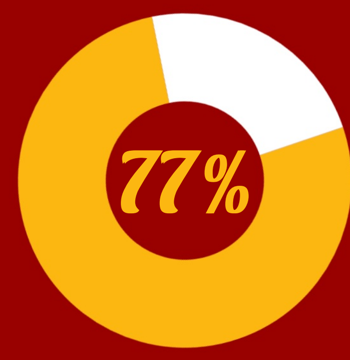
$13,014

Harvest Bucks redeemed

73%

redeemed

Funded program voucher recipients[5] reported they:

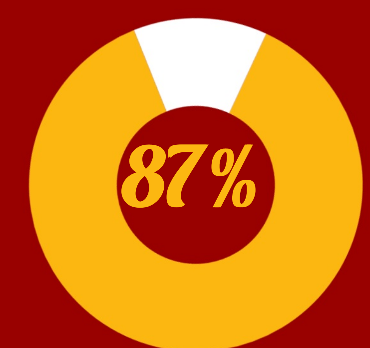


93%

ate all or most of the vegetables & fruit purchased

77%

ate more vegetables & fruit in general



87%

intend to buy vegetables & fruit at a farmers' market in the future

Interested in Donating?

100% of donations are used to purchase Harvest Bucks for funded programs.

Tax receipts are provided for donations of $100 or more.

To learn more, please contact: kim.leacy@mlhu.on.ca

Harvest Bucks is a partnership of:

Covent Garden Market
EatGreen Organics
Farmers' & Artisans' Market at the Western Fair
London's Child and Youth Network
Middlesex-London Health Unit
Southdale Farmers' and Artisans' Market

[1] Source: Canadian Community Health Survey 2011 - Public Use Microdata File.
[2] Programs apply for funding for Harvest Bucks [3] Programs directly purchase Harvest Bucks
[4] Covent Garden Market (indoor and outdoor), EatGreen Organics (delivery only), Farmers' and Artisans' Market at the Western Fair, Masonville Farmers' and Artisans' Market and Southdale Farmers' and Artisans' Market
[5] Based on a 42% response rate (n=70) in 2014

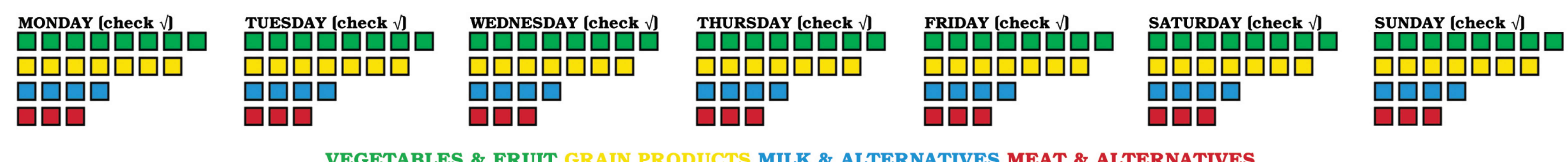
Middlesex-London Health Unit, June 2015

MALE --> 14-18 yrs.

NAME: ___________

My Balanced Plate

WHAT DID I EAT THIS WEEK?



VEGETABLES & FRUIT GRAIN PRODUCTS MILK & ALTERNATIVES MEAT & ALTERNATIVES

SAMPLE SERVING SIZES

Vegetables & Fruit (8)

Example Serving Size:
- 125 mL (½ cup) fresh/frozen/canned vegetable or fruit
- 250 mL (1 cup) leafy raw vegetables or salad
- 1 piece of fruit

1 tennis ball = 1/2 cup of fruit or vegetables

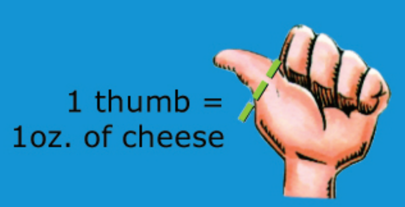
Grain Products (7)

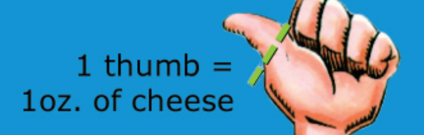
Example Serving Size:
- 1 slice of (35 g) bread or ½ bagel (45 g)
- ½ pita (35 g) or ½ tortilla (35 g)
- 125 mL (½ cup) cooked rice or pasta

1 fist or cupped hand = 1 cup

Milk & Alternatives (3-4)

Example Serving Size:
- 250 mL (1 cup) milk or fortified soy beverage
- 175 g (¾ cup) yogurt
- 50 g (1 ½ oz.) cheese

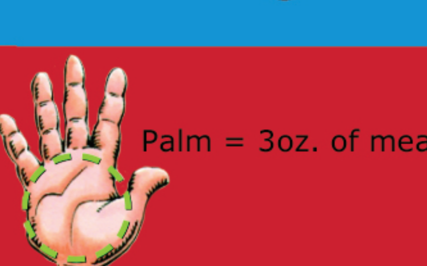




1 thumb = 1oz. of cheese

Meat & Alternatives (3)

Example Serving Size:
- 75 g (2 ½ oz.) cooked fish, shellfish, poultry or lean meat
- 2 eggs
- 30 mL (2 tbsp.) peanut butter



Palm = 3oz. of meat

fruit

milk

vegetables

protein

grain

HEALTHY SNACK OPTIONS

- **cucumber** & tzatziki dip
- **fresh fruit** & cheese
- **veggie sticks** (add hummus or a yogurt dip)

- homemade **muffin**
- **whole wheat tortilla** with canned refried beans or black beans, salsa and shredded cheese
- cheese & **crackers**

- bagel with **cream cheese**
- **low fat yogurt** with fresh or frozen berries
- fruit smoothie made with **yogurt**

- trail mix (made with whole grain cereals, dried fruits, **nuts & seeds**)
- toast with **peanut butter** (or wow butter)
- apple with **peanut butter** (or wow butter)

Satisfy your thirst with water!
Drink more water in hot weather or when you are very active.

www.healthunit.com/canadas-food-guide

Physical Activity Guidelines
60 minutes per day, every day. (check √) Mon.☐ Tues.☐ Wed.☐ Thurs.☐ Fri.☐ Sat.☐ Sun.☐

Sedentary Guidelines
No more than 2 hours screen time (hand held device, computer, television) per day.

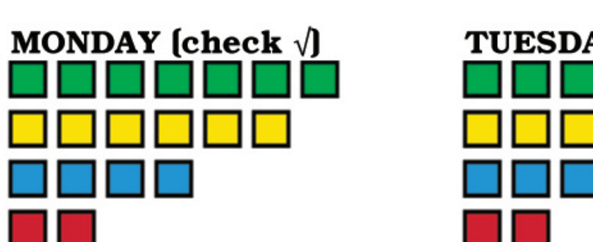
FEMALE --> 14-18 yrs.

NAME: ______________

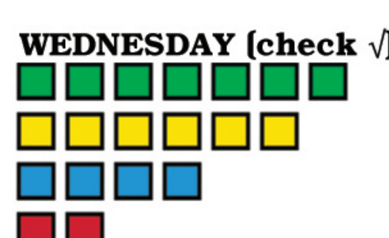
My Balanced Plate

WHAT DID I EAT THIS WEEK?

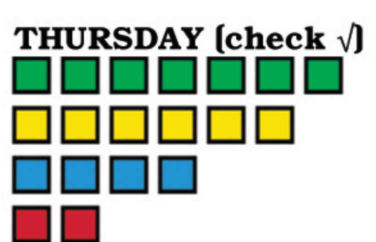
MONDAY (check √)



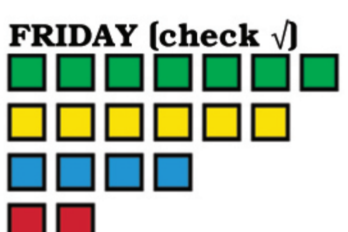
TUESDAY (check √)



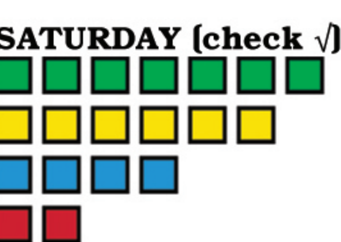
WEDNESDAY (check √)



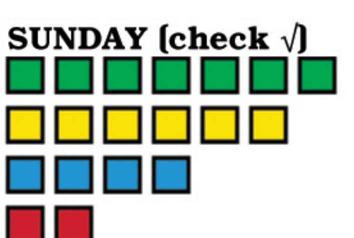
THURSDAY (check √)



FRIDAY (check √)



SATURDAY (check √)



SUNDAY (check √)

VEGETABLES & FRUIT GRAIN PRODUCTS MILK & ALTERNATIVES MEAT & ALTERNATIVES

SAMPLE SERVING SIZES

Vegetables & Fruit (7)

Example Serving Size:

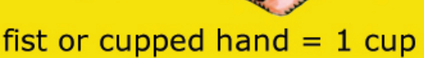
- 125 mL (½ cup) fresh/frozen/canned vegetable or fruit
- 250 mL (1 cup) leafy raw vegetables or salad
- 1 piece of fruit

1 tennis ball = 1/2 cup of fruit or vegetables

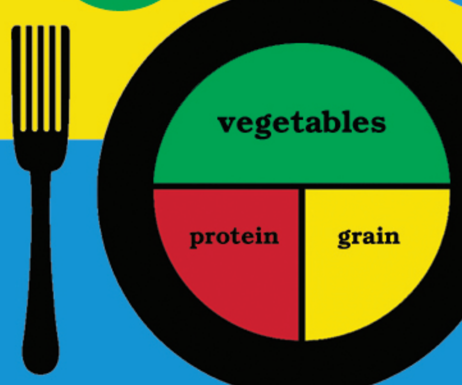
Grain Products (6)

Example Serving Size:

- 1 slice of (35 g) bread or ½ bagel (45 g)
- ½ pita (35 g) or ½ tortilla (35 g)
- 125 mL (½ cup) cooked rice or pasta



1 fist or cupped hand = 1 cup



Milk & Alternatives (3-4)

Example Serving Size:

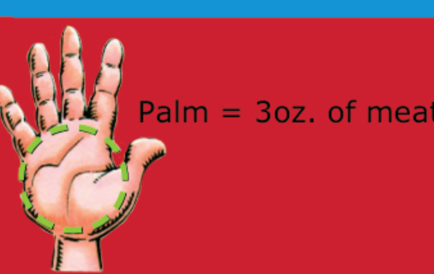
- 250 mL (1 cup) milk or fortified soy beverage
- 175 g (¾ cup) yogurt
- 50 g (1 ½ oz.) cheese

1 thumb = 1oz. of cheese

Meat & Alternatives (2)

Example Serving Size:

- 75 g (2 ½ oz.) cooked fish, shellfish, poultry or lean meat
- 2 eggs
- 30 mL (2 tbsp.) peanut butter



Palm = 3oz. of meat

HEALTHY SNACK OPTIONS

- **cucumber** & tzatziki dip
- **fresh fruit** & cheese
- **veggie sticks** (add hummus or a yogurt dip)

- homemade **muffin**
- **whole wheat tortilla** with canned refried beans or black beans, salsa and shredded cheese
- cheese & **crackers**

- bagel with **cream cheese**
- **low fat yogurt** with fresh or frozen berries
- fruit smoothie made with **yogurt**

- trail mix (made with whole grain cereals, dried fruits, **nuts & seeds**)
- toast with **peanut butter** (or wow butter)
- apple with **peanut butter** (or wow butter)

Satisfy your thirst with water!
Drink more water in hot weather or when you are very active.

www.healthunit.com/canadas-food-guide

Physical Activity Guidelines
60 minutes per day, every day. (check √) Mon.☐ Tues.☐ Wed.☐ Thurs.☐ Fri.☐ Sat.☐ Sun.☐

Sedentary Guidelines
No more than 2 hours screen time (hand held device, computer, television) per day.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 56-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 September 17

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – SEPTEMBER

Recommendation

It is recommended that Report No. 056-15 re Medical Officer of Health Activity Report – September be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the July Medical Officer of Health Activity Report to September 2, 2015.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

July 7 Meeting with Sean Quigley – Executive Director Emerging Leaders London Community Network

July 9 Attended a meeting in Owen Sound for South West Medical Officers of Health

July 13 As member of United Way Cabinet, met with Susanna Krimmer, London Public Library to discuss staff giving program
Introductory meeting with Adam Fearnall, founder of London Youth Advisory Council

July 14 Met with Megan Walker – London Abused Women's Centre (LAWC) to discuss women's shelter/support landscape in London
As member of United Way Cabinet, met with Vinay Sharma, Hydro One to discuss staff giving program
Attended the Non-Union Leadership Team meeting to assist with the 2015 PBMA Proposal Process Update discussion

July 15 Was interviewed by London Free Press reporter in regards to BOH Report 045-15 GenerationSqueeze
Participated in Cessation Strategy Advisory Group teleconference

July 18 Participated in Health Human Development Table teleconference

July 20 Was interviewed by CBC Ontario Morning Show in regards to the Health Unit's desire to support young families while maintaining services and benefits for older generations

July 26 Attended the London Pride Parade

July 27 Introductory teleconference meeting with Toni Pickard, Coordinator, Kingston Action Group for a Basic Income Guarantee
Meeting with Martha Powell, London Community Foundation

July 28 Participated in Code Red Champion teleconference meeting

Met with Board Members, Joanne Vanderheyden, Kurtis Smith and Marcel Meyer to discuss the upcoming Middlesex Municipal Day

July 29 Met with Andrew Lockie, Lynne Livingston and Glen Pearson for a Poverty Agenda meeting follow-up

July 30 Attended a Code Red Steering Committee meeting at the Thames Valley Family Health Team Offices
Telephone meeting with Susan Eng, Vice President of Advocacy at the Canadian Association of Retired Persons (CARP) to discuss partnering on an initiative related to early childhood development

August 6 Met with Hugh Mitchell, Chief Executive Officer Western Fair District to discuss United Way involvement

August 10 Met with Dan Oudshoorn to discuss harm reduction
Met with Chuck Lazenby of Unity Project to discuss poverty and mental health
Met with Michelle Baldwin, Executive Director of Pillar Non Profit

August 11 Introductory meeting with Stephen Giuliano (Executive Director of Operation Sharing)

August 14 Participated in a video shoot with CTV at the YMCA in regards to physical activity

August 31 Attended a Poverty Agenda Meeting with the City of London
Met with Chief Pare of London Police Services to discuss harm reduction. Also at the meeting was Michelle Hurtubise from London InterCommunity Health Centre (LIHC) and Brian Lester from Regional HIV AIDS Connection (RHAC)

September 1 Met with Tamar Meyer from The Centre for Addiction and Mental Health (CAMH) to discuss the Mental Health Promotion, Prevention, and Early Intervention Working Group

September 2 Attended the announcement of the Pillar Award finalists where the Health Unit was announced as a finalist for the Collaboration award
Attended a Poverty Agenda Meeting with Lindsay Sage
Met with Anna Iacobelli, Chair of the United Way of London and Middlesex Fundraising Cabinet to discuss personal, Health Unit, and municipal sector fundraising targets

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