AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, November 17, 2016 5:30 p.m.

1. DISCLOSURE OF CONFLICTS OF INTEREST

2. APPROVAL OF AGENDA

3. APPROVAL OF MINUTES

Public Session – July 21, 2016 Governance Committee Meeting

4. NEW BUSINESS

4.1. **2015 Year-End Performance on Accountability Indicators (Report No. 017-16GC)**

4.2. **Board of Health Governance By-Law and Policy Review (Report No. 018-16GC)**

5. OTHER BUSINESS

Next meeting: To Be Determined.

6. ADJOURNMENT

MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, July 21, 2016 6:00 p.m.

Committee Members Present: Mr. Trevor Hunter (Chair)
Mr. Jesse Helmer
Mr. Kurtis Smith

Others Present: Mr. Ian Peer
Ms. Joanne Vanderheyden
Dr. Christopher Mackie, Medical Officer of Health & CEO
Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Mr. Jordan Banninga, Manager, Strategic Projects
Ms. Laura Di Cesare, Director, Corporate Services

Chair Hunter called the meeting to order at 6:00 p.m.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

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

2. APPROVAL OF AGENDA

It was moved by Mr. Helmer, seconded by Mr. Hunter *that the AGENDA for the July 21, 2016 Governance Committee meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Helmer, seconded by Mr. Hunter *that the MINUTES from the April 21, 2016 Governance Committee meeting be approved.*

Carried

4. NEW BUSINESS

4.1 Board of Health Development Session (Report No. 013-16GC)

Discussion ensued about risk mitigation, the importance of developing Board member skills and scheduling a date for the development session. Staff will poll Board members to find a date that works best for the majority.

Mr. Smith arrived at 6:04 pm.

It was moved by Mr. Smith, seconded by Mr. Helmer *that the the Governance Committee:*
1) Receive Report No. 013-16GC re: Board of Health Development Session for information; and
2) Recommend that the Board of Health approve the scheduling of a Board development session in the Fall.

Carried

4.2 2015-2020 Strategic Plan Update (Report No. 014-16GC)

Chair Hunter summarized the addition of a strategic objective that was made in the Strategic Plan, for Program Excellence. Discussion ensued around the importance of adding this strategic objective.

It was moved by Mr. Helmer seconded by Mr. Smith *that the Governance Committee:*
1) Recommend that the Board of Health approve the addition of a strategic objective for Program Excellence; and
2) Receive Report No. 014-16GC 2015-2020 Strategic Plan Update.

Carried

4.3 Nomination and Appointment Process Update (Report No. 015-16GC)

Chair Hunter introduced and provided some context to this report and why the diversity survey was developed.

Discussion ensued about the following items:

- The structure of questions on the survey and a request to add an open-ended text box at the end.
- The urgency in filling vacant positions to ensure full Board and sub-committee complement.
- How survey questions will be analyzed and weighted in order to fill vacant positions.
- The importance of ensuring that vacancies are advertised to a wide audience and pool of candidates.
- Discussion highlights the need for an open text box at the end of the survey.

It was moved by Mr. Helmer, seconded by Mr. Smith *that the the Governance Committee:*

1) Recommend that the Board of Health request that Board Members complete the updated diversity survey, attached as Appendix A;
2) Recommend that the Board of Health approve the forwarding of the anonymized results of the survey to the Ministry of Health and Long-Term Care for their consideration during the public appointments process and to other appointing bodies as appropriate; and
3) Recommend that the Board of Health provide direction to staff regarding the promotion of Board of Health position opportunities.

Carried

Chair Hunter flagged the current membership complement for discussion. Since the Board of Health is currently not functioning at capacity, the Governance Committee is missing a Provincial representative. The Committee agreed to appoint a Provincial representative on an interim basis. This request will be brought forward for discussion at the Board of Health meeting during the verbal update.

4.4 Review of 2016 Governance Meeting Dates (Report No. 016-16GC)

Chair Hunter suggested the Governance Committee meet at a different date or time to provide additional time to review reports when making recommendation to the Board of Health.

Discussion ensued about changing the date and time, creating a template to summarize Governance Committee motions and starting the meeting earlier.

Dr. Mackie advised that Committee meetings are set at the beginning of the year and additional meetings are at the call of the Chair. The next Governance Committee meeting identified by staff would be in November, since the October meeting would likely be replaced with the Board of Health development session.

It was moved by Mr. Helmer seconded by Mr. Smith *that the the Governance Committee:*

1) *Receive Report No. 016-16GC; and*
2) *Set Governance Committee meeting time to 5:30 p.m., going forward.*

Carried

5. OTHER BUSINESS

The next Governance Committee meeting is scheduled for Thursday November 17 at 5:30 p.m.

Mr. Smith flagged the membership complement and Dr. Mackie advised that quorum is 50 percent of the member plus 1.

6. ADJOURNMENT

At 6:51 p.m. it was moved by Mr. Smith, seconded by Mr. Helmer *that the meeting be adjourned.*

Carried

_____ _____

TREVOR HUNTER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 017-16GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

2015 YEAR-END PERFORMANCE ON ACCOUNTABILITY INDICATORS

Recommendation

It is recommended that Report No. 017-16GC re 2015 Public Health Performance Indicators Year-End Results be received for information.

Key Points

- The Health Unit has demonstrated strong performance on the 2015 Year-End Accountability Agreement performance indicators by meeting or exceeding the targets on 11 out of 17 indicators.
- The performance indicator data is a limited representation of the work of the Health Unit.
- 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 were 25 indicators that are reported to the MOHLTC in 2015. 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 17 of these indicators, a 2015 performance target was negotiated and agreed upon by both the Board and MOHLTC.

2015 Year-End Results

In September 2016, the MOHLTC published the Health Unit's 2015 year-end performance on 25 indicators. The 2015 Mid-Year Indicator Summary Table for Health Promotion Indicators and 2015 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, 2015 – December 31, 2015 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 17 performance indicators reported, the Health Unit met or exceeded the targets set on 11 of them. Of the remaining six indicators, four were within 1.3% of their performance targets and the following two indicators had performance noted below:

Indicator		Year	Performance	Target	Compliance Report?
1.5	% of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)	2015	89.3%	100.0%	No
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	2015	94.1%	100.0%	Yes

A compliance report for indicator 3.4 was submitted to the Ministry of Health and Long-Term Care in April 2016 and an update was brought to the Board of Health at the April 2016 meeting.

Monitoring Indicators

Monitoring indicators do not have performance targets 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
- Monitor risks related to program delivery.

Limitations in the Data

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;
- Demonstrate 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;
- Be reported on due to availability of data sources; and
- Highlight indicators that are 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

2016 MID-YEAR INDICATOR SUMMARY TABLE: HEALTH PROMOTION INDICATORS

Board of Health for the Middlesex-London Health Unit

August 2016

#	Indicator		Baseline		2015 Year-End			2016					
								Mid-Year				Year-End	
			Reporting Period	Performance	Reporting Period	Performance	Target	Reporting Period	Numerator	Denominator	Performance	Target/ Monitoring	Performance/ Compliance Required
1.1	% of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines		2013+ 2014	25.5%								Monitoring	N/A
1.2	Fall-related emergency visits in older adults aged 65 +		2009	5,826								Monitoring	N/A
1.3	% of youth (ages 12 - 18) who have never smoked a whole cigarette		2009 + 2010	83.6%								Monitoring	N/A
1.4	% of tobacco vendors in compliance with youth access legislation at the time of last inspection		2011	96.0%	January 1, 2015 - December 31, 2015	98.7%	≥90%	January 1, 2016 - June 30, 2016	305	309	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%	January 1, 2015 - December 31, 2015	89.3%	100.0%					100.0%	N/A
1.6	% tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA)	Non-Seasonal	2013	92.6%	January 1, 2015 - December 31, 2015	99.4%	100.0%					100.0%	N/A
		Seasonal	2015	0.0%	January 1, 2015 - December 31, 2015		100.0%					100.0%	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, 2015 - December 31, 2015	98.7%	100.0%					100.0%	N/A
1.8	Oral health Assessment and Surveillance: % of schools screened		July 2013- June 2014	100.0%	July 1, 2014- June 30, 2015	100.0%	100.0%	July 1, 2015- June 30, 2016	123	123	100.0%	100.0%	NO
	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%	July 1, 2014- June 30, 2015	100.0%	100.0%	July 1, 2015- June 30, 2016	11285	11285	100.0%	100.0%	
1.9	Implementation status of NutriSTEP® Preschool Screen		2013	Initiation	January 1, 2015 - December 31, 2015	Intermediate	Intermediate	January 1, 2016 - June 30, 2016	Advanced			Advanced	N/A
1.10	Baby-Friendly Initiative (BFI) Status		2011	Preliminary	January 1, 2015 - December 31, 2015	Designated	Designated	January 1, 2016 - June 30, 2016	Designated			Designated	N/A

LEGEND:

No data/ no report required for specified reporting period.

N/A **Not applicable for specified reporting period.**

2016 YEAR-END INDICATOR SUMMARY TABLE: HEALTH PROTECTION INDICATORS

Board of Health for the Middlesex-London Health Unit

August 2, 2016

#	Indicator	2015				2016					
		Reporting Period	Performance	Target (%)/ Monitoring/ Baseline	Performance/ Compliance Report Submitted	Reporting Period	Numerator	Denominator	Performance	Target (%)/ Monitoring/ Baseline	Performance/ Compliance Report Required
2.1	**% of high-risk food premises inspected once every 4 months while in operation**	January 1, 2015 - December 31, 2015	100.0%	Monitoring	NO	January 1, 2016 - December 31, 2016	--	--	--	Monitoring	--
2.2	**% of moderate-risk food premises inspected once every 6 months while in operation**	January 1, 2015 - December 31, 2015	99.4%	Monitoring	NO	January 1, 2016 - December 31, 2016	--	--	--	Monitoring	--
2.3	**% of Class A pools inspected while in operation**	January 1, 2015 - December 31, 2015	100.0%	100.0%	NO	January 1, 2016 - December 31, 2016	--	--	--	Monitoring	--
2.4	**% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection**	January 1, 2015 - December 31, 2015	100.0%	100.0%	NO	January 1, 2016 - December 31, 2016	--	--	--	100.0%	--
2.5	**% of public spas inspected while in operation**	January 1, 2015 - December 31, 2015	100.0%	Monitoring	NO	January 1, 2016 - December 31, 2016	--	--	--	Monitoring	--
2.6	**% of restaurants with a Certified Food Handler (CFH) on site at time of routine inspection**	N/A	N/A	N/A	N/A	January 1, 2016 - December 31, 2016	--	--	--	Baseline	--
3.1	**% of personal services settings inspected annually**	January 1, 2015 - December 31, 2015	98.2%	Monitoring	NO	January 1, 2016 - December 31, 2016	--	--	--	Monitoring	--
3.2	**% of suspected rabies exposures reported with investigation initiated within one day of public health unit notification**	January 1, 2015 - December 31, 2015	99.2%	100.0%	NO	January 1, 2016 - December 31, 2016	--	--	--	100.0%	--
3.3	**% of confirmed gonorrhea cases where initiation of follow-up occurred within two business days**	January 1, 2015 - December 31, 2015	100.0%	Monitoring	NO	January 1, 2016 - December 31, 2016	--	--	--	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, 2015 - December 31, 2015	94.1%	100.0%	YES	January 1, 2016 - December 31, 2016	--	--	--	Monitoring	--
3.5	**% of salmonellosis cases where one or more risk factor(s) other than "Unknown" was entered into iPHIS**	January 1, 2015 - December 31, 2015	95.0%	90.0%	NO	January 1, 2016 - December 31, 2016	--	--	--	95.0%	--
3.6	**% of confirmed gonorrhea cases treated according to recommended Ontario treatment guidelines**	January 1, 2015 - December 31, 2015	59.2%	Baseline	N/A	January 1, 2016 - December 31, 2016	--	--	--	Monitoring	--
4.1	**% of HPV vaccine wasted that is stored/administered by the public health unit ***	September 1, 2014 - August 31, 2015	0.0%	0.0%	NO	September 1, 2015 - August 31, 2016	--	--	--	Monitoring	--
4.2	**% of influenza vaccine wasted that is stored/administered by the public health unit ***	September 1, 2014 - August 31, 2015	0.7%	0.2%	NO	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, 2015 - December 31, 2015	100.0%	100.0%	NO	January 1, 2016 - December 31, 2016	--	--	--	100.0%	--

2016 YEAR-END INDICATOR SUMMARY TABLE: HEALTH PROTECTION INDICATORS

Board of Health for the Middlesex-London Health Unit

August 2, 2016

#	Indicator	2015				2016					
		Reporting Period	Performance	Target (%)/ Monitoring/ Baseline	Performance/ Compliance Report Submitted	Reporting Period	Numerator	Denominator	Performance	Target (%)/ Monitoring/ Baseline	Performance/ Compliance Report Required
4.4	**% of school-aged children who have completed immunizations for hepatitis B**	As of June 30, 2015	67.9%	Monitoring	NO	As of June 30, 2016	2,778	4,488	61.9%	Monitoring	TBD
4.5	**% of school-aged children who have completed immunizations for HPV**	As of June 30, 2015	48.2%	Monitoring	NO	As of June 30, 2016	1,145	2,259	50.7%	Monitoring	TBD
4.6	**% of school-aged children who have completed immunizations for meningococcus**	As of June 30, 2015	77.2%	Monitoring	NO	As of June 30, 2016	3,450	4,488	76.9%	Monitoring	TBD
4.7	**% of MMR vaccine wastage**	N/A	N/A	N/A	N/A	January 1, 2016 - December 31, 2016	--	--	--	Baseline	--
4.8	**% of 7 or 8 year old students in compliance with the ISPA**	N/A	N/A	N/A	N/A	As of June 30, 2016	4,529	4,704	96.3%	Baseline	TBD
4.9	**% of 16 or 17 year old students in compliance with the ISPA**	N/A	N/A	N/A	N/A	As of June 30, 2016	3,456	4,952	69.8%	Baseline	TBD

LEGEND:

N/A Not Applicable

-- Data not yet collected

TBD To be determined

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 018-16GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

BOARD OF HEALTH GOVERNANCE BY-LAW AND POLICY REVIEW

Recommendation

It is recommended that the Governance Committee:

a) Receive report No. 018-16GC for information;
b) Forward the applicable policies for review by the Finance and Facilities Committee;
c) Recommend that the Board of Health approve the by-laws;
d) Schedule an additional meeting to review and approve the drafted policies outlined in Appendix B; and
e) Recommend that the Board of Health approve the plan for the development of policies as outlined in Appendix C.

Key Points

- The Board of Health Governance Manual which includes Board by-laws and policies is the responsibility of the Governance Committee to maintain.
- A proposed policy model was brought forward to the Governance Committee in April 2016 and staff were directed to review the policy program and bring the new policy program forward to the Governance Committee.
- The new policy program is based on Mr. Graham Scott's session on Critical Elements of Board Governance.

Background

An updated policy model for the Board of Health was recommended at the April 2016 Governance Committee meeting. This policy model incorporates governance best practices from the Ontario Public Health Organizational Standards and Mr. Graham Scott's session on Critical Elements of Board Governance.

Staff have taken the opportunity between April and November to enhance the current policy model (Appendix A) to reflect the recommendation provided by Mr. Scott. Changes to existing policies are included as blacklined documents in this appendix.

By-law and Policy Model 2.0

The transition from the contemporary policy model to the proposed policy model, dubbed By-law and Policy Model 2.0 required extensive review of relevant legislation to ensure that no gaps were created in moving from the old model to the new. Key modifications to model 2.0 include the segmentation of the Board of Health by-laws, the addition of new policies and the consolidation of some of the existing policies.

The comprehensive listing of by-laws, policies, scheduled dates of Governance Committee review and a summary of changes made to date can be found as Appendix B. Additionally, this appendix also contains all revised, moved or developed policies.

Next Steps

The Governance Committee now has the opportunity to review the By-law and Policy Model 2.0 as well as the constituent by-law and policy amendments and additions. It is recommended that finance policies be forwarded to the Finance and Facilities Committee for review prior to approval from the Board of Health.

Once the Governance Committee is satisfied with the review of the policies, they will be forwarded to the Board of Health for approval.

Additional policies will continue to be brought forward to the Governance and Finance and Facilities Committees to meet the full requirements of the By-law and Policy Model 2.0, the schedule of which is outlined in Appendix C.

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

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

Appendix A to Report No. 018-16GC

Current Policy Manual and Proposed Changes

Policy #	*Section*	*Policy & Appendices*	*Proposed Changes*
1-010	Governance	Structure And Responsibilities Of The Board Of Health ➢ Appendix A – Bylaws ➢ Appendix B - Provincial Appointee Reappointments Process ➢ Appendix C - Electronic Participation	• Policy 1-010 will be retired • This large policy with embedded by-laws has been replaced in the By-law and Policy Model 2.0 with the following: o Individual by-laws o G-270 Roles and Responsibilities of the Board of Health o G-280 Board Size and Composition o G-290 Standing and Ad Hoc Committees o G-350 Nominations and Appointments to the Board of Health • Electronic participation is not allowed under the municipal act and has been removed
1-020	Governance	Orientation For Board of Health Members	• Policy 1-020 will be retired • Replaced with G-370 • Completely redrafted
1-030	Governance	Strategic Planning	• Policy 1-030 will be retired • Replaced with G-010 • See blackline for changes
1-040	Governance	Reports to the Board of Health	• Policy 1-040 will be retired • Replaced with G-490 • See blackline for changes
1-050	Governance	Organizational Structure ➢ Appendix A - MLHU Org Chart	• Policy 1-050 will be retired • Replaced with A-000
1-060	Governance	Financial Signing Authority	• Policy 1-060 will be retired • Replaced with G-200 • No changes
1-070	Governance	Procurement ➢ Appendix A - Procurement Guidelines	• Policy 1-070 will be retired • Replaced with G-230 • Changes made to staff titles and organizational structure references
1-080	Governance	Contractual Services ➢ Appendix A - Directory of Approval of Contracts	• Policy 1-080 will be retired • Replaced with G-220 • No changes

Current Policy Manual and Proposed Changes

1-090	Governance	Media Relations	• Policy 1-090 will be retired • Replaced with G-480 • See blackline
1-100	Governance	Annual Report to the Public	• Policy 1-100 will be retired • Replaced with G-490 • See blackline
1-110	Governance	Code of Conduct	• Policy 1-110 will be retired • Replaced with G-390 • See blackline

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

First Reading – April 19, 2012

Second Reading - April 19, 2012

Third Reading - April 19, 2012

Current Policy Manual and Proposed Changes

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

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

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

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First Reading – April 19, 2012

Second Reading - April 19, 2012

Third Reading - April 19, 2012

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

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

Current Policy Manual and Proposed Changes

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

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Policy Manual and Proposed Changes

1.0 General

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

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

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

1.4 No persons shall smoke in the Board meeting room.

2.0 Convening Meeting

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

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

3.0 Special Meetings

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

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

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

4.0 Notifying Board Members of Meetings

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

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

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

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

4.5 The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

5.0 Notifying the Public of Board Meetings

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

communication:

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

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

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

6.0 Meetings Open to the Public

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

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

7.1 Pre-requirements for in-camera sessions

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

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

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

7.2 Criteria for in-camera meetings

Current Policy Manual and Proposed Changes

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

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

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

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

(d) labour relations or employee negotiations;

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

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

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

7.3 Criteria for in-camera voting

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

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

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

7.4 In-camera record keeping requirements

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

8.0 Preparation of the "Agenda"

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

(a) Call to Order and Declarations of Interest;

(b) Minutes of Previous Meeting;

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

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

(e) Other Business from the Floor;

(f) Date of Next Meeting;

(g) Adjournment

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

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

9.0 Commencement of Meetings

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

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

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

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

10.0 Rules of Debate and Conduct of Members of the Board

Current Policy Manual and Proposed Changes

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

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

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

10.4 When a member finds it impossible to attend any meeting, the onus is upon the member to advise the Secretary-Treasurer prior to the holding of such meeting, and to advise of his wishes with respect to having an agenda item tabled.

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

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

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

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

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

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

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

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

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

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

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

Current Policy Manual and Proposed Changes

11.0 Motions and Order of Putting Questions

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

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

(a) to adopt;

(b) to amend;

(c) * to table;

(d) to refer;

(e) to receive;

(f) * to adjourn the meeting; or

(g) * that the vote be now taken.

* these items are to be voted on without debate.

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

11.4 When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the

motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

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

12.0 Voting

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

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

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

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

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

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

deemed as voting in the negative.

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

12.8 After any matter has been decided, any member may move for a reconsideration at the same meeting or may give notice of a motion for reconsideration of the matter for a subsequent meeting in

the same year, but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried, and no matter shall be reconsidered more than once in the same calendar year.

13.0 Minutes

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

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

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

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

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

Current Policy Manual and Proposed Changes

14.0 Adjournment

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

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

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

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

15.0 Communications

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

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

16.0 Proceedings on Bylaws

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

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

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

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

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

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

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

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

17.0 Secretary-Treasurer and Board Solicitor

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

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

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

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

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

17.2 It shall be the duty of the Board Solicitor:

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

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

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

18.0 Elections and Appointment of Committees

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

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

18.3 At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first

meeting by the Board to other boards, bodies, or commissions where appropriate.

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

19.0 Conduct of Business in Committees

19.1 The rules governing the proceedings of the Board shall be observed in

the Committees insofar as applicable.

19.2 It shall be the duty of the Committee:

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

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

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

19.3 The procedures of the Board with respect to:

(a) incurring of liabilities and paying of accounts;

(b) contracts and expenditures;

(c) petty cash;

(d) tenders and quotations;

shall be in accordance with the Agreement.

20.0 Corporate Seal

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

21.0 Execution of Documents

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

22.0 Duties of Officers

22.1 The Chair of the Board shall:

(a) preside at all meetings of the Board;

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

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

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

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

23.0 Remuneration

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

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

24.0 Board of Health Performance Assessment

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

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

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

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

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

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

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

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

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

25.0 Amendments

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

26.0 General

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

First Reading – April 19, 2012

Second Reading - April 19, 2012

Third Reading - April 19, 2012

Current Policy Manual and Proposed Changes

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

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

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

MIDDLESEX-LONDON HEALTH UNIT

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

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

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

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

2. The Auditor shall:

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

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

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

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

Current Policy Manual and Proposed Changes

First Reading – April 19, 2012

Second Reading - April 19, 2012

Third Reading - April 19, 2012

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

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

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

Current Policy Manual and Proposed Changes

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT:	Orientation For Board of Health Members	**POLICY NUMBER:**	1-020
SECTION:	Governance	Page 33 of 50	
IMPLEMENTATION:	July 8 1992	**APPROVAL:**	Board of Health
SPONSOR:	Board of Health	**SIGNATURE:**	

PURPOSE

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

POLICY

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

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

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

PROCEDURE

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

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

Current Policy Manual and Proposed Changes

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

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

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

BOARD OF HEALTH ORIENTATION HANDBOOK: TABLE OF CONTENTS

Structure and Responsibilities of the Board of Health
- Board meeting dates
- List of current Board members and contact information
- Board of Health Remuneration and Expense Reimbursement Form
- Board of Health – Role Description
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Organizational Background and Planning Documents
- Strategic Plan
- Planning Cycle
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Community Demographics and Emergency Preparedness
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- The Health Protection and Promotion Act
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- Smoke Free Ontario Act
- Safe Drinking Water Act
- Chapter 32 – Bill 195
- Regulation 170/03 – Drinking Water Systems

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- Regulation 169/03 – Ontario Drinking Water Quality Standard

Recommended Reading

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

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: Strategic Planning		**POLICY NUMBER:**	
SECTION:		**PAGE:**	
IMPLEMENTATION:	1992-09-09	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	

PURPOSE

To ensure the development, implementation and review of the strategic plan that outlines the organization's goals and objectives.

POLICY

A strategic plan will be developed in consultation with the Board of Health, staff, stakeholders and community members as appropriate to identify the strategic directions for the Health Unit.

The Strategic Plan will cover a 3 to 5 year timeframe, and will:

- Describe the philosophy/mission, a values statement, and the goals and objectives of the board of health;
- Describe how equity issues will be addressed in the delivery and outcomes of programs and services;
- Describe how the outcomes of the Foundational Standard will be achieved;
- Establish policy direction regarding a performance management and quality improvement system;
- Consider organizational capacity; and
- Establish strategic priorities for the organization that address local contexts and integrate local community priorities;

PROCEDURE

Development and Review

The strategic plan will be reviewed annually by management and the Board of Health. Input from Board of Health members, staff, stakeholders and community members will be sought as appropriate.

Revision and Approval

Any proposed revisions to the plan resulting from the annual review process will be finalized by the Directors Committee and presented to the Board of Health for final approval.

Implementation and Evaluation

Upon approval by the Board of Health, the strategic plan will be implemented and evaluated as identified in the agency planning cycle. The Medical Officer of Health & CEO will ensure the strategic plan is implemented. As appropriate, each Service Area will adapt their operational plans to align with the strategic directions of the plan.

Dissemination

The strategic plan will be made available to all staff and to the public.

APPLICABLE LEGISLATION

Ontario Public Health Organizational Standards

RELATED POLICIES

REVISION DATES (* = major revision)**:**

2012-04-19

2010-06-23*

2009-04-01*

2004-06-17

2003-10-16

MIDDLESEX-LONDON HEALTH UNIT

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SUBJECT: Strategic Planning **POLICY NUMBER:**
SECTION: **PAGE:**

2002-03-21

2000-03-21

1997-10-16

1995-03-02

1993-01-07

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT:	Board of Health Reports	**POLICY NUMBER:**	
SECTION:		**PAGE:**	
IMPLEMENTATION:	June 15, 1994	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	

PURPOSE

To ensure reports to the Board of Health are prepared and processed in a standardized format.

POLICY

All reports submitted by staff to the Board of Health must be addressed and formatted as per the MLHU Corporate Identity and Graphic Standards Manual and in accordance with the procedure in this policy.

In-camera reports will be typed by the Executive Assistant (EA) to the Medical Officer of Health (MOH).

PROCEDURE

General

Board of Health reports are initiated and prepared by appropriate Health Unit staff. Preparation of the agenda is the responsibility of the MOH in order to maintain a coordinated Board meeting agenda and to handle the inclusion of urgent issues.

Format

The Board Report template must be used to prepare board reports. Referencing will follow the most current version of the American Psychological Association (APA). Additional formatting details are in the MLHU Corporate Identity and Graphic Standards Manual.

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: Board of Health Reports **POLICY NUMBER:**
SECTION: **PAGE:**

Submission Protocol

After the agenda has been set, reports will be numbered sequentially from January 1 to December 31 with a two-digit reference to the year the report appeared before the Board. The EA to the MOH maintains a register of Board reports by report number, meeting date, subject matter and author(s).

Draft reports are to be reviewed by the Director and Manager before proceeding to the next step in the submission protocol.

Ten working days prior to the Board meeting, the following information must be submitted to the EA to the MOH for review by the MOH: a hard copy of the draft report and the relevant appendices. Staff will contact the EA to the MOH to determine the number of appendices required for each report. The EA to the MOH will provide an updated schedule of Board meeting dates and report submission deadlines to all staff.

The draft electronic version of the report is sent as an attachment through outlook to the EA of the MOH who will maintain computer files of the board reports in order to expedite minor revisions and to provide centralized management of the reports.

Major revisions to the draft reports by the MOH will be discussed with the author(s)/appropriate manager. If time permits the author is responsible for completing major revisions and resubmitting the report.

The final version of the report must be approved and signed by the MOH. The EA to the MOH will maintain a hard copy binder of in-camera reports.

Distribution

Board reports will be incorporated into packages for distribution to Board members by the EA to the MOH. The EA to the MOH will arrange for the delivery of packages to Board members to be received no later than the Friday of the week before the scheduled Board meeting.

SUBJECT: Board of Health Reports **POLICY NUMBER:**
SECTION: **PAGE:**

The EA to the MOH will distribute Board meeting packages, including in-camera reports, where appropriate to all members of the Directors Committee, the Communications Manager and the Manager of Special Projects, prior to the Board meeting. Directors circulate Board agenda, reports and minutes to staff in accordance with Service Area policies.

The EA to the MOH will send an electronic copy of the final Board Report to each of the Director(s)/Manager(s) who originally submitted them.

Board packages, excluding in-camera reports, will be made available to the Media by the Communications Manager prior to the scheduled Board meeting. The EA will also provide the Communications administrative assistant with a disc copy of the Board agenda package (excluding in-camera reports) to be posted to the Health Unit website.

APPLICABLE LEGISLATION

RELATED POLICIES

REVISION DATES (* = major revision)**:**

February 12 1997; July 20 2000; June 17 2004

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT:	Contractual Services	**POLICY NUMBER:**	**1-**
SECTION:		**PAGE:**	
IMPLEMENTATION:	August 30, 2000	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	January 18, 2007

PURPOSE

To outline the procedures for negotiating and documenting contractual agreements.

POLICY

A written contract will be negotiated with each provider or recipient of services.

The Board of Health is responsible for the approval of all contracts and agreements and may delegate this authority as specified in the Schedule for Approval of Contracts (Appendix A).

Board approval of contracts is done by resolution.

Unless otherwise specified, documents are to be executed (i.e., signed) by the approving authority of the non-Health Unit contractor/recipient. Documents that are to be executed by the Board of Health are to be signed by any two of the Chair, Vice-Chair or Secretary-Treasurer, unless otherwise required.

This policy applies to contracts for professional services invoiced on a fee for services basis, but does not apply to employment contracts, which are covered under Policy 5-25: Recruitment & Hiring. Professional services contracts are for services that generally are not performed by union employees.

PROCEDURE

Negotiation of the Contract

- The Director/Manager or designate will be responsible for negotiating the contract with the provider/recipient. Where the content of the contract is subject to a provincial policy or standard, the Director/Manager is responsible for ensuring that such policies and standards are followed.
- The Director/Manager will call upon the expertise of Finance and Human Resources, as appropriate to assist in the development, writing and review of the draft contract for services. The Medical Officer of Health (MOH) will be consulted as appropriate.
- It is highly recommended that the draft of the contract be submitted to the Health Unit solicitor for review where there is no recent precedent for the contract or where the contract is for a substantial amount of money or involves significant liability. See Policy 1-060: Signing Authority.
- A contract, with the exception of short-term contracts, may contain wording that provides for its amendment or early termination.
- All contracts should be fully executed prior to the commencement date for the provision of services.
- All original contracts will be filed with the Finance and Operations and/or Human Resources and Labour Relations Directors. A copy will be retained by the Director/Manager and by the other party/parties to the contract.

Contract Terms

All contracts will include the following:

- the term of the agreement (start and end dates);
- a description of the services to be provided;
- the rates to be paid for service and the method and frequency of payment;
- requirements for confidentiality;
- liability or consequences for failure to fulfil contract obligations;
- statement that the contracting agency or party is not an employee (and not subject to the applicable law of Ontario relating to employees), agent or partner of the health unit, and is an independent contractor;
- except with short-term contracts provisions for amending the contract or early termination and the processes and results involved;
- the required signatures (i.e. involved parties, witnesses) and the date of each signature;
- licensing and certification requirements for the contracting agency and/or qualifications, training, licensing and certification of the recipient party;
- statement that the law of Ontario is the applicable law;
- statement that the written contract is the entire agreement and any verbal agreement(s) are of no force and effect;

- statement that if any provision of contract is determined to be invalid or unenforceable in whole or in part, such invalidity or unenforceability shall attach only to such provision or part thereof and the remaining part of such provision and all other provisions hereof shall continue if full force and effect;
- statement regarding how and when notice in contract are to be delivered; and
- statement prohibiting the assignment of services.

A contract may also address the following terms, as appropriate:

- the conditions for the provision of service to the Health Unit, (i.e. who will provide the services, what expenses may be approved for reimbursement, required meetings);
- the nature and type of reporting to the Health Unit and procedures for recording and reporting service (e.g. quarterly reports);
- performance standards;
- conditions for liability from losses suffered as a result of the actions, negligence or any conduct of the provider/recipient;
- evidence of general liability and professional liability insurance of a specified amount;
- requirement to audit the provider/recipient's internal control records and documents;
- labour disruption (strike) clauses;
- confirmation that the contractor/recipient has no conflict of interest related to the subject matter of the contract;
- commitment to adhere to the MLHU policies, rules, regulations, procedures and guidelines;
- outline clearly the parties' respective roles and responsibilities with respect to joint appointments under affiliation agreements;
- outline recognition of authorship, ownership and proprietary rights and give direction concerning the retention or destruction of working papers, documents, etc.;
- funding specifications (i.e., any limitations or restrictions on the use or application of funds, whether continuation of the work is dependent on funding or advances of funds that are not spent to provide services, etc.) will be returned to the Health Unit or funder, as appropriate. See Policy 4-060: Grant Applications and Agreements.

Evaluation of Contracts

- Service provision under contract is evaluated informally on an ongoing basis. Periodic review of the contract and its standards, will be measured against achievements.
- Variances or discrepancies from contract requirements will be addressed in a timely manner by the Director/Manager that negotiated the terms of the contract and/or the Directors of Finance and Operations/Human Resources and Labour Relations.
- All contracts are evaluated before renewal.

APPLICABLE LEGISLATION

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: Contractual Services **POLICY NUMBER:** **1-**
SECTION: **PAGE:**

[A list of legislation that is applicable to the policy, ranked from most applicable to least applicable]

RELATED POLICIES

[A list of Administration Policies that are related to this policy]

Document should strive to NOT exceed two pages, and ALWAYS use plain language

REVISION DATES (* = major revision)**:**

[Revision dates should be listed vertically]

[Month DD, YYYY]

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ADMINISTRATION MANUAL

SUBJECT:	Media Relations	**POLICY NUMBER:**	
SECTION:		**PAGE:**	
IMPLEMENTATION:	September 23, 1992	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	July 27, 2011

PURPOSE

To maximize the media's interest in and coverage of public health issues, programs, activities and services.

To ensure that information is accurate, timely, relevant and maintains client confidentiality.

POLICY

The media plays an important role in the Health Unit's efforts to inform and raise awareness regarding public health issues, programs and services in Middlesex-London. Staff's prompt response to media requests allows the Health Unit to maintain strong and open lines of communication with both the media and the residents of Middlesex-London.

A Health Unit spokesperson is to be designated through consultation with the Communications Manager/Designate. The type of request and its potential implications will be taken into consideration.

The Communications Manager should be contacted to coordinate media requests and to provide guidance, advice or assistance to staff in how to respond to media inquiries.

Staff should inform the Communications Manager promptly when they are approached directly by the media.

The Communications Manager is to be consulted in the development of media messages and approaches when crisis communications are required.

The Health Unit has a legal obligation to keep medical information private and confidential. Information about patients/clients must not be released without the permission of the patient/client unless deemed essential to protect the health of the community.

PROCEDURE

Media Enquiries

All media requests should be directed to and cleared by the Communications Manager

The Communications Manager will act as media liaison and ask the appropriate Director/Manager/staff to respond to a media request. S/he will offer Health Unit staff advice, guidance or assistance as needed. In the event of a public health emergency/crisis all media requests are to be referred to and coordinated by the Communications Manager as outlined below. The Communications Program Assistant will act as media liaison in the absence of the Communications Manager.

Staff contacted directly by the media should refer the call to the Communications Manager, unless the staff person is the designated spokesperson on a media release. Members of the media are to be met by a staff person in the main reception area, on the first floor and must be escorted by a staff person at all times when on Health Unit premises. The Health Unit has the right to prohibit members of the media from interviewing patients/clients and staff, taking photographs or otherwise invading the privacy of individuals or staff.

MLHU-Initiated Media Communications

In order to ensure that Health Unit media projects or approaches are not compromised, all staff must consult with the Communications Manager before initiating contact with the media. All complaints or rebuttals regarding media coverage or the conduct of a member of the media must be handled by the Communications Manager. Media Releases are issued by the Office of the Medical Officer of Health and approved by the Communications Manager prior to release. When sending out a Media Release the Communications Manager will:

- work with staff to develop effective media messages;
- edits releases;
- distributes the release to appropriate media outlets;
- send a copy of the media release to the MOH, the Management Team, the designated spokesperson and posts the media release on the MLHU website; releases will be distributed to all staff via e-mail
- monitor, evaluate, and track media coverage and, if needed, advise/respond to media coverage.

Crisis Media Communications

Procedure(s) for this response are described in the Emergency Response Plan.

Staff Training

The Communications Manager educates staff about media relations and provides media training as required.

APPLICABLE LEGISLATION

RELATED POLICIES

REVISION DATES (* = major revision)**:**

[Revision dates should be listed vertically]

[Month DD, YYYY]

IMPLEMENTATION:	September 23, 1992	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	April 19, 2012

PURPOSE

To ensure that Health Unit activities are summarized annually and are available for review by key stakeholders and the general public as a means to document accountability.

POLICY

The Health Unit will have an annual report.

Information will be gathered from all Service Areas in order to highlight the program activities and fiscal accountabilities for the previous year.

PROCEDURE

Development of the Annual Report

The Communications Manager coordinates the development of the report.

Distribution of the Report

The Medical Officer of Health will present the report to the Board of Health.

Contents of the Report

The report shall be addressed to the public; include annual financial information; include a description of the mission, roles, processes, programs and operation of the public health unit; and include performance indicators that ensure transparency and accountability.

APPLICABLE LEGISLATION

RELATED POLICIES

REVISION DATES (* = major revision)**:**

June 1 1995

July 12 2000

October 13 2004

April 19 2012

Proposed Governance Manual with Change Summary and Next Steps

Appendix B to Report No. 018-16GC

Policy #	*Section*	*Policy & Appendices*	*Expected Date of Completion*	*Summary of Changes / Next Steps*
G-000	**Board of Health**	By-law, Policy and Procedures ➢ Appendix A - Development and Review Process ➢ Appendix B - Development and Review Checklist ➢ Appendix C - Development and Review Form ➢ Appendix D - Development and Review Change Table ➢ Appendix E - Archiving Process	November 2016	• Moved from Administrative Manual to Governance Manual • Amended to include Governance by-laws • Additional language included for guidelines, protocols and medical directives.
G-B10	**By-Laws**	By-law #1 - Management of Property	November 2016	• Replaces 1-010 • Separated into an individual by-law • Minor revisions for clarity
G-B20	**By-Laws**	By-law #2 - Banking & Finance	November 2016	• Replaces 1-010 • Separated into an individual by-law • Minor revisions for clarity
G-B30	**By-Laws**	By-law #3 - Proceedings of the Board of Health	November 2016	• Replaces 1-010 • Separated into an individual by-law • Minor revisions for clarity
G-B40	**By-Laws**	By-law #4 - Duties of the Auditor	November 2016	• Replaces 1-010 • Separated into an individual by-law • Minor revisions for clarity
G-010	**Strategic Direction**	Strategic Planning	November 2016	• Replaces 1-030 • Policy number changed • Revised – see blackline in Appendix A
G-020	**Leadership and Board Management**	MOH/CEO Direction	November 2016	• Newly developed policy
G-030	**Leadership and Board Management**	MOH/CEO Position Description ➢ Appendix A – MOH / CEO Position Description	November 2016	• Newly developed policy • Based on previous Board of Health reports

G-040	**Leadership and Board Management**	MOH/CEO Selection and Succession Planning	Q2 – 2017	• TBD
G-050	**Leadership and Board Management**	MOH/CEO Performance Appraisal ➢ Appendix A - Performance Appraisal Process ➢ Appendix B - Performance appraisal check-list ➢ Appendix C - Main performance appraisal form to be completed by the appraisers and the MOH/CEO ➢ Appendix D - Stakeholder performance appraisal tools process outline ➢ Appendix E - Sample email and performance appraisal questions for Board of Health members ➢ Appendix F - Sample email and performance appraisal questions for Direct Reports ➢ Appendix G - Sample email and performance appraisal questions for Community Partners	November 2016	• Newly developed policy • Based on previous Board of Health reports
G-060	**Leadership and Board Management**	MOH/CEO Compensation	Q4 – 2017	• TBD
G-070	**Leadership and Board Management**	MOH/CEO Reimbursement and Travel	Q4 – 2017	• TBD
G-080	**Program Quality and Effectiveness**	Occupational Health and Safety - Framework	Q2 – 2017	• TBD
G-090	**Program Quality and Effectiveness**	Quality Improvement - Framework	Q4 – 2017	• TBD
G-100	**Program Quality and Effectiveness**	Privacy & Security of Information ➢ Appendix A - Municipal Freedom of Information and Protection of Privacy Act Declaration	Q1 – 2017	• TBD
G-110	**Program Quality and Effectiveness**	Performance Monitoring	Q3 – 2017	• TBD
G-120	**Program Quality and Effectiveness**	Risk Management	Q1 – 2017	• TBD
G-130	**Program Quality and Effectiveness**	Ethics	Q3 – 2017	• TBD
G-140	**Program Quality and Effectiveness**	Respect for Diversity	Q3 – 2017	• TBD

Proposed Governance Manual with Change Summary and Next Steps

G-150	**Program Quality and Effectiveness**	Complaints	Q3 - 2017	• TBD
G-160	**Program Quality and Effectiveness**	Jordan's Principle	Q4 – 2016	• TBD
G-170	**Financial and Organizational Accountability**	Financial Objectives	Q2 – 2017	• TBD
G-180	**Financial and Organizational Accountability**	Financial Planning and Performance	Q2 – 2017	• TBD
G-190	**Financial and Organizational Accountability**	Asset Protection	Q2 – 2017	• TBD
G-200	**Financial and Organizational Accountability**	Approval and Signing Authority	November 2016	• Replaces 1-060 • Policy number changed • Reviewed – no content changes • ***Forward to FFC for review and approval***
G-210	**Financial and Organizational Accountability**	Borrowing	Q2 – 2017	• TBD
G-220	**Financial and Organizational Accountability**	Contractual Services ➢ Appendix A – Approval Directory	November 2016	• Replaces 1-080 • Policy number changed • Reviewed – no content changes • ***Forward to FFC for review and approval***
G-230	**Financial and Organizational Accountability**	Procurement ➢ Procurement Guidelines	November 2016	• Replaces 1-070 • Policy number changed • Reviewed – updated for new organizational structure • ***Forward to FFC for review and approval***
G-240	**Financial and Organizational Accountability**	Tangible Capital Assets	Q2 – 2017	• TBD

Proposed Governance Manual with Change Summary and Next Steps

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G-250	**Financial and Organizational Accountability**	Reserve and Reserve Funds	Q2 – 2017	• TBD
G-260	**Board Effectiveness**	Governance Principles and Board Accountability	Q1 – 2017	• TBD
G-270	**Board Effectiveness**	Roles and Responsibilities of the Board of Health ➢ Appendix - Board of Health Members ➢ Appendix - Board of Health Chair & Vice Chair ➢ Appendix - Board of Health Secretary-Treasurer	November 2016	• Replaces 1-010 • Newly developed policy • Based on previous Board of Health reports • Additional content integrated from other policy examples
G-280	**Board Effectiveness**	Board Size and Composition	November 2016	• Replaces 1-010 • Newly developed policy • Based on previous Board of Health reports
G-290	**Board Effectiveness**	Standing and Ad Hoc Committees ➢ Appendix A - Governance Committee Terms of Reference ➢ Appendix B - Governance Committee Reporting Calendar ➢ Appendix C – Finance and Facilities Committee Terms of Reference ➢ Appendix D – Finance and Facilities Committee Reporting Calendar	November 2016	• Replaces 1-010 • Newly developed policy • Based on previous Board of Health reports
G-300	**Board Effectiveness**	Board of Health Self- Assessment ➢ Appendix A – Board of Health Self-Assessment Tool	November 2016	• Replaces 1-010 • Newly developed policy • Based on previous Board of Health reports
G-310	**Board Effectiveness**	Board of Health Corporate Sponsorship	Q1 – 2017	• TBD
G-320	**Board Effectiveness**	Board of Health Donations	Q1 – 2017	• TBD
G-330	**Board Effectiveness**	Board of Health Gifts and Honorariums	Q1 – 2017	• TBD
G-350	**Board Effectiveness**	Nominations and Appointments to the Board of Health	November 2016	• Replaces 1-010 • Newly developed policy • Based on previous Board of Health reports

Proposed Governance Manual with Change Summary and Next Steps

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G-360	**Board Effectiveness**	Resignation and Removal of Board Members	Q3 - 2016	• TBD
G-370	**Board Effectiveness**	Board of Health Orientation and Development	November 2016	• Replaces 1-020 • Newly developed policy • Based on previous Board of Health reports
G-380	**Board Effectiveness**	Conflicts of Interest & Declaration ➢ Declaration Form	November 2016	• Newly developed policy
G-390	**Board Effectiveness**	Code of Conduct ➢ Appendix A – Corporate Code of Conduct ➢ Appendix B – BOH Code of Conduct	Q3 – 2017	• Replaces 1-110 • Policy number change • Contained in the November policy manual but to be reviewed more extensively in 2017
G-410	**Board Effectiveness**	Board Member Remuneration	Q1 – 2017	• TBD
G-420	**Board Effectiveness**	Board Member Reimbursement and Travel	Q1 – 2017	• TBDs
G-430	**Communications and External Relations**	Advocacy	Q4 – 2017	• TBD
G-440	**Communications and External Relations**	Community Engagement	Q4 – 2017	• TBD
G-450	**Communications and External Relations**	Relationship with the Ministry of Health and Long-Term Care and Local Health Integration Network	Q4 – 2017	• TBD
G-460	**Communications and External Relations**	Relationships with Other Health Service Providers and Key Stakeholders	Q4 – 2017	• TBD
G-470	**Communications and External Relations**	Annual Report	November 2016	• Replaces 1-100 • Policy number change • Revised – see blackline in Appendix A

G-480	**Communications and External Relations**	Media Relations	November 2016	• Replaces 1-090 • Policy number change • Revised – see blackline in Appendix A
G-490	**Communications and External Relations**	Board of Health Reports ➢ Appendix A – Board of Health Report Template ➢ Appendix B – Governance Report Template ➢ Appendix C – Finance and Facility Report Template	November 2016	• Replaces 1-040 • Policy number change • Addition of Appendices • Revised – see blackline in Appendix A

SUBJECT:	By-laws, Policy and Procedures	**POLICY NUMBER:**	**G-000**
SECTION:	Board of Health	**PAGE:**	1 of 5

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

The Middlesex-London Health Unit (MHLU) is committed to providing a consistent approach to effective, open, and supportive systems of governance and management. The purpose of this policy is to outline the process for the development and review of the policies contained within the Health Unit's Governance and Administration Manual.

POLICY

All by-laws and policies at the Middlesex-London Health Unit must:

- Reflect the goals and values of MLHU and the Board of Health;
- Comply with relevant legislation and regulations;
- Be specific and clearly worded;
- Be relevant to the current and future needs of the MLHU and the Board of Health;
- Follow the prescribed development and review process (Appendix A);
- Be published according to MLHU policy standards (Appendix B); and
- Undergo biannual review.

PROCEDURE

Middlesex-London Health Unit Governance and Administration Manual shall include:

Governance By-laws and Policies

The Board of Health is responsible for the Health Unit's governance by-laws and policies. These represent the principles that set the direction, limitations and accountability frameworks for MLHU. Governance by-laws relate to management of property, banking and finance, proceedings of the Board of Health, and duties of the auditor. Governance Policies relate to strategic direction, leadership and board management, program quality and effectiveness, financial and organizational accountability, board effectiveness and communications and external relations.

Administrative Policies & Procedures

The Senior Leadership Team is responsible for the Health Unit's administrative policies. These policies align the procedures for managing MLHU and to establish efficiency, consistency, responsibility and accountability. Administrative policies relate to general administration, property, finance, human resources, records and privacy, information technology, health and safety, and communications.

Policy	Brief statement(s) that clearly set out Board of Health and/or Health Unit principles and rules with respect to a particular matter to provide the organization with a specific direction.
Procedure	Clear, high-level description of responsibilities and steps to implement the policy. Separate from program guidelines, plans and/or manuals. Note: often legislation will require the employer to create both a policy and a program to address a specific issue (e.g., fit testing). Program details are best outlined separate from written policy, and made available to staff on the intranet or in standards, protocols or guidelines.

Standards, Protocols and Guidelines

The Middlesex-London Health Unit Governance and Administration Manual does not include standards, protocols or guidelines that further operationalize policies and procedures at the divisional or team level. These are developed at the sole discretion of Directors and Program Managers who are responsible for the standards, guidelines and protocols that apply specifically to the work of their divisions and team.

Standards	Establishes the acceptable level of quality with quantifiable low level mandatory controls.
Protocols	A protocol is a step by step descriptive guideline to achieve completion of a task and is to be followed in letter and spirit in all circumstances.
Guidelines	Provide additional recommended guidance to implement programs and services or to adhere to administrative policies and procedures.

Medical Directives

The Middlesex-London Health Unit Governance and Administration Manual does not include medical directives which apply to a specific patient population who meet specific criteria. A medical directive is role specific (e.g., NP, RD, RN) not person specific and users within the role must possess the necessary knowledge, skill and judgment before implementing a medical directive.

- Given in advance to enable an implementer to act under specific conditions without a direct assessment by the physician.
- Implementers are not ordering a procedure when they implement a directive; rather they are implementing a physician's order.
- Must have the integrity of a direct order, thus physicians potentially responsible must approve it.
- Is approved only when all affected regulated professionals and relevant administrators participate in their development.
- Is always written and has essential components.

Policy Development

Governance policy development can be initiated by the Board of Health. The Senior Leadership Team may also provide recommendations regarding governance policies to the Board of Health for consideration.

Administrative policy development can be initiated by the Medical Officer of Health and Chief Executive Officer and/or the Senior Leadership Team. Additionally, an administrative policy development and revision form (Appendix C) can be submitted by a member of the Non-union Leadership Team for consideration and direction from the Senior Leadership Team.

For both governance and administrative policy development, the Senior Leadership Team will determine the assignment of responsibility for development of the policy, the consultation process and timelines. The consultation and development process will include input from the Manager of Strategic Projects, the policy sponsor(s), content expert(s) and additional stakeholders, as required.

Standard, protocol and guideline development can be initiated in response to a specific need. It is recommended that standards, protocols and guidelines align with administrative policies and serve as appendices to organization-wide policies rather than stand-alone documents.

Policy Review

Policies contained within the Administration Manual will be reviewed every two years (biannually) or as needed, based on changing legislation or organizational needs.

The Manager of Strategic Projects is responsible for the biannual review and will coordinate policy workgroups (where appropriate) to ensure that review of each policy occurs according to this cycle.

Review and revision of governance policies can be initiated at any time by the Board of Health or recommended to the Board of Health by the Senior Leadership Team.

Administrative policy review and revision can also be initiated at any time by a member of the Senior Leadership Team or the Non-union Leadership Team. Review and revision from the Non-union Leadership Team should be submitted through a policy development and revision form (Appendix C) to the Manager of Strategic Projects and then on to the Senior Leadership Team for consideration.

For both governance and administrative policy development, the Senior Leadership Team will determine the assignment of responsibility for development of the policy, the consultation process and timelines. The consultation and development process will include input from the Manager of Strategic Projects, the policy sponsor(s), content expert(s) and additional stakeholders, as required.

All changes to policy should be tracked with the policy change table (Appendix D) to streamline consideration and approval.

The most recent review date will be listed on each policy in addition to the original implementation date. Each revision date is listed after the previous revision date(s).

Policy Approval

Governance policies can only be approved by the Board of Health. New or revised policies will be ratified by the signature of the current Board of Health Chair.

The Senior Leadership Team will approve all new or revised administrative policies that pertain to the operational management of the Health Unit, except where Board of Health approval is also required. New or revised policies will be ratified by signature of the Medical Officer of Health and Chief Executive Officer.

Standards, protocols and guidelines will be approved and ratified by signature of Divisional Directors and are to be reviewed regularly for alignment with organizational policies.

Policy Distribution and Retention

The Manager of Strategic Projects is responsible for ensuring the Administration Manual is posted on the MLHU Intranet, and that all new policies and revisions are communicated to staff.

Withdrawn Policies

The Manager of Strategic Projects, in consultation with sponsors and/or content experts will recommend policies to be withdrawn from the agency manual to the appropriate approval body. The Manager of Strategic Projects will maintain a copy of withdrawn policies including their withdrawal date, the reason for withdrawal, and the appropriate signature.

Administrative Manual Archiving

The Manager of Strategic Projects will ensure that each change to the Administrative Manual is tracked and that copies of each revision are kept to protect against potential future litigation.

The process for Administration Manual distribution, policy withdraws and archiving can be found in Appendix E.

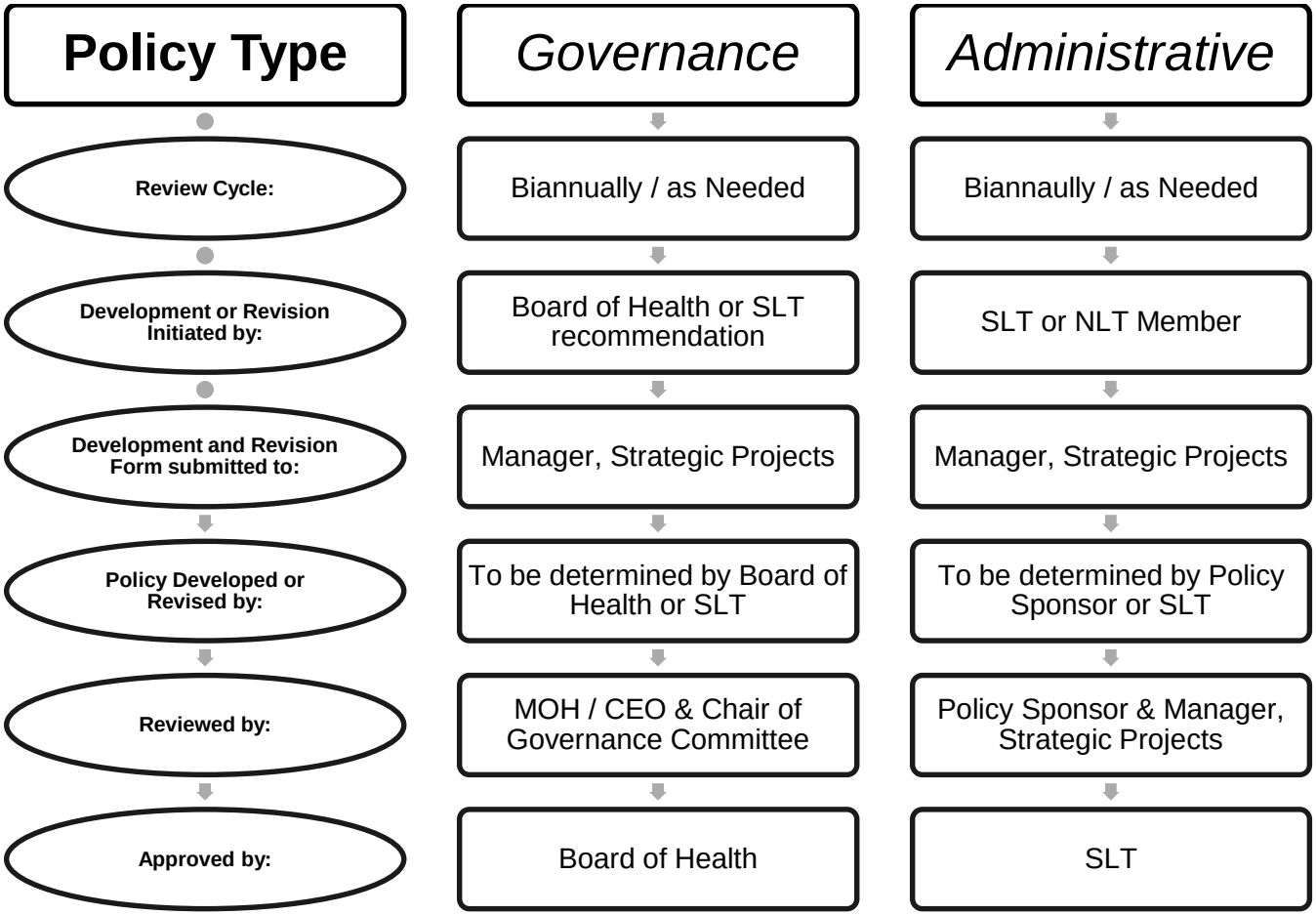
APPLICABLE LEGISLATION

Health Protection and Promotion Act, R.S.O. 1990, c. H.7
Ontario Public Health Organizational Standards

RELATED POLICIES

REVISION DATES (* = major revision)**:**

Policy Development and Review Process



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Policy Development and Review Checklist

Purpose

1. Do all review members understand the policy goal?
2. Is it clear to whom and what the policy applies?
3. Will the policy be uniformly applied and enforced in all Service Areas?
    a. If not, ensure Service Area identifies how it will be applied and/or enforced.

Risk, Best-Practice and Impact

1. If appropriate, have policies from other Boards of Health been examined for comparison?
    a. If yes, list the Boards of Health that were examined.
2. If appropriate, have policies from similar institutions been examined for comparison?
    a. If yes, list the institutions that were examined.
3. If appropriate, has applicable legislation been identified and reviewed to ensure adherence?
    a. Ensure applicable legislation is identified in policy.
4. Have proposed major practice changes been reported to and/or discussed with stakeholders so that they are aware of the implications of any potential change?
    a. If yes, does this policy affect the organization's reporting, service delivery or planning cycles?
    b. If yes, list stakeholders that were engaged.
5. Are the responsibilities under this policy assigned to a person(s), in a way that is compatible with organizational roles?

Alignment

1. Does the document align with the Middlesex-London Health Unit Vision, Mission and Values?
2. Does the document align with the Middlesex-London Health Unit Code of Conduct?
3. Is there another policy with the same or a similar intent?
    a. If yes, can these be integrated?
    b. If yes, are appropriate references included to related policies?
    c. If yes, is it clear when each policy will apply?

Implementation

1. Will there be any training or professional development requirements associated with the development, implementation or monitoring of this policy?
    a. If yes, ensure these are explicit in the policy?
2. Is there a defined implementation date (the date the policy comes into force)?
3. Is there a unique proposed review date?

Structure & Appropriateness

1. Does the document follow our policy template?
2. Do all logos and/or images follow our graphics standards?
3. Has appropriate formatting been used (e.g., bullets, numbered-lists, headings, etc.)
4. Is the "purpose" section clearly distinct from the "policy" section?
5. Have all procedures been separated from the "policy" section?
6. Does the document consider diversity, accessibility or equal opportunity?
7. Does the document employ gender-neutral and inclusive language?
8. Have all references in the draft policy been verified as accurate and current?

Clarity

9. Are key terms (and any new terms) adequately defined?
10. Is terminology consistent across all documents?
11. Is the policy written in a manner that can be understood by a wide audience (i.e., plain language)?

Implementation Checklist

Administrative Manual

1. Approved document added to master copy
2. Replaced document removed (if applicable)
3. Table of contents updated (if applicable)

Intranet

4. Approved document added to policy page

Archive

5. Add replaced document to electronic policy archive

Implementation

6. Is there a plan to inform all staff of the relevant policy changes?

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Appendix C
Policy G-000

Development and Revision Form

Review Type:	☐Develop (New policy) ☐Consider (New policy) ☐Review, no changes required ☐Move ☐Redraft ☐Revision ☐Remove/ Withdraw	Indicate if this is a new by-law, policy or a revision or if the policy is being rescinded.
Title:		Enter title as it will appear on the by-law or policy.
Section:		List the section that best applies.
Associated Documents:	•	Enter all associated documents.
Keywords:		Enter 10 keywords for ease of searching.

Purpose

Issue or need to be addressed:	•	State the problem, issue or need that the by-law or policy is intended to address.
Scope of the proposed by-law policy or revision:	•	Does this by-law or policy apply to a specific division, program, collective agreement, etc.?

Development Plan

Sponsor:	•	Person responsible for the by-law or policy. Mandatory for all documents.
Development Responsibility:	•	Identify the person responsible and accountable for the development process for the by-law or policy.
Consultation Group & Stakeholder List:	•	Stakeholders to be consulted – list name and title; If Committees/Groups: list name of committee, group, department, etc.
Approver:	•	Board of Health or Senior Leadership Team

Development and Review Change Table

Suggested Revision	**Rationale**
Input itemized revisions to the by-law or policy being made	Provide the rationale for why the revision was made
List subsequent revisions in the space below – add additional rows if necessary	

Manual Archiving and Update Process

Prior to adding a new or revised policy to the Policy Manual:

- Obtain signature from the relevant signing authority (Board of Heath or Medical Officer of Health & CEO)
- Copy the current ***AdminManual- Master***, to the ***AdminManual-Archive*** and place in a new folder labelled ***year-month-day*** with the date that it was archived.

To add a new, revised, or to document a withdrawn policy for the ***AdminManual-Master***:

- After archiving, remove all policies in the ***Approved-New Policies***, ***Approved-Revised Policies*** and ***Approved-Withdrawn Policies*** from each of these folders.
- For the new policies, include a copy of the newly added policy in the ***Approved-New Policies*** folder and add the new policy with signed master to the ***Master Copy***.
- For revised policies, include a copy of the newly revised policies in the ***Approved-Revised Policies*** folder and add the revised policy to the ***Master Copy***.
- For withdrawn policies, include a copy of the withdrawn policies in the ***Approved-Withdrawn Policies*** folder and remove the withdrawn policy from the ***Master Copy***.

Update the Table of Contents

- Make note of any changes that resulted to the table of contents

Post new and revised policies, updated table of contents and delete withdrawn policies from the HUB

Update Policy Tracking Form

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

2. The Board shall hold title to any real property acquired by the Board for the purpose of carrying out the functions of the Board and may sell, exchange, lease, mortgage, or otherwise charge or dispose of real property owned by it, subject to Section 52(4) of the Act. Section 52(4) of the Act does not apply unless the board of health has first obtained the consent of the councils of the majority of the municipalities within the health unit served by the board of health. R.S.O. 1990, c. H.7, s. 52 (4); 2002, c. 18, Sched. I, s. 9 (8).

3. (a) The Secretary-Treasurer shall be responsible for the care and maintenance of all properties as required by the Board.

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

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

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

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

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

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

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

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

First Reading – November 17, 2017
Second Reading – November 17, 2017
Third Reading – November 17, 2017

This Bylaw to be in force and effect from , 2017, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this 17th **day of NOVEMBER, 2017.**

Reviewed by:	Governance Committee	
Approved by:	Board of Health	
Date:	November 17, 2016	
Signature:	Jesse Helmer Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

4. Two signatures shall be required on each cheque, comprising one Board Member and the Secretary-Treasurer. These signatures shall be kept and held in custody with the Associate Director, Finance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First Reading – November 17, 2016
Second Reading – November 17, 2016
Third Reading – November 17, 2016

This Bylaw to be in force and effect from November 17, 2016, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this 17th day of November 2016.

Reviewed by:	Finance & Facilities Committee	
Approved by:	Board of Health	
Date:	November 17, 2016	
Signature:	Jesse Helmer Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. In this bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.0 General

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

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

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

1.4 No persons shall smoke in the Board meeting room.

2.0 Convening Meeting

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

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

3.0 Special Meetings

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

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

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

4.0 Notifying Board Members of Meetings

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

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

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

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

4.5 The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

5.0 Notifying the Public of Board Meetings

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

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

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

6.0 Meetings Open to the Public

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

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

7.1 Pre-requirements for in-camera sessions

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

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

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

7.2 Criteria for in-camera meetings

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

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

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

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

(d) labour relations or employee negotiations;

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

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

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

7.3 Criteria for in-camera voting

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

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

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

7.4 In-camera record keeping requirements

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

8.0 Preparation of the "Agenda"

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

(a) Call to Order and Declarations of Interest;

(b) Minutes of Previous Meeting;

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

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

(e) Other Business from the Floor;

(f) Date of Next Meeting;

(g) Adjournment

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

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

9.0 Commencement of Meetings

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

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

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

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

10.0 Rules of Debate and Conduct of Members of the Board

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

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

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

10.4 When a member finds it impossible to attend any meeting, the onus is upon the member to advise the Secretary-Treasurer prior to the holding of such meeting, and to advise of his wishes with respect to having an agenda item tabled.

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

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

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

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

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

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

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

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

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

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

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

11.0 Motions and Order of Putting Questions

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

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

(a) to accept;

(b) to recommend for approval;

(c) to approve in principle;

(d) to approve;

(e) to ratify;

(f) to adopt;

(g) to amend;

(h) * to table;

(i) to refer;

(j) to receive;

(k) * to adjourn the meeting; or

(l) * that the vote be now taken.

* these items are to be voted on without debate.

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

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

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

12.0 Voting

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

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

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

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

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

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

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

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

13.0 Minutes

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

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

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

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

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

14.0 Adjournment

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

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

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

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

15.0 Communications

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

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

16.0 Proceedings on Bylaws

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

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

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

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

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

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

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

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

17.0 Secretary-Treasurer and Board Solicitor

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

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

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

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

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

17.2 It shall be the duty of the Board Solicitor:

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

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

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

18.0 Elections and Appointment of Committees

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

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

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

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

19.0 Conduct of Business in Committees

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

19.2 It shall be the duty of the Committee:

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

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

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

20.0 Corporate Seal

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

21.0 Execution of Documents

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

22.0 Duties of Officers

22.1 The Chair of the Board shall:

(a) preside at all meetings of the Board;

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

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

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

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

23.0 Remuneration

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

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

24.0 Board of Health Performance Assessment

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

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

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

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

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

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

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

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

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

25.0 Amendments

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

26.0 General

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

First Reading – November 17, 2016
Second Reading – November 17, 2016
Third Reading – November 17, 2016

This Bylaw to be in force and effect from November 17, 2016, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this 17th day of November 2016.

Mr. Jesse Helmer
Chair

Dr. Christopher Mackie
Secretary-Treasurer

Reviewed by:	Governance Committee	
Approved by:	Board of Health	
Date:	November 17, 2016	
Signature:	Jesse Helmer Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

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

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

1. (a) The Board shall appoint an Auditor who shall not be a member of the Board and shall be licensed under the *Public Accountancy Act, 2004,* S.O. 2004, c. 8..

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

2. The Auditor shall:

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

   (b) perform such duties as are prescribed by the Ministry of Municipal Affairs and Housing, Ministry of Health and Long-Term Care, and the Ministry of Children and Youth Services with respect to local boards under the *Municipal Act*, S.O. 2001, c. 25 and the *Municipal Affairs Act*, R.S.O. 1990, c. M. 46 and Health Protection and Promotion Act, R.S.O. 1990, c. H.7

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

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

First Reading – November 17, 2016
Second Reading – November 17, 2016
Third Reading – November 17, 2016

This Bylaw to be in force and effect from November 17, 2016, and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this 17th day of November 2016.

Reviewed by:	Finance & Facilities Committee	
Approved by:	Board of Health	
Date:	November 17, 2016	
Signature:	Jesse Helmer Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

SUBJECT:	Strategic Planning	**POLICY NUMBER:**	**G-010**
SECTION:	Strategic Directions	**PAGE:**	1 of 2

IMPLEMENTATION:	1992-09-09	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

To ensure the development, implementation and review of the strategic plan that outlines the organization's goals and objectives.

POLICY

A strategic plan will be developed in consultation with the Board of Health, staff, stakeholders and community members as appropriate to identify the strategic directions for the Health Unit.

The Strategic Plan will cover a 3 to 5 year timeframe, and will:

- Describe the philosophy/mission, a values statement, and the goals and objectives of the board of health;
- Describe how equity issues will be addressed in the delivery and outcomes of programs and services;
- Describe how the outcomes of the Foundational Standard will be achieved;
- Establish policy direction regarding a performance management and quality improvement system;
- Consider organizational capacity; and
- Establish strategic priorities for the organization that address local contexts and integrate local community priorities;

PROCEDURE

Development and Review
The strategic plan will be reviewed annually by management and the Board of Health. Input from Board of Health members, staff, stakeholders and community members will be sought as appropriate.

Revision and Approval
Any proposed revisions to the plan resulting from the annual review process will be finalized by the Directors Committee and presented to the Board of Health for final approval.

Implementation and Evaluation
Upon approval by the Board of Health, the strategic plan will be implemented and evaluated as identified in the agency planning cycle. The Medical Officer of Health & CEO will ensure the strategic plan is implemented. As appropriate, each Division will adapt their operational plans to align with the strategic directions of the plan.

Dissemination
The strategic plan will be made available to all staff and to the public.

APPLICABLE LEGISLATION

Ontario Public Health Organizational Standards

RELATED POLICIES

REVISION DATES (* = major revision)**:**
2012-04-19
2010-06-23*
2009-04-01*
2004-06-17
2003-10-16
2002-03-21
2000-03-21
1997-10-16
1995-03-02
1993-01-07

SUBJECT:	MOH / CEO Direction	**POLICY NUMBER:**	**G-020**
SECTION:	Leadership and Board Management	**PAGE:**	1 of 2

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

Governance and management are more effective and efficient when they are separated – the Board being responsible for governance, and the Medical Officer of Health / Chief Executive Officer (MOH / CEO) for management. The Board provides direction to the MOH / CEO, who is responsible for the execution of those directions. This policy outlines the parameters of that authority.

POLICY

As part of its responsibility for providing excellent management, the Board of Health selects and appoints the Medical Officer of Health / Chief Executive Officer (MOH / CEO) and delegates responsibility and authority to the MOH / CEO for the management and operation of The Middlesex-London Health Unit (MLHU). The MOH / CEO is accountable to the Board of Health and is the Board's sole official connection to MLHU management and operations.

The Board provides direction to the MOH / CEO in accordance with policies established by the Board, who has the authority to manage and direct the business affairs of MLHU except where matters and duties must be performed or transacted by the Board according to law, MLHU by-laws or other statutes.

PROCEDURE

The MOH / CEO is required to followed the direction of the Board as received through the Chair. Only decisions that have been made by the Board, when acting as a body are binding on the MOH / CEO. When requests are made by Board members or Board sub-committees and not subject to full Board of Health approval, such requests can be accepted at the MOH / CEO's discretion when the request may entail significant staff time or financial resources to be accommodated. These matters may be referred to the Board Chair for discussion should a request be denied.

The MOH / CEO will report, and be responsible to the Board for implementing the strategic plan, management of property, banking and finance and day-to-day operations of MLHU.

Specifically, the MOH / CEO will ensure:

- MLHU operations are conducted and that client care is provided in accordance with MLHU by-laws and polices established by the Board and all applicable legislation;
- Ensure that MLHU practices are undertaken prudently, lawfully and in an equitable and congruent manner with commonly accepted business practices and professional ethics;

- Ensure that MLHU assets are protected, adequately maintained and not placed at unnecessary risk;
- Ensure that Board-approved strategic priorities are reflected in the allocation of resources;
- Ensure that budgeting is based on generally accepted financial planning practices that balance expenditures in any fiscal year against expected revenues;
- Promote a healthy workplace culture for staff, students and volunteers consistent with the values of MLHU;
- Represent MLHU in the community, government and media in ways that enhance the public image and credibility of MLHU; and
- Perform such duties as outlined in the CEO position description.

The MOH / CEO shall also provide support to the Board in the discharge of its responsibilities by ensuring the Board if well-informed and supported in its work.

APPLICABLE LEGISLATION

- Health Protection and Promotion Act, R.S.O. 1990, c. H.7
- Municipal Act, 2001, S.O. 2001, c. 25

RELATED POLICIES

- G-010 Strategic Planning

REVISION DATES (* = major revision)**:**

SUBJECT:	Medical Officer of Health / Chief Executive Officer Position Description	**POLICY NUMBER:**	**G-030**
SECTION:	Leadership and Board Management	**PAGE:**	1 of 2

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

This policy identifies the detailed duties and responsibilities of the Medical Officer of Health and Chief Executive Officer (MOH / CEO). The position description provides the foundation for effective performance management of incumbents and for selection and succession planning.

POLICY

The MOH / CEO position is essential for the overall success of the Middlesex-London Health Unit (MLHU) in achieving compliance with Ontario Public Health Standards, Ontario Public Health Organizational Standards, Public Health Financial and Accountability Agreements and ensuring that MLHU is meeting its strategic objectives.

The Health Protection and Promotion Act (HPPA) outlines the duties of the Medical Officer of Health, but it does not detail the role and responsibility of the CEO. The role of the CEO in guiding the organization in the management and administration of financial resources, community partnerships, public health systems infrastructure, organizational design and strategic planning are integral to the overall success of MLHU.

PROCEDURE

A detailed position description for the MOH / CEO can be found attached as Appendix A.

APPLICABLE LEGISLATION

- Health Protection and Promotion Act, R.S.O. 1990, c. H.7
- Ontario Public Health Standards
- Ontario Public Health Organizational Standards

SUBJECT:	Medical Officer of Health / Chief Executive Officer Position Description	**POLICY NUMBER:**	**G-030**
SECTION:	Leadership and Board Management	**PAGE:**	1 of 2

RELATED POLICIES

- By-law #1 – Management of Property
- By-law #2 – Banking & Finance
- By-law #3 – Proceedings of the Board of Health
- G-010 Strategic Planning
- G-050 Performance Management and Evaluation

REVISION DATES (* = major revision)**:**

MIDDLESEX-LONDON HEALTH UNIT

Title: **MEDICAL OFFICER OF HEALTH & CHIEF EXECUTIVE OFFICER**	HR Code: NU18 Page: 1 of 5
Salary Range: See Policy G-060 MOH / CEO Compensation	Status: Non-union
Reports to: Board of Health	Salary Band: N/A
Original Date Approved: September 1997	Revision Date: April 2000 January 1, 2001 March 16, 2006 October 19, 2006 August 2010 October 2014 November 17, 2016

Signature: _____
Chair, Board of Health

_____
Director, Corporate Services

Summary:

Based on the Health Protection and Promotion Act (HPPA), the Medical Officer of Health (MOH) reports directly to the Board of Health and is responsible for the strategic leadership of the health unit and management of public health programs and services for the City of London and County of Middlesex as described in the HPPA, its regulations, the Ontario Public Health Standards, Ontario Public Health Organizational Standards, Public Health Financial Accountability Agreements, and any other Legislative Act.

The MOH acts as the public health medical consultant and the Chief Executive Officer (CEO) accountable to the Board of Health for the achievement of MLHU's mandate to protect and promote health and to prevent disease.

Staff:

Associate Medical Officer of Health & Director, Foundational Standard; Director, Corporate Services; Director, Environmental Health & Infectious Disease; Associate Director, Finance; Director, Health Living; Director, Healthy Start; Manager, Communications; Executive Assistant to the Medical Officer of Health

Expectations:

Knowledge of the organization:

The MOH / CEO must have detailed knowledge of all aspects of the organization as a whole in order to carry out the duties of the role.

Decision Making and Responsibility:

This position is responsible for solving problems that are complex and unique. Improper interpretation of Provincial and/or Federal legislation and policies could result in financial loss and legal, health or political impact to the health unit, the province, the public, education and social service agencies, and other interests.

Failure to provide sound advice and guidance to the management team and community with regard to public health matters could result in inappropriate decision-making, the development of ineffective strategies and programs that have significant financial, health and public relations costs to the health unit and the community.

Failure to identify key emerging public health issues and trends to ensure appropriate strategies and programs are in place could result in the health unit being unable to meet health challenges and therefore unable to effectively meet is legislated requirements, mandates for health promotion and protection, disease prevention and strategic goals.

Communication:

The Manager of Strategic Projects is expected to have excellent verbal and written skills. Regular presentations to and reports for the Board of Health are requirements of the position. As Chair of the Senior Leadership Team, excellent group facilitation skills are necessary.

The position requires liaison and negotiation with external stakeholders, as appropriate. These include the Chief Medical Officer of Health, other provincial government personnel, municipal representatives and personnel from other health units. The MOH / CEO maintains effective and ongoing communication with those served by the Board of Health, as well as key partner agencies including, but not limited to local hospital administrators, LHIN's, academic institutions, family health teams, community health centres and other healthcare institutions.

The MOH / CEO also maintains a profile with the public through regular and ongoing media communications.

Technical knowledge and skills:

The MOH / CEO requires sufficient knowledge, skills and abilities to fulfill the purpose and key responsibilities of the position. This includes the ability to determine the health needs of the populations served by the Board of Health and to lead the health unit to optimally provides for these public health needs.

Leadership skills are considered essential to this position to facilitate engagement with Board members, management, staff, and stakeholders to achieve an alignment of goals, action and resources with the identified public health needs and to communication effectively to achieve these changes.

A willingness and abilities to meet and work with people throughout the health unit area and elsewhere in the province for community engagement and advocacy processes is also required.

Sensory, Physical Demands, and Health and Safety Requirements:

This position is carried out in a standard office setting and potential to work in a clinical exam setting.

Physical:

- Working after hours is required;
- Significant travel and occasional time away overnight; and
- Potential for periods of prolonged working hours (i.e. public health emergencies)

Mental:

- Required to monitor, read comprehend and synthesize information from a wide range of sources, determine relevance and application to public health, determine strategic direction required for public health intervention and overall agency strategies and regulatory compliance;
- Needs to identify community health needs and exercise community medicine specialty skill base to effectively provide leadership and direction to staff and advice to the Board of Health;
- Advocate for governance and management core competencies to be identified and met such as Board of Health skill sets and management team competencies;
- Use information to develop health intelligence to be applied to decision-making for public health programs and advocacy for public health policy;
- Manage multiple demands and priorities from the community, government, the Board of Health, including short, medium and long-term deadlines, crisis management, future orientation, change management and ongoing consultation; and
- Leading, developing strategies and making decisions involving major resource of the health unit.

Professionalism and Standards of Performance:

The MOH / CEO is expected to meet all professional standards and follow all applicable legislation requirements under the Health Protection and Promotion Act, Organizational Standards, Public Health Standards, and other relevant legislation and protocols.

Medical Officer of Health Duties:

Maintain compliance to all legislative components of the HPPA or any other relevant legislation to ensure the achievement of the Ontario Public Health Standards (OPHS), Ontario Public Health Organizational Standards (OPHOS) and the Public Health Financial and Accountability Agreements (PHFAA).

Keep informed of population health needs as well as the most effective and appropriate means of addressing these concerns in accordance with HPPA, OPHS, OPHOS, and PHFAA. This requires that the MOH / CEO maintain an awareness of the most useful information sources, monitors them, interprets, and synthesizes information in order to determine changes required in health unit programming or action for healthy public policy advocacy.

Work in collaboration and provide leadership to the Board of Health, health unit management and staff, partner agencies, the community and broader public health community. The MOH / CEO has the ability to create opportunities to speak out on an ongoing basis regarding public health matters.

Ensure optimally functioning systems are in place for population health surveillance and assessment, operational planning, program monitoring, evaluation and implementation of improvements based on evaluation findings and program delivery.

Work effectively with colleagues (other health units, Ministry of Health and Long-Term Care and Municipal Governments) to safeguard and enhance the public health system.

Participate in the education and mentoring of public health professionals, and students/trainees through a range of education forums.

Maintain effective relations and communication with the Chief Medical Officer of Health (CMOH) and other personnel within the Ministry of Health and Long-Term Care and other provincial agencies. As part of these relationships the MOH / CEO seeks consultation and provides input and information into matters of mutual interest. The MOH / CEO defers authority to the CMOH as required by the HPPA.

Chief Executive Officer Duties:

1. Accountable to the Board of Health for the management of public health programs. Staff report to the MOH / CEO and the MOH / CEO in turn reports to the Board on program delivery as well as population health needs and issues, program delivery and financial and human resources matters.
2. Responsible for all aspects of resource management. These include the management of financial resources as well as human resources. The MOH / CEO shall appoint an individual(s) to carry out responsibilities assigned to them by the Board of Health.
3. In collaboration with management and staff, the MOH / CEO develops the annual budget for consideration, input and approval of the Board of Health.
4. Ensure the development, implementation and regular review of Board of Health by-laws, policies and administrative policies and procedures.
5. Responsible for ensuring that systems are in place to fulfill the PHFAA as signed by the Board of Health and the Ministry of Health and Long-Term Care.
6. Maintain compliance with HPPA, OPHS, OPHOS and PHFAA.
7. Maintain a positive public image for the health unit and positive and effective working relations with partner organizations by ensuring that there are optimal systems for the management of media communications and for effective partnership collaboration.
8. Act of the primary spokesperson for the agency on all matters of public health significance.

Qualifications

The MOH / CEO must be a physician appointed by the Board of Health and the Minster of Health and Long-Term Care, and based on the HPPA is required to have the following credentials:

- License to practice medicine in the Province of Ontario;
- A fellowship in community medicine from The Royal College of Physicians and Surgeons of Canada;
- A minimum of five years experience in community medicine practice.
- A certificate, diploma or degree from a university in Canada that is granted after not less than one academic year of full-time post-graduate studies or its equivalent in public health comprising.
    - Epidemiology
    - Quantitative methods
    - Management and administration
    - Disease prevention and health promotion.
- Or: a qualification from a university outside Canada that is considered by the Minister of Health and Long-Term Care to be equivalent

Additionally, the MOH / CEO position requires the following experience:

- Senior management experience of at least seven (7) years in public health;
- Eligible for appointment to the University of Western Ontario, Faculty of Medicine;
- Proven leadership ability;
- Experience in business and risk management would be an asset; and
- Master's Degree in Business Administration or Finance would be an asset.

SUBJECT:	MOH / CEO Performance Appraisal	**POLICY NUMBER:**	**G-050**
SECTION:	Leadership and Board Management	**PAGE:**	1 of 2

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

An essential part of determining the health unit's performance is the assessment of the Medical Officer of Health and Chief Executive Officer (MOH / CEO). The MOH / CEO is accountable to the Board of Health for leading the health unit and implementing board direction and decisions. The MOH / CEO also manages all aspects of the health unit's operations.

POLICY

The performance appraisal is a systematic process to support and assess job performance in relation to established criteria and organizational objectives. The evaluation should not only highlight the achievement of desired outcomes but reflect how well the outcomes were achieved. It should emphasize how the MOH/CEO's performance reflects the health unit's values, vision, mission, mandate and policies and contributed to the achievement of the strategic goals.
3. It is one of several processes used by the Board and the MOH/CEO to negotiate, articulate and review progress in meeting agreed upon performance standards and expectations.

PROCEDURE

The Medical Officer Performance Appraisal Process can be found in Appendix A.

Additional tools are also available to assist with the performance appraisal process including:

Appendix B	Performance appraisal check-list
Appendix C	Main performance appraisal form to be completed by the appraisers and the MOH/CEO
Appendix D	Stakeholder performance appraisal tools process outline,
Appendix E	Sample email and performance appraisal questions for Board of Health members
Appendix F	Sample email and performance appraisal questions for Direct Reports
Appendix G	Sample email and performance appraisal questions for Community Partners

APPLICABLE LEGISLATION

- Ontario Public Health Organizational Standards

RELATED POLICIES

- G-010 Strategic Planning
- G-020 MOH / CEO Direction
- G-030 MOH / CEO Position Description
- 5-050 Performance Appraisal

REVISION DATES (* = major revision)**:**

MEDICAL OFFICER OF HEALTH AND CHIEF EXECUTIVE OFFICER PERFORMANCE APPRAISAL PROCEDURE

PRINCIPLES

1. An essential part of determining the health unit's performance is the assessment of the Medical Officer of Health and Chief Executive Officer (MOH/CEO). The MOH/CEO is accountable to the BOH for leading the health unit and for implementing its decisions. The MOH/CEO leads and manages all aspects of the Health Unit's (HU) operations.

2. The performance appraisal is a systematic process to support and assess job performance in relation to established criteria and organizational objectives. The evaluation should not only highlight the achievement of desired outcomes but reflect how well the outcomes were achieved. It should emphasize how the MOH/CEO's performance reflects the health unit's values, vision, mission, mandate and policies and contributed to the achievement of the strategic goals.

3. It is one of several processes used by the Board and the MOH/CEO to negotiate, articulate and review progress in meeting agreed upon performance standards and expectations.

AREAS OF FOCUS

1. **Program Excellence** – This area reflects on how the MOH/CEO has influenced the impact the HU has on: population health measures; the use of health status data; evidence-informed program decision making; delivery of mandated and locally needed public health services as measured by the accountability indicators
2. **Client and Community Impact –** This area reflects on the MOH/CEO's representation of the HU in the community
3. **Employee Engagement and Learning –** This area reflects on how the MOH/CEO has influenced the HU's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning
4. **Governance –** This area reflects on how the MOH/CEO has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This area also reflects on the MOH/CEO's responsibility for actions, decisions and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health

KEY STEPS

1. The Governance Committee of the Board of Health is responsible to strike a performance appraisal sub-committee made up of members of the Governance Committee and/or other Board of Health Members as may be deemed appropriate.

2. The sub-committee reviews and approves the appraisal tool.

3. The performance appraisal includes:
    a. A summary and assessment of performance for the previous review period; and
    b. The establishment of goals for the coming review period.

4. The performance appraisal is initiated in the first quarter of each year. Results are presented to the Board of Health before the end of the second quarter. This timing allows the results of the current years planning and year-end outcomes to be considered.

5. The performance appraisal form (Appendix A) is completed by the sub-committee based on the following inputs:

    a. Goals and targets to be achieved as articulated in the previous performance appraisal (where applicable), the strategic plan, the OPHS, OPHOS and other direction provided by the Board of Health.

    b. Evidence provided by the MOH/CEO, which includes a completed copy of the same performance appraisal form, specified required reports and may include other reports as deemed relevant by the MOH/CEO.

    c. Key informant feedback is collected using standardized questions (appended) with:
        i. Two Board of Health members, chosen by the sub-committee;
        ii. Two direct reports of the MOH/CEO, chosen by the sub-committee;
        iii. Two external stakeholders from two of the following sectors.
            1. Public health
            2. Health care; and
            3. Municipal.

        The stakeholders selected to provide feedback are chosen by the sub-committee from a list of at least three names for each sector provided to them by the MOH/CEO.

    d. Their observed behavior of the MOH/CEO; and

    e. A meeting with the MOH/CEO to discuss preliminary findings and to set future goals.

6. The sub-committee provides verbal updates to the Board of Health throughout the process.

7. The sub-committee will determine who will meet with the MOH/CEO to discuss the performance appraisal. This should include the Chair of the Board.

    a. The MOH/CEO may provide any additional or written comments.

8. Those in attendance at the appraisal meeting, including the MOH/CEO will sign the performance appraisal, acknowledging that the appraisal has been discussed and received by the MOH/CEO.

9. The signed performance appraisal is filed with Human Resources in a sealed envelope.

a. Only the MOH/CEO and Chair of the Board may access the sealed document.

Note – Please refer to the following appendices:

Appendix B	Performance appraisal check-list
Appendix C	Main performance appraisal form to be completed by the appraisers and the MOH/CEO
Appendix D	Stakeholder performance appraisal tools process outline,
Appendix E	Sample email and performance appraisal questions for Board of Health members
Appendix F	Sample email and performance appraisal questions for Direct Reports
Appendix G	Sample email and performance appraisal questions for Community Partners

MLHU MOH/CEO PERFORMANCE APPRAISAL CHECKLIST

This checklist is a tool to assist the appraisal sub-committee to complete the performance appraisal process.

Activity	Date completed	By
1. Contact MOH/CEO to arrange dates and logistics for this performance appraisal process (could be in person, by phone, email). Request names and contact info of 3 external contacts in each sector (public health, health care, municipal)		
2. Collect copies of the position description, Monthly Activity Reports, listings of BOH Report titles both public and in-camera and goals and targets as set out in the previous performance appraisal, the strategic plan, the OPHS, OPHOS and other direction provided by the Board of Health.		
3. Board Member feedback #1		
4. Board Member feedback #2		
5. Direct Report feedback #1		
6. Direct Report feedback #2		
7. External stakeholder Feedback #1		
8. External stakeholder Feedback #2		
9. Evidence package received from the MOH/CEO, including completed appraisal form		
10. Meeting of the sub-committee to compile preliminary findings, discuss the MOH/CEO's completed portion of the appraisal and complete Board portion of the appraisal		
11. The two documents are then merged and sent to the sub-committee to review.		
12. The sub-committee can meet with the MOH/CEO to discuss any questions or concerns they may have with the appraisal.		
13. Once the sub-committee has concluded their review of the materials, a summary is presented by the sub-committee in camera to the entire Board for their review and approval.		
14. The Board members reach agreement on the contents of the review.		
15. The Board Chair meets with the MOH/CEO to discuss PA and provide feedback. It is then signed by the Board Chair and the MOH/CEO.		

MLHU MOH/CEO PERFORMANCE APPRAISAL

Name:	
Title:	**Medical Officer of Health and Chief Executive Officer**

This performance appraisal is due on:	

It reviews the performance for the period:			
From:		**To:**	

And sets objectives for the period:			
From:		**To:**	

The following <u>RATING SCALE</u> is used in this performance appraisal:	
Exceeds expectations	Performance consistently exceeds all expectations/standards. Accomplishments are clearly obvious.
Meets Expectations	Solid reliable performance that substantially meets expectations. In some instances, expectations are exceeded. In some instances, expectations are still being developed.
Partially Meets Expectations	Performance does not meet expectations in certain areas. Improvement in these areas is required. The rationale needs to be explored, goals re-negotiated and/or an action plan established.
Additional Growth Required	Performance associated with the job requires additional resources. An action plan is needed which may include, but not limited to, training, coaching or other support.
Not applicable (n/a)	The Board of Health is not able to rate this area at this time.

Append additional sheets / documentation where required/appropriate.

Once completed, discussed and all signatures obtained, the <u>original</u> of this form is to be retained in the Employee's personnel file in a sealed envelope, accessible only to the employee and the Chair of the Board of Health.

Program Excellence *– This area reflects on how the MOH/CEO has influenced the impact the HU has on: population health measures; the use of health status data; evidence-informed program decision making; delivery of mandated and locally needed public health services as measured by the accountability indicators*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Responds effectively to health hazards and provides effective control of communicable diseases under the Health Protection and Promotion Act (HPPA)					
• Champions coordinated approaches and engagement of clients and community partners in planning and evaluation of programs and services					
• Maintains statutory obligations through the delivery of mandated and locally needed public health services (OPHS)					
• Anticipates and plans for major trends in needs and services					
• Uses evidence-informed decision making in developing programs and services to meet community needs					
• Considers Health Equity in all program work					
• Ensures processes in place to regularly evaluate public health programs and services, seeking ways to improve efficiency and effectiveness					
Comments: (include major strengths in this area of focus and any areas that may need future development)					

Client and Community Impact – *This area reflects on the MOH/CEO's representation of the HU in the community*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Contributes to increasing community awareness about public health					
• Promotes productive relationships with the media and acts as a resource to the media regarding public health issues.					
• Promotes productive relationships, maintains regular communication and strong working partnerships with external stakeholders including Boards of Education, business, labour, government and media, health care providers, community organizations, citizen groups and the Ministry of Health					
• Seeks new and innovative ways to work with partners to advance mutual goals in the community.					
• Promotes excellence in customer service within the health unit. Responds quickly and efficiently to enquiries/complaints/issues from citizens/community groups. Exhibits tact and diplomacy in dealing with citizen/group complaints. Resolves complaints to citizen/groups' satisfaction whenever feasible. Provides helpful explanation where legislatively or otherwise constrained. Researches/facilitates appropriate contact when referral is necessary.					
Comments: (include major strengths in this area of focus and any areas that may need future development)					

Employee Engagement and Learning – *This area reflects on how the MOH/CEO has influenced the HU's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Promotes a positive working environment. Advocates integrity, empowerment, collaboration and striving for excellence among staff. Sets a professional example for staff.					
• Allocates resources to maximize departmental and program effectiveness. Proposes revision to staff structure and numbers as necessary. Collaborates with the Management team on opportunities for sharing/reallocating existing staff/resources wherever possible. Explores alternatives such as cost-sharing/joint services with other agencies and/or contract services.					
• Provides adequate supervision and direction of direct-reporting staff. Includes working with them to identify and prioritize short and longer-term goals. Conducts meaningful performance reviews in a timely manner, and identifies their strengths and areas for development. Identifies and takes actions necessary to obtain improved performance where necessary. Recognizes and commends staff for outstanding work. Identifies and deals with performance concerns quickly and effectively by dealing with performance / communication / disciplinary issues in an appropriate manner.					
• Maintains effective communication with staff. Fosters a workplace climate conducive to open communication. Holds regular Management meetings. Institutes feedback mechanisms to gauge leadership effectiveness.					
• Identifies areas where staff training and development would be of benefit to the team and/or agency as a whole. Encourages staff commitment and ownership to upgrading and maintaining job related effectiveness. Promotes the view of training as a shared responsibility between staff					

Employee Engagement and Learning – *This area reflects on how the MOH/CEO has influenced the HU's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
and the health unit. Supports planning of short and long term departmental training and development initiatives.					
• Regularly evaluates corporate services, seeking ways to improve efficiency and effectiveness.					
• Exhibits excellent time management skills. Systematically organizes own time. Commits to and meets deadlines. Respects others' time. Is punctual for meetings.					
• Sets and achieves personal and professional development objectives.					
Comments: (include major strengths in this area of focus and any areas that may need future development)					

Governance – *This area reflects on how the MOH/CEO has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This area also reflects on the MOH/CEO's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Monitors overall HU financial situation demonstrating effective management of financial resources. Ensures transparency and understanding of financial processes and procedures.					
• Develops innovative approaches to financing and revenue generation. Devises strategies to protect HU assets.					
• Ensures agency compliance with the Ontario Public Health Organizational Standards.					
• Abides by employment and other relevant legislation including Employment Standards Act, Labour Relations Act, Occupational Health and Safety Act, Accessibility for Ontarians with Disabilities Act and the Human Rights Code. Adheres to terms of union and other contracts.					
• Develops and maintains HU by-laws, policies and procedures and ensures adherence within the health unit. Advises and consults with the BOH on significant matters.					
• Communicates regularly with the Chair of the Board and provides support in identifying agenda items for the BOH and Committee meetings.					
• Ensures adequate orientation and on-going education of BOH members.					
• Informs BOH of important developments affecting Public Health and the HU (e.g. legislative changes, public health emergencies, organizational problems, system development, environmental trends.) Makes recommendations as appropriate and includes financial analysis for					

Governance – *This area reflects on how the MOH/CEO has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This area also reflects on the MOH/CEO's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
recommendations.					
• Provides appropriate and timely written and verbal reports to the BOH. Writes and speaks clearly. Reports are easily understood by the BOH members.					
Comments: (include major strengths in this area of focus and any areas that may need future development)					

SUMMARY OF OVERALL PERFORMANCE

AREA OF FOCUS	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required
Program Excellence				
Community and Client Impact				
Employee Engagement and Learning				

Governance				
Comments – (Including comments with respect to the major strengths of the MOH/CEO and areas for future development.)				

GOALS FOR THE NEXT PERIOD – BY AREA OF FOCUS

Program Excellence	Key Performance Indicator

Client and Community Impact	Key Performance Indicator

Employee Engagement and Learning	Key Performance Indicator

Governance	Key Performance Indicator

Personal Development	Key Performance Indicator

Other	Key Performance Indicator

SIGNATURES

Medical Officer of Health

I discussed this performance appraisal with the Chair of the Board of Health.

I have participated in the setting of goals and targets for the next performance period, have reviewed my job responsibilities with the Chair of the Board of Health, and agree to the goals, targets and measurement standards noted above for the next performance period.

Comments

_____

_____

_____

_____

Medical Officer of Health and Chief Executive Officer **Date**

For the Board of Health

We have discussed the performance appraisal with the Medical Officer of Health and Chief Executive Officer. We have reviewed the past period's work performance and goals and objectives, and have discussed goals and objectives for the coming performance period. We have also discussed professional development and training needs. The goals and objectives for the coming year have been established, including job responsibilities and measurement methods.

_____

Chair, Board of Health **Date**

_____

Board of Health **Date**

STAKEHOLDER PROCESS

1) Key informant feedback is one of the inputs into the MOH/CEO performance appraisal process. The sub-committee uses standardized questions:
    i) Two Board of Health members, chosen by the sub-committee;
    ii) Two direct reports of the MOH/CEO, chosen by the sub-committee;
    iii) Two external stakeholders from two of the following sectors.
        (1) Public health
        (2) Health care; and
        (3) Municipal.

        The stakeholders selected to provide feedback are chosen by the sub-committee from a list of at least three names for each sector provided to them by the MOH/CEO.

2) Feedback is collected by telephone, in face-to-face meetings, as logistics allow, or by email. They may be done by the Chair and/or other members as decided by the sub-committee of the Board of Health (i.e., individually or together).

3) Those selected to provide feedback are sent an email explaining the process with the questions attached.
    a) Sample emails are enclosed that can be used as the basis of actual emails to be sent. Modify or personalize the emails as required.
    b) If the email is being sent to multiple recipients please send the email by “blind carbon copy” (bcc) so that recipients don’t know who the other recipients are.
    c) Set all out-going emails to return a read or delivery receipt message to the sender.
    d) Ask recipients to reply to the invitation by a specific date. This allows the sub-committee time to invite others to participate if the initial recipients are unable or unwilling to participate.
    e) You may choose to encourage either a phone or face-to-face meeting with some stakeholders as often stakeholders do not return completed surveys.

BOARD OF HEALTH MEMBERS

Sample email

The Board of Health of the Middlesex- London Health Unit is in the process of completing the annual performance review of Dr. Christopher Mackie, the Medical Officer of Health and Chief Executive Officer (MOH/CEO).

As part of this process we ask two Board of Health members that are not part of the sub-committee responsible for conducting the performance appraisal to provide feedback.

To that end we would like to invite you to provide your feedback as part of our performance appraisal process this year.

Completion of these questions takes 45 - 60 minutes. It can be done face-to-face, by phone or by email, depending on what works best for you. The standardized questionnaire is attached.

Participation in the process is confidential. The MOH/CEO will not know who was interviewed. Answers are summarized on a general performance appraisal form and all feedback responses will be destroyed.

Please let me know your preferred method of providing feedback. We hope to have all of the feedback completed by insert date.

If you have any questions or comments, please contact me by reply email or at insert phone number.

Thank you in advance for your input into the MOH/CEO performance appraisal process.

Insert name
Chair, Board of Health

MOH/CEO PERFORMANCE APPRAISAL

BOARD OF HEALTH MEMBER

MOH/CEO PERFORMANCE APPRAISAL – FEEDBACK QUESTIONS

BOARD OF HEALTH MEMBER

Person Providing Feedback			
Date		**By**	

Thank you for taking the time to provide your feedback.

The Board of Health of the Middlesex- London Health Unit is in the process of completing the annual performance review of Dr. Christopher MAckie, the Medical Officer of Health and Chief Executive Officer (MOH/CEO).

As part of this process we ask two Board of Health members that are not part of the sub-committee responsible for conducting the performance appraisal to provide feedback.

We use a standardized questionnaire for the interviews and the process usually takes 45-60 minutes.

Participation in the process is confidential. The MOH/CEO will not know who provided feedback. Answers are summarized on a general performance appraisal form and all written notes will be destroyed.

Program Excellence *– This area reflects on how the MOH/CEO has influenced the impact the HU has on: population health measures; the use of health status data; evidence-informed program decision making; delivery of mandated and locally needed public health services as measured by the accountability indicators*	
What example(s) can you think of that demonstrate the MOH/CEO's work to ensure that the health unit achieves the Health Unit's mission and strategic plan?	
What example(s) can you think of that demonstrate the MOH's work to ensure the evaluation of public health programs and services to ensure efficient and effective use of agency resources?	

MOH/CEO PERFORMANCE APPRAISAL

BOARD OF HEALTH MEMBER

What example(s) can you think of that demonstrate the MOH/CEO's work to ensure adequate agency compliance with the Ontario Public Health Standards.	
Client and Community Impact – *This area reflects on the MOH/CEO's representation of the HU in the community*	
What example(s) can you think of that demonstrate the MOH/CEO's work with the media to enhance the community's awareness of the health unit, our reputation and/or public health issues?	
What example(s) can you think of that demonstrate the MOH/CEO's efforts to maintain strong working relationships with our partner agencies and/or seeking new and innovative ways to work with partners to advance mutual goals in the community?	
Employee Engagement and Learning – *This area reflects on how the MOH/CEO has influenced the HU's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning*	
What example(s) can you think of that demonstrate the MOH/CEO providing leadership to the health unit?	
What example(s) can you think of that demonstrate the MOH/CEO maintaining effective communication with staff, fostering a workplace climate conducive to open communication?	

MOH/CEO PERFORMANCE APPRAISAL

BOARD OF HEALTH MEMBER

Governance – *This area reflects on how the MOH/CEO has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This area also reflects on the MOH/CEO's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health*	
What example(s) can you think of that demonstrate the MOH/CEO informing the Board of important developments regarding Public Health in Ontario and/or the health unit (e.g., legislative changes, system development, environmental trends).	
Are you getting the information and education you need as a Board member from the MOH/CEO to fulfill your governance role? Do those reports need to change in any way?	
What example(s) can you think of that demonstrate the MOH/CEO effectively managing the financial resources of the HU?	
Are you aware of any example(s) where the MOH/CEO did not adhere to HU policy or applicable legislation without informing the Board of Health or Chair in an expeditious manner?	

MOH/CEO PERFORMANCE APPRAISAL

BOARD OF HEALTH MEMBER

Summary	
What would you identify as being the MOH/CEO's major strengths? (List 2-3)	
What would you identify if any as being the MOH/CEO's areas for future development? (List 2-3)	
Do you have any further comments to make about the MOH/CEO's performance in the past year?	

Thank you for your time and participation in this process.

DIRECT REPORTS

Sample email

The Board of Health of the Middlesex- London Health Unit is in the process of completing the annual performance review of Dr. Christopher Mackie, the Medical Officer of Health and Chief Executive Officer (MOH/CEO).

As part of this process we ask two direct reports of the MOH/CEO to provide feedback.

To that end we would like to invite you to provide your feedback as part of our performance appraisal process this year.

Completion of these questions takes 45 - 60 minutes. It can be done face-to-face, by phone or by email, depending on what works best for you. The standardized questionnaire is attached.

Participation in the process is confidential. The MOH/CEO will not know who was interviewed. Answers are summarized on a general performance appraisal form and all feedback responses will be destroyed.

Please let me know your preferred method of providing feedback. We hope to have all of the feedback completed by insert date.

If you have any questions or comments, please contact me by reply email or at insert phone number.

Thank you in advance for your input into the MOH/CEO performance appraisal process.

Insert name
Chair, Board of Health

MOH/CEO PERFORMANCE APPRAISAL

DIRECT REPORT

MEDICAL OFFICER OF HEALTH AND CHIEF EXECUTIVE OFFICER PERFORMANCE APPRAISAL QUESTIONS

DIRECT REPORTS

Person being interviewed			
Date		**By**	

Thank you for taking the time to provide your feedback.

The Board of Health of the Middlesex- London Health Unit is in the process of completing the annual performance review of Dr. Christopher Mackie, the Medical Officer of Health and Chief Executive Officer (MOH/CEO).

As part of this process we ask two Board of Health members that are not part of the sub-committee responsible for conducting the performance appraisal to provide feedback.

We use a standardized questionnaire for the interviews and the process usually takes 45-60 minutes.

Participation in the process is confidential. The MOH/CEO will not know who provided feedback. Answers are summarized on a general performance appraisal form and all written notes will be destroyed.

Program Excellence *– This area reflects on how the MOH/CEO has influenced the impact the HU has on: population health measures; the use of health status data; evidence-informed program decision making; delivery of mandated and locally needed public health services as measured by the accountability indicators*	
What example(s) can you think of that demonstrate the MOH/CEO's work to create the organizational culture that is needed to carry out the mission , strategic direction and organizational goals of the health unit?	
What example(s) can you think of that demonstrate the MOH/CEO evaluating public health programs and services, seeking ways to improve efficiency and effectiveness?	

MOH/CEO PERFORMANCE APPRAISAL

DIRECT REPORT

What example(s) can you think of that demonstrate the MOH/CEO's work to ensure adequate agency compliance with the Ontario Public Health Standards.	
Client and Community Impact – *This area reflects on the MOH/CEO's representation of the HU in the community*	
What example(s) can you think of that demonstrate the MOH/CEO's work with the media to enhance the community's awareness of the health unit, our reputation and/or public health issues?	
What example(s) can you think of that demonstrate the MOH/CEO's efforts to maintain strong working relationships with our partner agencies and/or seeking new and innovative ways to work with partners to advance mutual goals in the community?	
Employee Engagement and Learning – *This area reflects on how the MOH/CEO has influenced the HU's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning*	
What example(s) can you think of that demonstrate the MOH/CEO providing leadership to the health unit?	
What example(s) can you think of that demonstrate the MOH/CEO encouraging cross-departmental interaction and collaboration? How does the MOH/CEO foster the view of the health unit as a whole, supporting the breaking down of silos?	

MOH/CEO PERFORMANCE APPRAISAL

DIRECT REPORT

Employee Engagement and Learning – (Cont'd)	
What example(s) can you think of that demonstrate the MOH/CEO collaborating with management on opportunities for sharing/reallocating existing staff resources wherever possible?	
What example(s) can you think of that demonstrate the MOH/CEO supporting staff performance by identifying short and long term goals, recognizing and commending staff for outstanding work, etc?	
What example(s) can you think of that demonstrate the MOH/CEO maintaining effective communication with staff, fostering a workplace climate conducive to open communication?	
What example(s) can you think of that demonstrate the MOH/CEO supporting staff development either on an individual or collective level. How does the MOH/CEO contribute to an environment of continuous learning?	

MOH/CEO PERFORMANCE APPRAISAL

DIRECT REPORT

Governance – *This area reflects on how the MOH/CEO has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This area also reflects on the MOH/CEO's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health*	
Are you aware of any example(s) where the MOH/CEO <u>did not adhere</u> to HU policy or applicable legislation without informing the Board of Health or Chair in an expeditious manner?	

Summary	
What would you identify as being the MOH/CEO's major strengths? (List 2-3)	
What would you identify if any as being the MOH/CEO's areas for future development? (List 2-3)	
Do you have any other comments to make about the MOH/CEO's performance in the past year before we end?	

Thank you for your time and participation in this process.

COMMUNITY PARTNERS

Sample email

The Board of Health of the Middlesex- London Health Unit is in the process of completing the annual performance review of Dr. Christopher Mackie, the Medical Officer of Health and Chief Executive Officer (MOH/CEO).

As part of this process we ask two community partners of the MOH/CEO to provide feedback.

To that end we would like to invite you to provide your feedback as part of our performance appraisal process this year.

Completion of these questions takes 45 - 60 minutes. It can be done face-to-face, by phone or by email, depending on what works best for you. The standardized questionnaire is attached.

Participation in the process is confidential. The MOH/CEO will not know who was interviewed. Answers are summarized on a general performance appraisal form and all feedback responses will be destroyed.

Please let me know your preferred method of providing feedback. We hope to have all of the feedback completed by insert date.

If you have any questions or comments, please contact me by reply email or at insert phone number.

Thank you in advance for your input into the MOH/CEO performance appraisal process.

Insert name
Chair, Board of Health

MEDICAL OFFICER OF HEALTH AND CHIEF EXECUTIVE OFFICER PERFORMANCE APPRAISAL QUESTIONS

COMMUNITY PARTNER

Person being interviewed			
Date		**By**	

Thank you for taking the time to provide your feedback.

The Board of Health of the Middlesex- London Health Unit is in the process of completing the annual performance review of Dr. Christopher Mackie, the Medical Officer of Health and Chief Executive Officer (MOH/CEO).

As part of this process we ask two community partners to provide feedback for the performance appraisal.

We use a standardized questionnaire for the interviews and the process usually takes 45-60 minutes.

Participation in the process is confidential. The MOH/CEO will not know who provided feedback. Answers are summarized on a general performance appraisal form and all written notes will be destroyed.

Client and Community Impact – *This area reflects on the MOH/CEO's representation of the HU in the community*	
How does our MOH/CEO contribute to a strong working relationship with your agency?	

MOH/CEO PERFORMANCE APPRAISAL

COMMUNITY PARTNER

Can you think of one or more examples where the MOH/CEO has worked to identify new or innovative ways to work with partner agencies, yours included, to advance our mutual goals in the community?	

Summary	
What would you identify as being the MOH/CEO's major strengths? (List 2-3)	
What would you identify if any as being the MOH/CEO's areas for future development? (List 2-3)	
Do you have any other comments to make about the MOH/CEO's performance in the past year before we end?	

Thank you for your time and participation in this process.

SUBJECT:	Approval and Signing Authority	**POLICY NUMBER:**	**G-200**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 4

IMPLEMENTATION:	July 20, 2000	**APPROVAL:**	Board of Health
SPONSOR:	Associate Director, Finance	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	May 1, 2014

PURPOSE

The purpose of this policy is to outline the financial signing authority and responsibilities for those who can approve Health Unit financial transactions, both revenue generating and expenditures, purchase orders, expense reports, credit card statements, mileage claims, petty cash vouchers and all other binding agreements on behalf of the Health Unit.

POLICY

This policy applies to all financial commitments made for Health Unit funds, whether charged to a credit card, paid by the staff/board member, or paid by a cash advance. This policy also applies to purchase orders/requisitions or contractual agreements entered into. Full time staff, part time staff and the Board Chair (or his/her delegate) are permitted to authorize expenses; contract staff or consultants are not.

Granting Signing Authority
In granting signing authority, the Health Unit is allowing staff to make financial commitments or expenditures on behalf of the organization. Individuals must respect this privilege and abide by this policy or risk having their signing authority revoked or revised. The individual's manager, director or Associate Director, Finance can report any violations of this policy and recommend appropriate action.

Supporting Documentation
Individuals when committing Health Unit financial resources must do so within the context of the budgets or funding for which they are responsible. It is the responsibility of the individual incurring the expense, as well as the individual authorizing the expense, to ensure all claims are supported by adequate documentation and that the expense is appropriate and in accordance with Health Unit policies. Reimbursements for items of an individual nature are subject to closer scrutiny than regular program expenses.

Approval of Expenses
Approval should only be given when it is confirmed that goods were received in excellent condition and/or services were performed adequately, as stated in the original signed contract and/or purchase order.

Signing Authority Structure
Signing authority is automatically vested in the individual at the next higher level of authority in the direct line of reporting. Under no circumstance is the individual submitting the expense permitted to approve their own expense.

Approval Limits

Total Amount of Expense Per Transaction (in CAD, inclusive of taxes & gratuities)	Submitter	Approver
Category A: $0-$1,250	Staff	Manager
	Manager	Director
	Director	Medical Officer of Health and Chief Executive Officer
	MOH	Associate Director, Finance
Category B: $1,251-$10,000	Manager	Director
	Director	Medical Officer of Health and Chief Executive Officer
	MOH	Associate Director, Finance
Category C: $10,001-$50,000	Director	Medical Officer of Health and Chief Executive Officer
	MOH	Associate Director, Finance
Category D: >$50,000	MOH	Chair, Board of Health
Category E: Moving expense pre-approval >$2,000*	Staff	Medical Officer of Health and Chief Executive Officer

**After the moving expenses have been incurred, and are submitted for reimbursement, then categories A-D apply.*

Similar and Related Transactions
Similar and related transactions that would normally be processed concurrently must not be split in order to avoid signing authority levels.

Delegation of Approval Authority
Delegation of approval is permitted during temporary absences of an approver. The delegate must be of an equivalent or higher managerial rank to the approver they are replacing. The approver cannot sign his or her own expenses. The absence of the approver should be noted beside the delegate's signature. The person that has been delegated signing authority will remain ultimately responsible, and cannot further delegate the responsibility.

Under no circumstances should an individual allow (or ask) one of their staff to submit an expense that they would subsequently approve as a way of getting around the approval levels outlined in this policy.

Signatures
A list of names, titles and signatures for the Chair, Board of Health, the Medical Officer of Health, all Directors and all Managers will be maintained by the Finance Department. This complies with Board of Health Bylaws.

Controlled digital signatures are permitted when approved by the Finance Department, typically in situations where a workflow process requires electronic signature for document processing/approvals. The approval is based on the network login id. Network logon ids should never be shared between employees.

DEFINITIONS

Adequate Documentation: itemized receipt (original preferred) including total cost of purchase, where possible.

Individual items: mileage, travel, accommodation, meals, staff education, purchases at conferences (books, DVDs, etc).

Contract: Any written or verbal agreement, contract, letter of intent, memorandum of understanding or memorandum of agreement, the provisions of which are binding upon the HU.

Purchasing Contract: Any purchase agreement, blanket order, Contract or purchase order for the acquisition by purchase, lease-back or rental of moveable effects including goods, supplies, equipment and services (including professional consulting services) for any HU purpose .

Expense Reimbursement: A claim by an employee or board member to recoup for the outlay of personal funds, in procuring goods and/or services needed to conduct the business of the Health Unit. Supporting documentation must be attached.

Approval Authority: Identifies the individual(s) who can bind the organization for financial commitments and to what dollar amount. It can refer to purchase orders, credit card expenses, contracts or any other transactions where the Health Unit is financially liable.

Delegate: A person of an equivalent or higher managerial rank who is designated to act for or represent another person

RELATED POLICIES

4-090 – Use of Personal Vehicle

4-030 – Corporate Expense
4-110 – Moving Expenses

REVISION DATES (* = major revision)**:**
July 20, 2000
June 17, 2004
February 17, 2011
April 19, 2012
May 1, 2014

SUBJECT:	Contractual Services	**POLICY NUMBER:**	**G-220**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 3

IMPLEMENTATION:	August 30, 2000	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	January 18, 2007

PURPOSE

To outline the procedures for negotiating and documenting contractual agreements.

POLICY

A written contract will be negotiated with each provider or recipient of services.

The Board of Health is responsible for the approval of all contracts and agreements and may delegate this authority as specified in the Schedule for Approval of Contracts (Appendix A).

Board approval of contracts is done by resolution.

Unless otherwise specified, documents are to be executed (i.e., signed) by the approving authority of the non-Health Unit contractor/recipient. Documents that are to be executed by the Board of Health are to be signed by any two of the Chair, Vice-Chair or Secretary-Treasurer, unless otherwise required.

This policy applies to contracts for professional services invoiced on a fee for services basis, but does not apply to employment contracts, which are covered under Policy 5-25: Recruitment & Hiring. Professional services contracts are for services that generally are not performed by union employees.

PROCEDURE

Negotiation of the Contract

- The Director/Manager or designate will be responsible for negotiating the contract with the provider/recipient. Where the content of the contract is subject to a provincial policy or standard, the Director/Manager is responsible for ensuring that such policies and standards are followed.
- The Director/Manager will call upon the expertise of Finance and Human Resources, as appropriate to assist in the development, writing and review of the draft contract for services. The Medical Officer of Health (MOH) will be consulted as appropriate.
- It is highly recommended that the draft of the contract be submitted to the Health Unit solicitor for review where there is no recent precedent for the contract or where the contract is for a substantial amount of money or involves significant liability. See Policy G-200 Approval and Signing Authority.

- A contract, with the exception of short-term contracts, may contain wording that provides for its amendment or early termination.
- All contracts should be fully executed prior to the commencement date for the provision of services.
- All original contracts will be filed with Corporate Services. A copy will be retained by the Director/Manager and by the other party/parties to the contract.

Contract Terms

All contracts will include the following:

- the term of the agreement (start and end dates);
- a description of the services to be provided;
- the rates to be paid for service and the method and frequency of payment;
- requirements for confidentiality;
- liability or consequences for failure to fulfil contract obligations;
- statement that the contracting agency or party is not an employee (and not subject to the applicable law of Ontario relating to employees), agent or partner of the health unit, and is an independent contractor;
- except with short-term contracts provisions for amending the contract or early termination and the processes and results involved;
- the required signatures (i.e. involved parties, witnesses) and the date of each signature;
- licensing and certification requirements for the contracting agency and/or qualifications, training, licensing and certification of the recipient party;
- statement that the law of Ontario is the applicable law;
- statement that the written contract is the entire agreement and any verbal agreement(s) are of no force and effect;
- statement that if any provision of contract is determined to be invalid or unenforceable in whole or in part, such invalidity or unenforceability shall attach only to such provision or part thereof and the remaining part of such provision and all other provisions hereof shall continue if full force and effect;
- statement regarding how and when notice in contract are to be delivered; and
- statement prohibiting the assignment of services.

A contract may also address the following terms, as appropriate:

- the conditions for the provision of service to the Health Unit, (i.e. who will provide the services, what expenses may be approved for reimbursement, required meetings);
- the nature and type of reporting to the Health Unit and procedures for recording and reporting service (e.g. quarterly reports);
- performance standards;
- conditions for liability from losses suffered as a result of the actions, negligence or any conduct of the provider/recipient;
- evidence of general liability and professional liability insurance of a specified amount;
- requirement to audit the provider/recipient's internal control records and documents;
- labour disruption (strike) clauses;

- confirmation that the contractor/recipient has no conflict of interest related to the subject matter of the contract;
- commitment to adhere to the MLHU policies, rules, regulations, procedures and guidelines;
- outline clearly the parties' respective roles and responsibilities with respect to joint appointments under affiliation agreements;
- outline recognition of authorship, ownership and proprietary rights and give direction concerning the retention or destruction of working papers, documents, etc.;
- funding specifications (i.e., any limitations or restrictions on the use or application of funds, whether continuation of the work is dependent on funding or advances of funds that are not spent to provide services, etc.) will be returned to the Health Unit or funder, as appropriate. See Policy 4-060: Grant Applications and Agreements.

Evaluation of Contracts

- Service provision under contract is evaluated informally on an ongoing basis. Periodic review of the contract and its standards, will be measured against achievements.
- Variances or discrepancies from contract requirements will be addressed in a timely manner by the Director/Manager that negotiated the terms of the contract and/or the Director of Corporate Services.
- All contracts are evaluated before renewal.

APPLICABLE LEGISLATION

RELATED POLICIES

5-25: Recruitment & Hiring.
G-200 Approval and Signing Authority
4-060: Grant Applications and Agreements

REVISION DATES (* = major revision)**:**
January 18, 2007

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Appendix A
Policy G-220

DIRECTORY FOR APPROVAL OF CONTRACTS

	Type of Contract	Signing Authority
1.	**General**	
	Union agreements	Board of Health
	Banking – choice of bank	Board of Health
	Banking – all else	Finance and Operations Director
	Insurance – choice of carrier/broker & coverage - employee group insurance benefits, Employee Assistance Program	Board of Health Medical Officer of Health
	Insurance – all else (liability, property)	Finance and Operations Director
	Auditor – appointment	Board of Health
	Auditor – Certificates & Undertakings	Medical Officer of Health
2.	**Consultants, Independent Contractors and Professional Services**	
	Lawyers/Labour Negotiators – appointment	Board of Health
	Physicians – appointment of Medical Advisors	Medical Officer of Health
	Physicians (e.g. Sexual Health Clinic, TB Clinic)	MOH/Associate Medical Officer of Health (A-MOH)
	Physicians – Acting Medical Officer of Health	Board of Health
	Dental Consultant	Medical Officer of Health
	Nurse Practitioners (RN Extended Class)	Medical Officer of Health, A-MOH
	Individual Service Provider (Not listed above) – Short-Term (i.e. Less than 6 months) (e.g. software programmer)	Director/Manager
	Individual Service Provider (Not listed above) – Long-Term (i.e. 7 months or more)	Medical Officer of Health
	Agency Service Provider – Short-Term (i.e. Less than 6 months) (e.g. Victorian Order of Nurses)	Director/ Manager
	Agency Service Provider – Long-Term (7 months or more) (e.g. tykeTALK)	Medical Officer of Health
3.	**Program-related Service Agreements**	
	Ministry of Health or other Ministries (e.g. Healthy Babies, Healthy Children (HBHC) program).	Board of Health or Medical Officer of Health or Director, as appropriate. Refer to *Policy 4-60 re Grant Applications and Agreements.*
	Other local agencies (coalition agreements, lead agency agreements.	
	Professional services (e.g. program evaluators) or other services for approved programs (i.e. facilitators, speakers, caterers, hall rentals, reprographics, surveys, vehicle rental, etc.)	Directors/Managers
4.	**Property and Equipment (and other budgeted expenses)**	
	Office leases	Board of Health
	Custodial services, Security, courier and mail services	Finance and Operations Director
	Leasing, service and maintenance contracts for phone, office equipment, repairs, renovations, etc.	Finance and Operations Director
5.	**Educational agreements**	

	Affiliation agreements, student placements, PHRED	Medical Officer of Health/Directors
6.	**Research/grants**	
	Applications, agreements and awards	Medical Officer of Health
7.	**Contracting Out of Board of Health Services**	
	Lead agency agreements (i.e. tykeTALK, Smart Start, Middlesex Ontario works), payroll & administrative services	Board of Health (for major ongoing commitments) Medical Officer of Health (all others)

SUBJECT:	Procurement	**POLICY NUMBER:**	**G-230**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 2

IMPLEMENTATION:	February 21, 2008	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	February 21, 2008

PURPOSE

To ensure that the Middlesex-London Health Unit obtains the best value when purchasing goods, or contracting services and to establish the guidelines for procurement decisions that make use of a competitive process which is open, transparent and fair.

POLICY

The Guidelines prescribed in this Policy shall be followed to make a contract award or to make a recommendation of a contract award to the Board of Health. This ensures that the Middlesex-London Health Unit (MLHU) procures the necessary quality and quantity of goods and/or services in an efficient, timely and cost effective manner, while maintaining the controls necessary for a public agency.

The policy encourages an open and competitive bidding process for the acquisition and disposal of good and/or services and the objective and equitable treatment of all vendors.

The policy also ensures the best value possible value is attained for MLHU. This may include, but not be limited to, the determination of the total cost of performing the intended function over the lifetime of the task, acquisition cost, installation, disposal value, disposal cost, training cost, maintenance cost, quality of performance and environmental impact.

PROCEDURE

The procedure to utilize the procurement process is documents in Appendix A: Middlesex-London Health Unit Procurement Guidelines.

APPLICABLE LEGISLATION

Ontario Public Health Organizational Standards

RELATED POLICIES

G-200 Approval and Signing Authority

REVISION DATES (* = major revision)**:**

Appendix A
To Policy G-230

Middlesex-London Health Unit Procurement Guidelines

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

February 21, 2008

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1.0 PURPOSE

(1) The purpose of the Guidelines is to ensure that the Middlesex-London Health Unit obtains the best value when purchasing goods, or contracting services.

(2) The guiding principle is for procurement decisions that make use of a competitive process which is open, transparent and fair.

2.0 GENERAL INFORMATION

(1) The procedures prescribed in these Guidelines shall be followed to make a contract award or to make a recommendation of a contract award to the Board of Health.

(2) Unless otherwise provided in accordance with the Procurement Guidelines, The Associate Director, Finance and the authorized employees of the Finance department shall be responsible for providing all necessary advice and services required for purchases authorized by these Guidelines.

(3) No purchase of goods and services shall be authorized unless it is in compliance with the Procurement Guidelines. Goods and services that are obtained without following the provisions of the aforementioned will not be accepted, and any invoices received will not be processed for payment.

(4) Unless otherwise provided in accordance with the Procurement Guidelines, the purchase of all goods and services shall be authorized in accordance with the provisions of these Guidelines.

(5) Requisitions or purchase orders shall not be arbitrarily structured to alter the relationship of the price to the pre-authorized expenditure limit.

2.1 Glossary of Terms

In these Guidelines, unless a contrary intention appears,

"agreement" means a formal written legal agreement or contract for the supply of goods, services, equipment or construction;

"best value" means the optimal balance of performance and cost determined in accordance with a pre-defined evaluation plan. Best value may include a time horizon that reflects the overall life cycle of a given asset.

"blanket purchase contract" means any contract for the purchase of goods and services which will be required frequently or repetitively but where the exact quantity of goods and services required may not be precisely known or the time period during which the goods and services are to be delivered may not be precisely determined.

"bid or bid price" Bid price, a price offered for a good by a potential buyer

"certificate of clearance" from the Workplace Safety and Insurance Board means a certificate issued by an authorized official of the Workplace Safety and Insurance Board certifying that the Board waives its rights under subsection 9(3) of the Workers' Compensation Act, R.S.O. 1990,Chapter W.11;

"contract" means any formal or deliberate written agreement for the purchase of goods, services, equipment or construction;

"contract record" is a document which outlines the terms and conditions of the agreement;

"declaration respecting Workers' Compensation Act, R.S.O. 1990/Corporation Tax Act" means a declaration that the bidder has paid all assessments or compensation payable and has otherwise complied with all requirements of the Workplace Safety and Insurance Board and that the bidder has paid all taxes and/or penalties imposed on it pursuant to the Corporation Tax Act, R.S.O. 1990;

"employee – employer relationship" refers to the definition utilized by the Canada Customs and Revenue Agency.

"executed agreement" means a form of agreement, either incorporated in the bid documents or prepared by the Health Unit or its agents, to be executed by the successful bidder and the Health Unit.

"goods and services" includes supplies, materials and equipment of every kind required to be used to carry out the operations of the Health Unit.

"insurance documents" means certified documents issued by an insurance company licensed to operate by the Government of Canada or the Province of Ontario certifying that the bidder is insured in accordance with the Health Unit's insurance requirements as contained in the bid documents;

"irregular result" means that in any procurement process where competitive bids or proposals are submitted and any of the following has occurred or is likely to occur:

(i) The lowest responsive bid or proposal exceeds the estimated cost or budget allocation;
(ii) For any reason the award of the contract to or the purchase from the lowest responsive bidder or proponent is procedurally inappropriate or not in the best interests of the Corporation;
(iii) The specifications of a tender call or request for proposal cannot be met by two or more suppliers;
(iv) A negotiated result in accordance with section 4.5 of these Guidelines; or
(v) Concurrence cannot be achieved between the Director and The Associate Director, Finance regarding the award of contract.

"irregularities contained in bids" is defined in Appendix "A" and includes the appropriate response to those irregularities;

"professional service supplier" means a supplier of services requiring professional skills for a defined service requirement including:

(i) Architects, engineers, designers, management and financial consultants; and
(ii) Firms or individuals having specialized competence in environmental, planning or other disciplines.

"purchase order" means the purchasing document used to formalize a purchasing transaction with a vendor;

"purchase requisition" means a written or electronically produced request in an approved format and duly authorized to obtain goods or services;

"quotation" means a request for prices on specific goods and/or services from selected vendors which are submitted verbally, in writing or transmitted by facsimile as specified in the Request for Quotation;

"request for expression of interest" is a focused market research tool used to determine vendor interest in a proposed procurement. It may be issued simultaneously with a Request for Qualifications when the proposed procurement is well defined and the purchaser has clear expectations for the procurement.

"request for information" is used prior to issuing a tender call as a general market research tool to determine what products and services are available, scope out business requirements, and/or estimate project costs;

"request for proposal" means a process where a need is identified, but the method by which it will be achieved is unknown at the outset. This process allows vendors to propose solutions or methods to arrive at the desired result;

"sealed bid" means a formal sealed response received as a part of a quotation, tender or proposal;

"supplier" means any individual or organization providing goods or services to the Health Unit including but not limited to contractors, consultants, vendors, service organizations etc.

"Tender" means a sealed bid which contains an offer in writing to execute some specified services, or to supply certain specified goods, at a certain price, in response to a publicly advertised request for bids;

"Triggering event" means an occurrence resulting from an unforeseen action or consequence of an unforeseen event, which must be remedied on a time sensitive basis to avoid a material financial risk to the Health Unit or serious or prolonged risk to persons or property;

"Value Analysis" typically refers to a life cycle costing approach to valuing a given alternative, which calculates the long term expected impacts of implementing the particular option;

2.2 Documentation

(1) In order to maintain consistency, the Associate Director, Finance shall provide guidelines to Divisions on procurement policies and procedures and on the structure, format and general content of procurement documentation.

(2) The Associate Director, Finance shall review proposed procurement documentation to ensure clarity, reasonableness and quality and shall advise the Services Areas of suggested improvements.

(3) Procurement documentation shall avoid use of specific products or brand names.

(4) Notwithstanding Subsection 2.2 (3), a Division may specify a specific product, brand name or approved equal for essential functionality purposes to avoid unacceptable risk or for

some other valid purpose. In such instances, the Associate Director, Finance shall manage the procurement to achieve a competitive situation if possible.

(5) The use of standards in procurement documentation that have been certified, evaluated, qualified, registered or verified by independent nationally recognized and industry-supported organizations such as the Standards Council of Canada shall be preferred.

(6) Divisions shall:

(i) give consideration to the need for value analysis comparisons of options or choices,
(ii) if required, ensure that adequate value analysis comparisons are conducted to provide assurance that the specification will provide best value, and
(iii) forward the value analysis to Finance for documentation in the procurement file.

(7) All substantive changes to standard clauses under Information to Bidders in bid solicitations and contracts shall be reviewed and approved by the Health Unit's Solicitor.

(8) The Associate Director, Finance in conjunction with the Division shall issue bid documents for goods and services. The Finance Department shall give notice of the purchasing procurement documents electronically via the Internet as well as any other means as appropriate.

2.3 Summary of Procurement Process

2.3.1 Chart 1 – Procurement Goals

Goal	Description
1. Effective	The extent to which the procurement process is achieving its intend results. The desired outcomes are substantive or quality results as opposed to process results.
2. Objective	The procurement of goods and services made in an unbiased way and not influenced by personal preferences, prejudice or interpretations.
3. Fair	Applying the policies equally to all bidders.
4. Open and Transparent	Is the clarity and disclosure about the process for arriving at procurement decisions. While promoting openness and transparency, the Procurement Guidelines should be governed by the legal considerations for confidentiality and the protection of privacy.
5. Accountable	Is the obligation to answer for procurement results and for the way that procurement responsibilities are delegated.
6. Efficient	Measures the quality, cost and amount of goods and services procured as compared to the time, money and effort to procure them.

2.3.2

Chart 2 Summary of Procurement Processes

Purchasing Option	Description	When to use this option	How to use this option	How to choose the appropriate vendor using this option	Who awards/ Comments
Formal Request for Proposals *Relates to Sections 4.1.3 & 4.1.4 of the Procurement Guidelines*	Vendors are asked to submit a description of how they would address a problem or need along with the costs associated with their solution.	There is a complex problem or need for which there is no clear single solution; and The anticipated cost is equal to or greater than $100,000.	Finance must be involved; Specific written information must be provided to Finance by the Division to initiate; Bids are solicited through an open process that includes public advertisements.	A Selection Committee evaluates each bid; A numeric evaluation tool is developed to assess the quality of the bid; Cost will always be a factor The bid with the best score and meets the minimum requirements is awarded the contract	The Medical Officer of Health is informed when the lowest bid is not being recommended. Board of Health authorizes the awarding of the contract.
Informal Request for Proposals *Relates to Sections 4.1.2 & 4.1.4 of the Procurement Guidelines*	Vendors are asked to submit a description of how they would address a problem or need along with the costs associated with their solution.	There is a complex problem or need for which there is no clear single solution; and The anticipated cost is less than $100,000.	Finance must be involved; Specific written information must be provided to finance by the Division to initiate. Bids are solicited on an invitational basis from a pre-determined bidder list but may be supplemented with public advertisements.	A Selection Committee evaluates each bid; A numeric evaluation tool is developed to assess the quality of the bid; Cost will always be a factor. The bid with the best score and meets the minimum requirements is awarded the contract	The Medical Officer of Health awards the contract.

Purchasing Option	Description	When to use this option	How to use this option	How to choose the appropriate vendor using this option	Who awards/ Comments
Request for Tender *Relates to Section 4.2 of the Procurement Guidelines*	Vendors are asked to submit a cost for the work that is specified through a competitive bid process	A clear or single solution exists; and The anticipated costs is equal to or greater than $100,000	Finance must be involved; Specific written information must be provided to finance by the Division to initiate; Bids are solicited through an open process that includes public advertisements.	A public opening is required with specific people in attendance; Finance integrates all the bids and recommends vendor with the lowest bid who meets requirements, subject to review by Division Director.	Board of Health awards the contract.
Formal Request for Quotations *Relates to Section 4.3.3.1 of the Procurement Guidelines*	Vendors are asked to submit a cost for the work that is specified through an invitational process from pre-determined bidders	A clear or single solution exists; and The anticipated cost is between $50,000 and less than $100,000.	Finance must be involved; Specific written information must be provided to finance by the Division to initiate; Bids are solicited on an invitational basis from a pre-determined bidder list but may be supplemented with public advertisements.	Divisions review the bids; Finance integrates all the bids and recommends vendor with the lowest bid who meets requirements, subject to review by Division Director.	The Medical Officer of Health awards the contract.

Purchasing Option	Description	When to use this option	How to use this option	How to choose the appropriate vendor using this option	Who awards/ Comments
Informal Request for Quotations *Relates to Section 4.3.3.2 of the Procurement Guidelines*	Vendors are asked to submit a cost for the work that is specified through an invitational process from pre-determined bidders	A clear or single solution exists; and The anticipated cost is between $10,000 and less than $50,000	Involvement of Finance is not required but available; Bids are solicited on an invitational basis from a pre-determined bidder list but may be supplemented with public advertisements. A minimum of 3 bids should be obtained although more are encouraged.	Division chooses the appropriate vendor based on the vendor who meets the specifications at the lowest cost.	The Medical Officer of Health awards the contract.
Informal, low value procurement *Relates to Section 4.3.3.2 of the Procurement Guidelines*	Quotes are obtained via phone, fax, email, or similar communication methods or vendor advertisements or catalogues	A clear or single solution exists; and The anticipated cost is between $5,000 and less than $10,000.	Involvement of Finance is not required but available; A minimum of 3 bids are sought and more cost effective methods may be used such as quotes received by fax, verbal (phone), advertisements etc.	Division chooses the appropriate vendor based on the vendor who meets the specifications at the lowest cost.	The Division Director awards the contract. The Medical Officer of Health is informed, prior to awarding the contract, if the lowest quote is not being accepted.

Purchasing Option	Description	When to use this option	How to use this option	How to choose the appropriate vendor using this option	Who awards/ Comments
Non-competitive purchases *Relates to Sections 3.0 and 5.11 of the Procurement Guidelines*	No bids or quotes are required for purchase but are encouraged.	The anticipated cost is less than $5,000;		Not applicable	Purchases under $5,000 a Board report is not required. Award is made based on signing authority governed in Policy 4-90
		Greater than $5,000 and only a single vendor exists; or During an emergency; or The vendor has particular expertise. See Guidelines for further indications.	The requirement for competitive bid solicitation may be waived under joint authority of the Director and Medical Officer of Health. Associate Director, Finance manages the process/negotiations.	Not applicable	A written report will be submitted to the Board of Health The Board of Health awards contracts greater than $50,000 unless it is an emergency under section 3.3 of the Procurement Guidelines; The Medical Officer of Health awards contracts for values of greater than $5,000 but less than $50,000

3.0 NON-COMPETITIVE PURCHASES

3.1 Goals

The primary goals of a non-competitive purchase are to allow for procurement in an efficient and timely manner.

3.2 Requirements

(1) The item is less than $5,000;

(2) The requirement for competitive bid solicitation for goods, services and construction may be waived under joint authority of the appropriate Director and Medical Officer of Health and replaced with negotiations by the Director and Finance under the following circumstances:

(i) where competition is precluded due to the application of any Act or legislation or because of the existence of patent rights, copyrights, technical secrets or controls of raw material;
(ii) where due to abnormal market condition, the goods, services or construction required are in short supply;
(iii) where only one source of supply would be acceptable and cost effective;
(iv) where there is an absence of competition for technical or other reasons and the goods, services or construction can only be supplied by a particular supplier and no alternative exists;
(v) where the nature of the requirement is such that it would not be in the public interest to solicit competitive bids as in the case of security or confidentiality matters;
(vi) where in the event of an *"Emergency"* as defined by these Guidelines, a requirement exists;
(vii) where the requirement is for a utility for which there exists a monopoly.

(3) When a Director/Manager intends to select a supplier to provide goods, services or construction pursuant to subsection 3.2(2), a written report indicating the compelling rationale that warrants a non-competitive selection will be submitted by the Division to the Board of Health.

(4) For contracts between $5,000 and $49,999, the Medical Officer of Health awards the contract.

(5) For contracts of $50,000 and over the Board of Health approves the contract, unless section 3.3 applies.

3.3 Procurement in Emergencies

(1) In subsection 3.2(1)(vi) "Emergency" includes

(i) an imminent or actual danger to the life, health or safety of a member of the Board of Health, volunteer or an employee while acting on the Health Unit's behalf;
(ii) an imminent or actual danger of injury to or destruction of real or personal property belonging to the Board of Health;
(iii) an unexpected interruption of an essential public service;
(iv) an emergency as defined by the Emergency Plans Act, R.S.O. 1990, Chapter E.9 and the emergency plan formulated thereunder by the Health Unit;

(v) a spill of a pollutant as contemplated by Part X of the Environmental Protection Act, R.S.O. 1990, Chapter E.19 and,
(vi) mandate of a non-compliance order.

(2) Where, in the opinion of the Medical Officer of Health or in his/her absence the Associate Medical Officer of Health, an emergency has occurred,

(i) the Associate Director, Finance on receipt of a requisition authorized by a Director and the Medical Officer of Health or designate may initiate a purchase order in excess of the pre-authorized expenditure limit; and
(ii) any purchase order issued under such conditions together with a source of financing shall be justified and reported to the next meeting of the Board of Health following the date of the requisition.

3.4 Direct Negotiations

(1) Unless otherwise provided in accordance with the Procurement Guidelines, goods and services may be purchased using the Direct Negotiation method only if one or more of the following conditions apply:

(i) the required goods and services are reasonably available from only one source by reason of the scarcity of supply in the market or the existence of exclusive rights held by any supplier or the need for compatibility with goods and services previously acquired and there are no reasonable alternatives or substitutes.
(ii) the required goods and services will be additional to similar goods and services being supplied under an existing contract;
(iii) an attempt to purchase the required goods and services has been made in good faith using a method other than Direct Negotiation under section 4.0 of these Guidelines which has failed to identify a successful supplier and it is not reasonable or desirable that a further attempt to purchase the goods and services be made using a method other than Direct Negotiation.
(iv) the goods and services are required as a result of an emergency, which would not reasonably permit the use of a method other than Direct Negotiation.
(v) the required goods and services are to be supplied by a particular vendor or supplier having special knowledge, skills, expertise or experience.

4.0 COMPETITIVE PROCESSES

4.1 Request For Proposal

4.1.1 Goals

To implement an effective, objective, fair, open, transparent, accountable, and efficient process for obtaining unique proposals designed to meet broad outcomes to a complex problem or need for which there is no clear or single solution.

4.1.2 Informal Process Requirements

(1) The Informal Request for Proposal procedure shall be used where:

(i) the item is less than $100,000;
(ii) the requirement is best described in a general performance specification;

(iii) innovative solutions are sought; and,
(iv) to achieve best value, the award selection will be made on an evaluated point per item or other method involving a combination of mandatory and desirable requirements.

(2) Bids are solicited on an invitational basis from a pre-determined bidders list but may be supplemented with public advertising of the procurement opportunity.
(3) The MOH awards the contract.
(4) A report to the Board of Health is required if the lowest bid is not accepted.

4.1.3 Formal Process Requirements

(1) A Formal Request for Proposal procedure shall be used where:

(i) the item is greater than $100,000;
(ii) the requirement is best described in a general performance specification;
(iii) innovative solutions are sought; and,
(iv) to achieve best value, the award selection will be made on an evaluated point per item or other method involving a combination of mandatory and desirable requirements.

(2) Bids are solicited through an open process that includes public advertising.
(3) The MOH is informed when the lowest bid is not being recommended.
(4) The Board of Health authorizes the award of the contract.

4.1.4 General Process

(1) The Request for Proposal method of purchase is a competitive method of purchase that may or may not include Vendor pre-qualification.

(2) A Request for Information or Request for Expression of Interest may be issued in advance of a proposal to assist in the development of a more definitive set of terms and conditions, scope of work/service and the selection of qualified Vendors.

(3) Where the requirement is not straightforward or an excessive workload would be required to evaluate proposals, either due to their complexity, length, number or any combination thereof, a procedure may be used that would include a pre-qualification phase.

(4) Finance shall maintain a list of suggested evaluation criteria for assistance in formulating an evaluation scheme using a Request for Proposal. This may include factors such as qualifications and experience, strategy, approach, methodology, scheduling and past performance, facilities, equipment, and pricing.

(5) Divisions shall identify appropriate criteria from the list maintained by Finance for use in a Request for Proposal but are not limited to criteria from the list. Cost will always be included as a factor, as best value includes both quality and cost.

(6) The Division shall provide to the Associate Director, Finance with a purchase request in writing containing the budget authorization, approval authority, terms of reference and evaluation criteria to be applied in assessing the proposals submitted.

(7) A Selection Committee, comprised of a minimum of one representative from the Division and the Associate Director, Finance or designate, shall review all proposals against the established criteria, reach consensus on the final rating results, and ensure that the final rating results, with supporting documents, are kept in the procurement file.

(8) During the proposal process all communication with bidders shall be through Finance.

(9) The Associate Director, Finance or designate shall forward to the Director(s) an evaluation summary of the procurement, as well as the Committee's recommendation for award of contract to the supplier meeting all mandatory requirements and providing best value as stipulated in the Request for Proposal. Where the lowest bid is not accepted, the Director is responsible for documenting the determination of best value, in a confidential report to the Medical Officer of Health prior to award of contract.

(10) With respect to all Board reports initiated for requests for proposals, the report shall include the sources of financing, summary of major expenditure categories, and other financial commentary as considered appropriate.

(11) Reporting will not include summaries of bids as this information will remain confidential. Any disclosure of information shall be made by the appropriate officer in accordance with the provisions of the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990.

(12) Unsuccessful proponents may, upon their request, attend a debriefing session with Finance to review their bid submission. Discussions relating to any bid submissions other than that of the proponent present will be strictly prohibited.

(13) The Health Unit reserves the right to accept or reject any submission.

4.2 Request For Tender

4.2.1 Goals

To implement an effective, objective, fair, open, transparent, accountable and efficient process for obtaining competitive bids based on precisely defined requirements for which a clear or single solution exists.

4.2.2 Requirements

Request for Tender procedures shall be used where:

(i) the item is greater than $100,000;
(ii) the requirement can be fully defined; and,
(iii) best value for the Board of Health can be achieved by an award selection made on the basis of the lowest bid that meets specifications.

4.2.3 General Process

(1) The Director or designate shall provide to the Associate Director, Finance a purchase request in writing containing the relevant specifications, budget authorization, approval authority and terms and conditions for the purchase of goods, services or construction.

(2) The Associate Director, Finance shall be responsible for arranging public advertising for the procurement opportunity.

(3) The Associate Director, Finance shall be responsible for arranging for the public opening of tender bids at the time and date specified by the tender call. There shall be in attendance at that time,

(i) Associate Director, Finance and
(ii) At least one representative from the requesting Division(s)
(iii) If the Associate Director, Finance is not available, the Medical Officer of Health or the Medical Officer's designate may act on his/her behalf.
(iv) The chair of the Board of Health shall be invited

(4) Finance shall forward to the Director a summary of the bids and recommend the award of contract to the lowest responsive bidder, subject to review by the Director or designate regarding specifications and contractor performance.

(5) With respect to all Board reports initiated for tenders, the report shall include the sources of financing, summary of major expenditure categories, and other financial commentary as considered appropriate. The Board will approve such contracts.

(6) The Health Unit reserves the right to accept or reject any submission.

4.3 Request For Quotation

4.3.1 Goals

To implement an effective, objective, fair, open, transparent, accountable and efficient process for obtaining competitive bids based on precisely defined requirements for which a clear or single solution exists.

4.3.2 Requirements

(1) Request for Quotation procedures shall be used where:

(i) the item is greater than $10,000 but not greater than $100,000;
(ii) the requirement can be fully defined; and,
(iii) best value for the Health Unit can be achieved by an award selection made on the basis of the lowest bid that meets specifications.

(2) Competitive bid solicitation is done primarily on an invitational basis from a pre-determined bidders list but may be supplemented with public advertising of the procurement opportunity.

4.3.3 General Process

4.3.3.1 Informal Quotation Process (Greater than $10,000 but no greater than $50,000)

(1) These guidelines are provided to assist a Division should it exercise its authority to purchase goods or services between $10,000 and $50,000 without the involvement of the Finance Department. Guidelines are organized by objective as follows:

(i) <u>OBJECTIVE 1: Efficiency</u>

Purchases must be for unique Division requirements, and therefore not duplicated in other Divisions, such that Health unit purchasing power or standardization is not a factor in costing. Requirements cannot be split in order to qualify for this process.

(ii) OBJECTIVE 2: Competitive Process

A competitive process is undertaken whereby a minimum of 3 bids is obtained, and the lowest compliant bid is awarded the contract. Care must be taken as to how bids are sought, bidders lists are maintained and how competition is encouraged. Although a minimum of 3 bids is required, an open process without a minimum number of bids will be more competitive, and is encouraged.

(iii) OBJECTIVE 3: Open process

Division needs are communicated to bidders, who are able to bid on goods or services they are qualified to provide. There should be no limitation of bids to an established listing. Divisions should check with the Finance Department to determine if there is an established list of potential relevant service providers that they may have for this purpose. An allowable exception to this, would be where in a formal process a short list was determined as a result of another competitive process (such as RFP), which has a pre-qualifying process to determine a short list.

(iv) OBJECTIVE 4: Transparent process

The process is undertaken based on clear definition of the product or service requirement, and a clear outline of the review and criteria to be undertaken. The decision to choose the low bidder will be based solely on the requirements as documented, the bidder document, and the application of the review criteria. The same decision should be arrived at each time given the same set of facts.

(v) OBJECTIVE 5: Fair process

The process will be fair, such that no action is undertaken by Health Unit staff to allow any given bidder an unfair advantage. This does not however, require Health Unit action to ensure that existing conditions are changed to ensure that any conversion costs from an incumbent to another supplier are ignored in an evaluation – it is in the best interest of the Health Unit to ensure that such “leveling of the playing field” is not required.

(vi) OBJECTIVE 6: Insurance and Risk Management

The Health Unit’s standard Insurance form (if required) must be completed and forwarded to the Associate Director, Finance for review and input into the Insurance Program. WSIB certificates of clearance (if required) must also be submitted to the Associate Director, Finance at the commencement of the project and periodically as the work is completed.

(2) The Medical of Officer of Health awards the contract.

4.3.3.2 Formal Quotation Process ($50,000 to $99,999)

(1) The Director or designate shall provide to the Associate Director, Finance a purchase request in writing containing the relevant specifications, budget authorization, approval authority and terms and conditions for the purchase of goods, services or construction.

(2) The Division shall be responsible to review the quote submission and verify that all specifications of the quote are met.

(3) Finance shall forward to the Director a summary of the bids and recommend the award of contract to the lowest responsive quote subject to review by the Director or designate regarding specifications and contractor performance.

(4) The MOH awards the contract.

(6) The Health Unit reserves the right to accept or reject any submission.

4.4 Informal, Low Value Procurement

4.4.1 Goals

To obtain competitive pricing for a one-time procurement in an expeditious and cost effective manner through phone, fax, e-mail, other similar communication method, vendor advertisements or vendor catalogues.

4.4.2 Requirements

(i) the item is greater than $5,000 but not greater than $10,000;
(ii) the requirement can be fully defined; and,
(iii) best value for the Health Unit can be achieved by an award selection made on the basis of the lowest bid that meets specifications.

4.4.3 General Process

(1) A minimum of 3 bids must be received. They may be obtained in a more cost-effective manner such as phone, fax, e-mail and current vendor advertisements or catalogues.

(2) The Division shall be responsible to ensure that all specifications are met.

(3) The Division Director may award the contract.

(4) The Division Director shall forward to the Associate Director, Finance all relevant procurement documentation including bid summaries to be included in the procurement file.

(5) The MOH will be informed, prior to awarding a contract, if the lowest bid/quote is not being accepted.

(6) The Health Unit has the right to cease negotiations and reject any offer.

5.0 BID AND CONTRACT ADMINISTRATION

5.1 Bid Submission

(1) Bids shall be delivered in paper form (if required) to the Associate Director, Finance or designate at the time and date specified in the bid solicitation.

(2) The opening of bids shall commence shortly after the time specified by the tender call unless the Associate Director, Finance or designate acting reasonably postpones the start to some later hour, but the opening shall continue, once started, until the last bid is opened.

(3) Any bids received by the Associate Director, Finance or designate later than the specified closing time shall be returned unopened to the bidder.

(4) A bidder who has already submitted a bid may submit a further bid at any time up to the official closing time and date specified by the bid solicitation. The last bid received shall supersede and invalidate all bids previously submitted by that bidder.

(5) A bidder may withdraw his or her bid at any time up to official closing time by letter bearing his or her signature as in his or her bid submitted to the Associate Director, Finance or designate.

(6) A tender requiring an appropriate bid deposit shall be void if such security is not received in the manner specified in section 5.5 and if no other bid is valid, the Associate Director, Finance shall direct what action is to be taken with respect to the recalling of tenders.

(7) All bidders may be requested to supply a list of all subcontractors to be employed on a project. Any changes to the list of subcontractors or addition thereto must be approved by the Director responsible for the project.

5.2 Lack of Acceptable Responses to Requests

(1) Where bids are received in response to a bid solicitation but exceed budget, are not responsive to the requirement, or do not represent fair market value, a revised solicitation shall be issued in an effort to obtain an acceptable bid.

(2) In the case of building construction contracts, where the total cost of the lowest responsive bid is in excess of the budget approved by the Board of Health, negotiations shall be made in accordance with the guidelines established by the Canadian Construction Documents Committee.

(3) The Health Unit has the right to cease negotiations and reject any offer.

5.3 Equal Bids

(1) If two or more bids are equal and are the lowest bid, the Health Unit will offer an opportunity for the tied bidders to re-bid. Should a tie persist the following factors will be considered:

(i) prompt payment discount,
(ii) when delivery is an important factor, the bidder offering the best delivery date be given preference,
(iii) a bidder in a position to offer better after sales service, with a good record in this regard shall be given preference,

(iv) a bidder with an overall satisfactory performance record shall be given preference over a bidder known to have an unsatisfactory performance record or no previous experience with the Health Unit,
(v) if (i) through (iv) do not break the tie equal bidders shall draw straws.

5.4 Insufficient Responses to Requests

(1) In the event only one bid is received in response to a request for tender, the Associate Director, Finance may return the unopened bid to the bidder when, in his/her opinion, additional bids could be secured. In returning the unopened bid the Associate Director, Finance shall inform the bidder that the Health Unit may be recalling the tender at a later date.

(2) In the event that only one bid is received in response to a request for tender, the bid may be opened in accordance with the Health Unit's usual procedures when, in the opinion of the Associate Director, Finance with consultation with appropriate Director, the bid should be considered by the Health Unit. If, after evaluation the bid is found not to be acceptable, they may follow the procedures set out in Subsection 5.2

(3) In the event that the bid received is found acceptable, it will be awarded as an Irregular result under Appendix "A" of the Purchasing Guidelines.

5.5 Guarantees of Contract Execution and Performance

(1) The Associate Director, Finance may require that a bid be accompanied by a Bid Deposit to guarantee entry into a contract.

(2) In addition to the security referred to in Subsection 5.5 (1), the successful supplier may be required to provide,

(i) a Performance Bond to guarantee the faithful performance of the contract,
(ii) a Labour & Material Bond to guarantee the payment for labour and materials to be supplied in connection with the contract and,
(iii) an irrevocable letter of credit.

(3) The Associate Director, Finance shall select the appropriate means to guarantee execution and performance of the contract. Means may include one or more of, but are not limited to, financial bonds or other forms of security deposits, provisions for liquidated damages, progress payments, and holdbacks.

(4) When a bid deposit is required the Associate Director, Finance shall determine the amount of the bid deposit which may be 10 per cent of the estimated value of the work prior to bidding or an amount equal to 10 per cent of the bid submitted.

(5) Prior to commencement of work and where deemed appropriate, evidence of Insurance Coverage satisfactory to the Health Unit's Insurer must be obtained, ensuring indemnification of the Health Unit from any and all claims, demands, losses, costs or damages resulting from the performance of a supplier's obligations under the contract.

(6) When a performance bond or labour and material bond is required, the amount of the bond shall be 50% of the amount of the tender bid, unless the Associate Director, Finance recommends and the Board of Health approves a higher level of bonding.

(7) If the risk to the Health Unit is not adequately limited by the progress payment provisions of the contract, a payment holdback shall be considered.

(8) A minimum payment holdback of 10 percent is mandatory for all construction contracts.

(9) The Associate Director, Finance may release the holdback funds on construction contracts upon:

(i) the contractor submitting a statutory declaration that all accounts have been paid and that all documents have been received for all damage claims,
(ii) receipt of clearance from the Workplace Safety and Insurance Board for any arrears of Workplace Safety and Insurance Board assessment,
(iii) all the requirements of the Construction Lien Act, R.S.O. 1990, being satisfied,
(iv) receipt of certification from the Health Unit Solicitor, where applicable, that liens have not been registered, and
(v) substantial performance

(10) The conditions for release of holdback funds provided in Subsection 5.5 (9) apply to other goods or services contracts with necessary modifications.

(11) The Health Unit is authorized to cash and deposit any bid deposit cheques in the Health Unit's possession which are forfeited as a result of non-compliance with the terms, conditions and/or specifications of a sealed bid.

5.6 Requirement at Time of Execution

(1) The successful bidder, if requested in the tender document shall submit the following documentation in a form satisfactory to the Health Unit within ten working days after being notified in writing to do so by the Health Unit:

(i) executed performance bonds and labour and material bonds;
(ii) executed agreement;
(iii) insurance documents in compliance with the tender documents;
(iv) declarations respecting the Workplace Safety and Insurance Board;
(v) certificate of clearance from the Workplace Safety and Insurance Board; and,
(vi) any other documentation requested to facilitate the execution of the contract (e.g. proof of required licenses and/or certificates).

5.7 Contractual Agreement

(1) The award of contract may be made by way of a formal agreement, or Purchase Order.

(2) A Purchase Order is to be used when the resulting contract is straightforward and will contain the Health Unit's standard terms and conditions.

(3) A formal agreement is to be used when the resulting contract is complex and will contain terms and conditions other than the Health Unit's standard terms and conditions.

(4) It shall be the responsibility of the Director or designate with the Associate Director, Finance and/or the Health Unit's Solicitor to determine if it is in the best interest of the Health Unit to establish a formal agreement with the supplier.

(5) Where it is determined that Subsection 5.7 (4) is to apply, the formal agreement should be made in accordance to Health Unit Policy 4-90, Contractual Services.

(6) Where a formal agreement is issued, Finance may issue a Purchase Order incorporating the formal agreement.

(7) Where a formal agreement is not required, Finance shall issue a Purchase Order incorporating the terms and conditions relevant to the award of contract.

5.8 Contract Amendments and Revisions

(1) No amendment or revision to a contract shall be made unless the amendment is in the best interest of the Health Unit.

(2) No amendment that changes the price of a contract shall be agreed to without a corresponding change in requirement or scope of work.

(3) Amendments to contracts are subject to the identification and availability of sufficient funds within the Board of Health approved operating budget.

(4) Health Unit staff may authorize amendments to contracts provided that their signing authority level, as outlined in Health Unit policies 4-90, 4-110, has not been exceeded. For clarity, the required authority level is the total of the original contract price plus any amendments.

(5) Where expenditures for the proposed amendment combined with the price of the original contract exceeds Board of Health approved budget for the project, a report prepared by the Director shall be submitted to the Board of Health recommending the amendment, and proposing the source of financing.

5.9 Contract Review/Renewal

(1) Where a contract contains an option for renewal, the Director may authorize the Associate Director, Finance to exercise such option provided that all of the following apply:

(i) the supplier's performance in supplying the goods, services or construction is considered to have met the requirements of the contract,
(ii) the Director and Associate Director, Finance agree that the exercise of the option is in the best interest of the Health Unit,
(iii) funds are available in the Board of Health approved operating budget to meet the proposed expenditure.
(iv) a valid business case has been completed.

(2) The business case shall be authorized by the Director and shall include a written explanation as to why the renewal is in the best interest of the Health Unit and include commentary on the market situation and trend.

5.10 Exclusion of Vendors from Competitive Process

5.10.1 Exclusion of Bidders in Litigation

(1) The Health Unit may, in its absolute discretion, reject a Tender or Proposal submitted by the bidder if the bidder, or any officer or director of the bidder is or has been engaged, either directly or indirectly through another corporation, in a legal action against the Health Unit, its elected or appointed officers and employees in relation to:

(i) Any other contract or services; or

(ii) Any matter arising from the Health Unit's exercise of its powers, duties, or functions.

(2) In determining whether or not to reject a quotation, tender or proposal under this clause, the Health Unit will consider whether the litigation is likely to affect the bidder's ability to work with the Health Unit, its consultants and representatives, and whether the Health Unit's experience with the bidder indicates that the Health Unit is likely to incur increased staff and legal costs in the administration of the contract if it is awarded to the bidder.

5.10.2 Exclusion of Bidders Due to Poor Performance

(1) The Director shall document evidence and advise the Associate Director, Finance in writing where the performance of a supplier has been unsatisfactory in terms of failure to meet contract specifications, terms and conditions or for Health and Safety violations.

(2) The Health Unit may, in consultation with it's Solicitor, prohibit an unsatisfactory supplier from bidding on future Contracts for a period of up to three years.

5.11 Single/Sole Source

(1) The procurement of materials, parts, supplies, equipment or services without competition (See also Section 3.0), is done under exceptional and limited circumstances.

(2) In circumstances where there may be more than one source of supply in the open market, but only one of these is recommended for consideration on the grounds that it is more cost effective or beneficial to the Health Unit approval must be obtained from the Medical Officer of Health & Chief Executive Officer, and the Associate Director, Finance prior to negotiations with the single source.

(3) In the event 5.4 (2) applies and the expenditure will exceed $50,000, approval must be obtained from the Board of Health prior to negotiations with the single source. The Director or designate shall be responsible for submitting a report detailing the rationale supporting the use if the single source.

(4) If the Health Unit requires goods, services or equipment deemed to be available from only one source of supply, and where the expenditure will exceed $50,000, the Director or designate with the concurrence of the Medical Officer of Health & Chief Executive Officer, and the Finance & Operations Officer shall obtain approval from the Board of Health to waive the competitive procurement process.

5.12 Blanket Purchases

(1) A Request for a Blanket Purchase Contract may be used where:

(i) one or more Division repetitively order the same goods or services and the actual demand is not known in advance, or
(ii) a need is anticipated for a range of goods and services for a specific purpose, but the actual demand is not known at the outset, and delivery is to be made when a requirement arises.

(2) Finance shall establish and maintain Blanket Purchase Contracts that define source and price with selected suppliers for all frequently used goods or services.

(3) To establish prices and select sources, Finance shall employ the provisions contained in these Guidelines for the acquisition of goods, services and construction.

(5) More than one supplier may be selected where it is in the best interests of the Health Unit and the bid solicitation allows for more than one.

(5) Where purchasing frequently used good or services is initiated by a Division, it is to be made with the supplier or suppliers listed in the Blanket Purchase Contract.

(6) In a Request for Blanket Purchase Contract, the expected quantity of the specified goods or services to be purchased over the time period of the agreement will be as accurate an estimate as practical and be based, to the extent possible, on previous usage adjusted for any known factors that may change usage.

5.13 Custody of Documents

(1) The Associate Director, Finance shall be responsible for the safeguarding of original purchasing and contract documentation for the contracting of goods, services or construction.

5.14 Co-operative Purchasing

(1) The Health Unit shall participate with other government agencies or public authorities in Co-operative Purchasing where it is in the best interests of the Health Unit to do so.

(2) The decision to participate in Co-operative Purchasing agreements will be made by the Finance & Operations Director.

(3) The policies of the government agencies or public authorities calling the cooperative tender are to be the accepted policy for that particular tender.

5.15 Receipt of Goods

(1) The Director or designate shall,

(i) arrange for the prompt inspection of goods on receipt to confirm conformance with the terms of the contract, and
(ii) inform the Associate Director, Finance of discrepancies immediately.

(2) The Associate Director, Finance Finance shall coordinate an appropriate course of action with the Director for any non-performance or discrepancies.

5.16 Receipt of Services

(1) The Director or designate shall:

(i) ensure the performance of the services is maintained in a satisfactory manner and in keeping with the terms of the contract and/or agreement.
(ii) Division staff are to document any discrepancies in the performance of services.
(iii) Inform the Associate Director, Finance of poor performance
(iv) Inform the Associate Director, Finance of any breach of contract and/or agreement.

5.17 Reporting to Board of Health

(1) The Associate Director, Finance shall submit to the Board of Health an information report each Board of Health meeting containing the details for all contracts awarded that exceed $50,000 including amendments and renewals. The report shall certify that the awards are in compliance with the Purchasing Guidelines.

(2) The Associate Director, Finance shall submit annually to the Board of Health an information report containing a list of suppliers for which the Health Unit has been invoiced a cumulative total value of $100,000 or more in a calendar year. The list shall include total payments.

5.18 Direct Solicitation of Divisions

(1) Unsolicited Proposals received by the Health Unit shall be reviewed by the Finance & Operations Director.

(2) Any procurement activity resulting from the receipt of an Unsolicited Proposal shall comply with the provisions of the Procurement Guidelines.

(3) A contract resulting from an Unsolicited Proposal shall be awarded on a noncompetitive basis only when the procurement complies with the requirements of a non-competitive procurement found in section 3.0 above.

5.19 Resolution of Questions of Guidelines

(1) Any question involving the meaning or application of these Guidelines is to be submitted to the Associate Director, Finance who will resolve the question.

5.20 Access to Information

(1) The disclosure of information received relevant to the issue of bid solicitations or the award of contracts resulting from bid solicitations shall be made by the appropriate officers in accordance with the provisions of the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, as amended.

(2) All records and information pertaining to tenders, proposals and other sealed bids, which reveal a trade secret or scientific, technical, commercial, financial or other labour relations information, supplied in confidence implicitly or explicitly, shall remain confidential if the disclosure could reasonably be expected to:

(i) prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organizations;
(ii) result in similar information no longer being supplied to the Health Unit where it is in the public interest that similar information continue to be so supplied;
(iii) result in undue loss or gain to any person, group, committee or financial institution or agency; or
(iv) result in information whose disclosure could reasonably be expected to be injurious to the financial interests of the Health Unit.

5.21 Environmental Considerations

(1) In order to contribute to waste reduction and to increase the development and awareness of environmentally sound purchasing, acquisitions of goods and services will ensure that, wherever possible, specifications are amended to provide for expanded use of durable products, reusable products and products (including those used in services) that contain the maximum level of post-consumer waste and/or recyclable content, without significantly affecting the intended use of the product or service. It is recognized that cost analysis is required in order to ensure that the products are made available at competitive prices.

5.22 Guidelines Amendment

(1) These Guidelines or any provision of it may be amended by the Directors Committee from time to time as long as, any change(s) is operational in nature and does not significantly alter the intention or goal of the Guidelines.

6.0 CAPITAL ASSET PURCHASES/IMPROVEMENTS AND DISPOSAL

(1) All construction, renovations or alterations to leased premises under $50,000 must be reviewed and approved by the Medical Officer of Health & Chief Executive Officer and the Finance & Operations Director. Projects over $50,000 require the authorization of the Board of Health.

(2) All purchases of computer hardware (including peripheral equipment) and software will be administered by the Manager of Information Services.

(3) All purchase of furniture will be administered by the Finance & Operations Director.

(4) Finance will be notified upon receipt of all purchases involving capital assets to ensure proper accounting and asset-tracking methods are applied.

(5) Finance will maintain an inventory of all capital assets that is in accordance to the Public Service Accounting Board guidelines (PSAB) and Generally Accepted Accounting Principles (GAAP).

Disposal of Assets

(6) All Divisions shall notify the Associate Director, Finance when items become obsolete or surplus to their requirements. The Associate Director, Finance shall be responsible for ascertaining if the items can be of use to another Division rather than disposed of.

(7) Items that are not claimed for use by another Division may be sold. If there is no suitable market, then the item could be considered for donation.

7.0 EXCLUDED GOODS AND SERVICES

The following purchases of good and services are excluded from the Procurement Guidelines:

(1) Purchases under the Petty Cash policy

(2) Training and Education including:
- (i) Conferences
- (ii) Courses
- (iii) Conventions
- (iv) Subscriptions
- (v) Memberships
- (vi) Association fees
- (vii) Periodicals
- (viii) Seminars
- (ix) Staff development
- (x) Staff workshops

(3) Refundable Employee Expenses including:
- (i) Cash advances
- (ii) Meal allowance
- (iii) Travel expenses
- (iv) Accommodation

(4) Employer's General Expenses including:
- (i) Payroll deductions remittances
- (ii) Medicals
- (iii) Insurance premiums
- (iv) Tax remittances

(5) Licenses, certificates, and other approvals required.

(6) Ongoing maintenance for existing computer hardware and software.

(7) Professional and skilled services to clients as part of Health Unit programs including but not limited to medical services (Clinics), counseling services, Speech and Language services and child care.

(8) Other Professional and Special Services up to $100,000 including:

- (i) Additional non-recurring Accounting and Auditing Services
- (ii) Legal Services
- (iii) Auditing Services
- (iv) Banking Services
- (v) Group Benefits (inc. Employee Assistance Program)
- (vi) General Liability Insurance
- (vii) Realty Services regarding the Lease, Acquisition, Demolition, Sale of Land and Appraisal of Land.

8.0 REVIEWING AND EVALUATING EFFECTIVENESS

(1) The Health Unit's Auditor shall review and test compliance with the Procurement Guidelines during its annual audit, and report any non-compliance to the Medical Officer of Health on a yearly basis.

(2) The Directors Committee will review the Guidelines annually to ensure the goals and Guidelines objectives are being met.

9.0 APPENDICES

Appendix A

IRREGULARITIES CONTAINED IN BIDS

IRREGULARITY	RESPONSE
1. Late Bids	Automatic rejection, not read publicly and returned unopened to the bidder.
2. Unsealed Envelopes	Automatic rejection
3. Insufficient Financial Security (No bid deposit or insufficient bid deposit)	Automatic rejection
4. Failure to insert the name of the bonding company in the space provided for in the Form of Tender.	Automatic rejection
5. Failure to provide a letter of agreement to bond where required.	Automatic rejection
6. Incomplete, illegible or obscure bids or bids which contain additions not called for, erasures, alterations, errors or irregularities of any kind.	May be rejected as informal
7. Documents, in which all necessary Addenda have not been acknowledged.	Automatic rejection
8. Failure to attend **mandatory** site visit.	Automatic rejection
9. Bids received on documents other than those provided by the Health Unit.	Automatic rejection
10. Failure to insert the Tenderer's business name in one of the two spaces provided in the Form of Tender.	Automatic rejection
11. Failure to include signature of the person authorized to bind the Tenderer in the space provided in the Form of Tender.	Automatic rejection
12. Conditions placed by the Tenderer on the Total Contract Price.	Automatic rejection
13. Only one bid is received.	a) Bid returned unopened if additional bids could be secured. b) If the bid should be considered in the opinion of the Finance & Operations Director, and is found acceptable, then it may be awarded.

IRREGULARITY	RESPONSE
14. Bids Containing Minor Mathematical Errors	a) If the amount tendered for a unit price item does not agree with the extension of the estimated quantity and the tendered unit price, or if the extension has not been made, the unit price shall govern and the total price shall be corrected accordingly b) If both the unit price and the total price are left blank, then both shall be considered as zero. c) If the unit price is left blank but a total price is shown for the item, the unit price shall be established by dividing the total price by the estimated quantity. d) If the total price is left blank for a lump sum item, it shall be considered as zero. e) If the Tender contains an error in addition and/or subtraction and/or transcription in the approved tender documentation format requested (i.e. not the additional supporting documentation supplied), the error shall be corrected and the corrected total contract price shall govern. f) Tenders containing prices which appear to be so unbalanced as to likely affect the interests of the Health Unit adversely may be rejected.

Appendix B

Summary of Types of Procurement with Goals

Competitive Process Seeking Multiple Bids or Proposals				Non-Competitive Procurement
Request for Proposal	**Request for Tender**	**Request for Quotation**	**Informal Low Value Procurement**	
To implement an effective, objective, fair, open, transparent, accountable and efficient process for obtaining unique proposals designed to meet broad outcomes to a complex problem or need for which there is no clear or single solution. To select the proposal that earns the highest score and meets the requirements specified in the competition, based on qualitative, technical and pricing considerations.	To implement an effective, objective, fair, open, transparent, accountable and efficient process for obtaining competitive bids based on precisely defined requirements for which a clear or single solution exists. To accept the lowest bid meeting the requirements specified in the competition.	Same as for Request for Tender, except that bid solicitation is done primarily on an invitational basis from a pre-determined bidders list but may be supplemented with public advertising of the procurement opportunity.	To obtain competitive pricing for a one-time procurement in an expeditious and cost effective manner through phone, fax, e-mail, other similar communication method, vendor advertisements or vendor catalogues.	To allow for procurement in an efficient and timely manner without seeking competitive pricing.

Appendix C

Procurement Circumstances

Item	Competitive Process Seeking Multiple Bids or Proposals				Non-Competitive Procurement
	Request for Proposal	**Request for Tender**	**Request for Quotation**	**Informal, Low Value Procurement**	
Dollar value of procurement	> $100,000	> $100,000	$10,000-$100,000	$5,000 - $10,000	< $5,000 or Any value, subject to proper authorization
Purchaser has a clear or single solution in mind and precisely defines technical requirements for evaluating bids or proposals	Rarely	Always			
In evaluating bids/proposals from qualified bidders, price is the primary factor and is not negotiated	Low to Moderate Likelihood	Always			Not Applicable

Appendix D

Descriptive Features of Procurement Processes

<table>
<tr><th rowspan="2">Item</th><th colspan="4">Competitive Process Seeking Multiple Bids or Proposals</th><th rowspan="2">Non-Competitive Procurement</th></tr>
<tr><th>Request for Proposal</th><th>Request for Tender</th><th>Request for Quotation</th><th>Informal, Low Value Procurement</th></tr>
<tr><td>Sealed bids or sealed proposals required</td><td colspan="3">Always</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Issue a Request for Information or a Request for Expressions of Interest/Pre-qualification prior to or in conjunction with a call for bids or proposals</td><td>Moderate to High Likelihood</td><td colspan="2">Low to Moderate Likelihood</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Call for bids or proposals advertised</td><td>Always if greater than $100,000, otherwise sometimes.</td><td>Always</td><td>Should consider</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Formal process used to pre-qualify bidders/ proponents (i.e. Request for Pre-qualification)</td><td colspan="2">Moderate to High Likelihood</td><td>Low Likelihood</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Seek bids or proposals from known bidders/ proponents (Bidders List)</td><td>Moderate to High Likelihood</td><td>Low to Moderate Likelihood</td><td>Always</td><td colspan="2">Moderate to High Likelihood</td></tr>
</table>

Appendix D (Cont'd)

Descriptive Features of Procurement Processes (Cont'd)

<table>
<tr><th rowspan="2">Item</th><th colspan="4">Competitive Process Seeking Multiple Bids or Proposals</th><th rowspan="2">Non-Competitive Procurement</th></tr>
<tr><th>Request for Proposal</th><th>Request for Tender</th><th>Request for Quotation</th><th>Informal Low Value Procurement</th></tr>
<tr><td>Two-envelope[1] or similar multi-stage approach used</td><td>Moderate to High Likelihood</td><td colspan="4">Not Applicable</td></tr>
<tr><td>Bids or proposals opened and reviewed at a meeting (** Public or not)) (excluding proprietary information)</td><td>Always</td><td>Always</td><td>Moderate to High Likelihood</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Type of agreement with supplier</td><td colspan="3">Purchase order, legally executed agreement, or blanket contract (standing agreement/offer).</td><td>Purchase by cash, purchase order, or credit card.</td><td>Cash, purchase order, credit card, legally executed agreement, or blanket contract (standing agreement/offer) .</td></tr>
<tr><td>May include In-house bidding in addition to external bidding</td><td colspan="3">No</td><td colspan="2">Not applicable</td></tr>
</table>

[1] In the two-envelope approach, qualitative and technical information is evaluated first and pricing information in a separate envelope is evaluated thereafter only if the qualitative and technical information meet a minimum score requirement predetermined by the municipality/local board. For more details, see Appendix F.

Appendix E

THE "TWO-ENVELOPE" PROCUREMENT PROCESS

The two-envelope approach is used when the purchaser wants to evaluate the technical and qualitative information of a given proposal without being influenced by prior knowledge of the corresponding pricing information. Proposal evaluation is done usually by a team of staff from possibly more than one department who have relevant expertise for making the evaluation.

In the two-envelope approach, each proponent must submit qualitative and technical information in a sealed envelope (envelope one) and pricing information in a second sealed envelope (envelope two). The contents of envelope one are evaluated and scored according to pre-determined criteria such as relevant firm experience, project team's qualifications/experience, personnel time allocation, understanding of scope of work, methodology/thoroughness of approach, quality and completeness of proposal submission, etc.

When the scoring of envelope one is completed, then the pre-determined process for moving to envelope two is followed. In some procurement strategies, a minimum score threshold is in place at envelope one, and only proposals which meet or exceed that threshold are eligible to proceed to the opening of envelope two and subsequent price evaluation. If a proposal is not eligible to proceed to price evaluation, the proponent is disqualified from further consideration and the second envelope is returned to the proponent unopened.

For each proposal where envelope two is opened, the bid price(s) are scored according to the pre-determined process. The particular procurement and evaluation strategy will dictate the process for scoring the price and subsequently taking the scores from the envelope one and envelope two processes into account, resulting in a total evaluated score for the proposal. The total evaluated scores are ranked, and the proposal with the highest ranked score is considered the successful proposal, unless council or the local board, as applicable, decides otherwise. In the event of a tie, the pre-determined process for handling a tie is followed.

SUBJECT:	Roles and Responsibilities of the Board of Health	**POLICY NUMBER:**	**G-270**
SECTION:	Board Effectiveness	**PAGE:**	1 of 4

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

To outlines the roles and responsibilities of the Board of Health as an entity as defined by the Health Protection and Promotion Act, R.S.O. 1990, c. H.7. Additionally, this policy outlines the roles of Board of Health members, the Board of Health Chair, Vice-Chair and Secretary-Treasurer.

POLICY

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

PROCEDURE

Mandate of the Board of Health
The Board of Health is responsible for public health program and service delivery, including understanding and meeting their communities' health needs and managing the delivery of services and programs. The *Health Protection and Promotion Act* (HPPA) outlines the mandated public health activities and authorizes the Board of Health to provide any other health program or service if the Board of Health is of the opinion that it is necessary or desirable.

The Board of Health is committed to good management practices and an effective organization. All programs delivered by the Board of Health aim to be based on sound evidence, epidemiological principles and a philosophy of achieving results efficiently and with accountability at all levels of the organization.

These primary duties of the Board of Health are carried out through planning and policy development, transparent fiscal management, labour relations and oversight of Health Unit operations. Day-to-day management is the responsibility of the Medical Officer of Health/Chief Executive Officer and senior staff.

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

- Delivery of the Ontario Public Health Standards (including the program, foundational, and organizational standards);
- Organizational effectiveness through evaluation of operational and strategic plans;
- Stakeholder relations and partnership building;
- Research and evaluations, including ethical review;

- Compliance with all applicable legislation and regulations;
- Workforce issues, including recruitment of the Medical Officer of Health and any other senior executives;
- Financial management, including procurement policies and practices; and
- Risk management.

Accountability

While the Board of Health is legally accountable to the Minister of Health and Long-Term Care and the people of Ontario through the Health Protection and Promotion Act, the Board also recognizes an implicit accountability to the communities of London and Middlesex.

Role of Board of Health Members and Duties of Officers

Board of Health Member:	The Board of Health for the Middlesex-London Health Unit is comprised of five Provincial Representatives, three Middlesex County Representatives and three City of London Representatives. Provincial Representatives are appointed for a term decided by the Lieutenant Governor in Council and Municipal Representatives are general appointed for the duration of the municipal term. (See Appendix A – Board Member Role Description)
Chair:	As per Bylaw No. 3 Section 18, the Chair is elected for one year, with a possible renewal of one additional year, and rotates among the three representative bodies. (See Appendix B – Chair and Vice-Chair Position Description).
Vice-Chair:	Bylaw No. 3 Section 18 stipulates that the Vice-Chair is elected for a one year term. (See Appendix B – Chair and Vice-Chair Position Description).
Secretary-Treasurer:	Traditionally, the Secretary-Treasurer functions have been performed by the Medical Officer of Health and CEO. (See Appendix C – Secretary-Treasurer position description).

Informing Municipalities of Financial Obligations

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

- The estimated total annual expense that will be required to pay for the Board of Health to deliver the mandatory program and services under the Ontario Public Health Standards.
- The specific proportion of the estimated amount for which each municipality is responsible, in accordance with the agreement respecting the proportion of the expenses to be paid by each municipality.
- The time at which the Board of Health requires payment to be made by each municipality and the amount of each payment required.

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

Appropriate current collective agreements are provided to employees by their union, and to management by the Director, Corporate Services. Original collective agreements are maintained in the Human Resources Offices. Copies of all current collective agreements are maintained in the Health Unit library and posted on the Health Unit intranet.

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

- Collective bargaining is successfully undertaken with both parties agreeing and signing a Memorandum of Settlement.
- The Memorandum of Settlement is presented in the form of a confidential Board report to the Board of Health at the next scheduled meeting or specially called meeting at which time the Board, by vote, will agree or disagree with the Memorandum of Settlement.
- If the Board agrees, the union is then notified of the Board's ratification of the Memorandum of Settlement, both by telephone and in writing, by the Director, Corporate Services.
- If the Board does not agree, the union is then notified of the Board's non-ratification of the Memorandum of Settlement, both by telephone and in writing, by the Director, Corporate Services.
- Each union will be responsible for following its ratification procedure and notifying the Director, Corporate Services of the outcome.

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

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

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

APPLICABLE LEGISLATION

Health Protection and Promotion Act, R.S.O. 1990, c. H.7

Municipal Act, 2001, S.O. 2001, c. 25

RELATED POLICIES

REVISION DATES (* = major revision)**:**

Governance Policy Manual – Board Member Role Description

Board Member Responsibilities and Expectations:

Each Board of Health Member has a responsibility to the Middlesex-London Health Unit. Consequently, members must have a strong commitment to the mandate of the Health Unit and be willing to develop an understanding of the services and programs that the Health Unit provides and how the policy decisions of the Board of Health affect these. This requires familiarity with local resources and the changing health needs and trends of the community.

Responsibilities of Members include:

- Acquiring a clear understanding of the fiscal operations and ensuring funds are adequate and responsibly spent;
- Engaging in generative thinking and planning;
- Working effectively within a group, including communicating effectively with other Board Members and staff during Board of Health and Committee meetings;
- Being supportive of the organization's mandate and management's ability to implement strategy;
- Continuing self-education, growth and understanding of public health principles; and
- Representing the Board at Health Unit, public or official functions.

To fulfill the aforementioned responsibilities, it is expected that Board of Health Members:

- Participate in orientation and annual retreats;
- Attend a minimum of 90% of regularly scheduled meetings and special sessions either in person, by telephone or other mediums available;
- Review agenda packages prior to meetings;
- Follow Board of Health bylaws, policies and procedures;
- Accurately represent decisions of the Board of Health;
- Disclose any potential conflicts of interest and remove themselves from any conversation where one may exist;
- Comply with the Board of Health Code of Conduct; and
- Meet expectations of the Ontario Public Health Organizational Standards, which establish management and governance requirements for all Boards of Health and public health units.

Governance Manual – Chair and Vice-Chair Role Description

The Chair and Vice-Chair of the Board of Health have specific responsibilities to the Middlesex-London Health Unit. In addition to fulfilling the responsibilities and expectations of MLHU Board members, there are additional obligations that the Board Chair and Vice-Chair must uphold.

Responsibilities of the Chair include:

1. ***Leadership*** - Guides and directs the governance process, centering the work of the board on the organization's mission, vision and strategic direction.
2. ***Agendas*** - Establishes agendas for Board and Executive Committee meetings, in collaboration with the CEO.
3. ***Meeting management*** - Presides over Board and Executive Committee meetings in a manner that encourages participation and information sharing while moving the board toward timely closure and prudent decision-making.
4. ***Committee direction*** - Appoints committee chairs and members, subject to board approval. Works with committee chairpersons to align the work of committees with the vision and goals.
5. ***MOH/CEO relationship*** - Serves as the board's central point of official communication with the CEO. Develops a positive, collaborative relationship with the CEO, including acting as a sounding board for the CEO on emerging issues and alternative courses of action. Stays up-to-date about the organization and determines when an issue needs to be brought to the attention of the full board or a committee.
6. ***MOH/CEO performance appraisal*** - Leads the processes of CEO goal-setting, performance evaluation and compensation review, consistent with Board policy.
7. ***Committee attendance*** - Serves as an ex-officio member of all committees.
8. ***Board conduct*** - Sets a high standard for board conduct by modeling, articulating and upholding rules of conduct set out in board bylaws and policies. Intervenes when necessary in instances involving conflict-of-interest, confidentiality and other board policies.
9. ***Board learning and development*** - Leads the development of the board's knowledge and capabilities by playing a central role in orientation of new board members, mentoring a chair-elect and providing continuing education for the entire board.
10. ***Succession planning*** - Participates in the recruitment of new board members and in the process of identifying candidates to serve as chairperson-elect.
11. ***Self-evaluation*** - Provides for an effective, objective board self-evaluation process and supports implementation of recommendations for improvement. Seeks feedback on his or her performance as chairperson.

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

Governance Manual – Secretary-Treasurer Role Description

The Secretary-Treasurer of the Board of Health has specific responsibilities to the Middlesex-London Health Unit.

Responsibilities of the Secretary-Treasurer include:

1. ***Agendas*** – Establishes agendas for Board and Committee meetings in collaboration with the Board of Health Chair and/or Vice Chair.
2. ***Meeting preparation*** – Ensures that all materials are prepared in a timely manner and of high quality to inform the Board of Health and Board of Health decisions.
3. ***Meeting minutes*** – Ensures full and accurate minutes of the meetings of all the Board meetings, text of Bylaws and Resolutions passed by it.
4. ***Budget preparation and reporting*** - Prepares and controls the Annual Budget under the jurisdiction of the Board for submission to the Board;
5. ***Board of Health Chair relationship*** - Serves as management's central point of official communication with the Chair of the Board of Health. Develops a positive, collaborative relationship with the Chair, including acting as a sounding board for the Chair on emerging issues and alternative courses of action. Stays up-to-date about the organization and determines when an issue needs to be brought to the attention of the full board or a committee.
6. ***Management of Board of Health property*** – Responsible for the care and maintenance of all property and keeping a written inventory.
7. ***Committee attendance*** - Serves as an ex-officio member of all committees.
8. ***Oversight of all Board of Health by-laws and policies*** – Every by-law and policy that is passed by the Board will be signed by the Board Chair at the meeting which it was passed and deposited with the Secretary-Treasurer for archiving and future reference.
9. ***Board learning and development*** – Assist with the development of the board's knowledge and capabilities by playing a central role in orientation of new board members, chair-elect and providing continuing education for the entire board.

SUBJECT:	Board Size and Composition	**POLICY NUMBER:**	**G-280**
SECTION:	Board Effectiveness	**PAGE:**	1 of 2

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

To outline the structure and composition of the Board of Health

POLICY

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

PROCEDURE

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

The number of Board members and their representation is as follows:
City of London – 3 appointees
County of Middlesex – 3 appointees
Province of Ontario – 5 appointees

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

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

Board Structure
Each year at its inaugural meeting, the Board will:
- Elect a Chair, Vice Chair and Secretary-Treasurer
- Decide whether to establish and/or continue standing committees or to have the Board deal with all matters directly.

The Chair of the Board is to rotate between one of the appointees of the County of Middlesex, the City of London or the Province of Ontario when terms of the Board Chair are not renewed.

APPLICABLE LEGISLATION

Health Protection and Promotion Act, R.S.O. 1990, c. H.7
Municipal Act, 2001, S.O. 2001, c. 25

RELATED POLICIES

By-law #3 Proceedings of the Board of Health
Policy G-270 Roles and Responsibilities of the Board of Health
Poly G-290 Standing and Ad Hoc Committees

REVISION DATES (* = major revision)**:**

SUBJECT:	Standing and Ad Hoc Committees	**POLICY NUMBER:**	**G-290**
SECTION:	Board Effectiveness	**PAGE:**	1 of 2

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

Standing and ad hoc committees are organized to assist the Board of Health in doing its work efficiently and effectively. These committees operate as a component of the collective body and are authorized by and report to the larger Board of Health.

POLICY

Standing and ad hoc committee must be authorized by the Board of Health and serve a specific purpose that is outlined in a Terms of Reference and Reporting Calendar.

PROCEDURE

Establishment and Appointment to Committees

The Board may establish committees to consider such matters as specified by the Board (e.g., Human Resources, Planning, etc.). At the first meeting of each calendar year, the Board shall appoint Board members to the standing and ad hoc committee of the Board of Health along with chairs for each committee.

All members of the Board of Health are expected to serve on at least one board committee with each standing committee including at least 5 members. In addition, the Board Chair will be an ex-officio voting member of every board committee.

Standing Committees

Standing Committees are constituted every year or frequently and they work on continuous basis. Standing Committees of the Board of Health include:

• Governance Committee	Terms of Reference (Appendix A) Reporting Calendar (Appendix B)
• Finance and Facilities Committee	Terms of Reference (Appendix C) Reporting Calendar (Appendix D)

Ad Hoc Committees

Ad hoc committees are temporary and created for specific task. Once that task is completed, the ad hoc committees cease to exist. Examples of an ad hoc committee include the Medical Officer of Health Performance Appraisal Committee.

Conduct of Business in Committees

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

It shall be the duty of the Committee:

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

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

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

APPLICABLE LEGISLATION

RELATED POLICIES

By-law #3 – Proceedings of the Board of Health
G-270 Roles and Responsibilities of the Board of Health

REVISION DATES (* = major revision)**:**

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GOVERNANCE COMMITTEE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer (MOH/CEO), and the Director, Corporate Services in the administration and risk management of matters related to board membership and recruitment, board self-evaluation and governance policy.

REPORTING RELATIONSHIP

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

MEMBERSHIP

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

The Secretary-Treasurer will be an ex-officio member

Staff support:

- Director, Corporate Services
- Executive Assistant to the Board of Health and Communications or the Executive Assistant to the Medical Officer of Health depending on availability.

Other Board of Health members are able to attend the Governance Committee but are not able to vote.

CHAIR

The Governance Committee will elect a Chair at the first meeting of the year to serve for a one or two year term. The Chair of the Committee may be appointed for additional terms following the completion of an appointment to enhance continuity of the Committee.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as he or she remains a Board of Health member.

DUTIES

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

1. Recruitment and nomination of suitable Board members.
2. Orientation and training of Board members.
3. Performance evaluation of individual members, the Board as a whole, and committees of the Board.
4. Compliance with the Board of Health Code of Conduct.
5. Performance evaluation of the MOH/CEO.
6. Governance policy and bylaw review and development.
7. Compliance with the Organizational Standards.
8. Strategic Planning.

FREQUENCY OF MEETINGS

The Committee will meet quarterly or at the call of the Chair of the Committee.

AGENDA & MINUTES

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

BYLAWS:

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

REVIEW

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

Implementation Date: June 20, 2013
Revision Date: April 21, 2016

Governance Committee Reporting Calendar

Q1 (Jan 1 to Mar 31) – January Meeting	Q2 (Apr 1 to Jun 30) – April Meeting
• Confirm Reporting Calendar. • Initiate Board of Health Orientation and Development. • Initiate Medical Officer of Health Performance Appraisal. • Initiate Board of Health Self-Assessment and Member Evaluations. • Initiate Terms of Reference Review (biannually)	• Complete Board of Health Orientation and Development. • Complete Medical Officer of Health Performance Evaluation. • Report on Board of Health Self-Assessment and Member Evaluations. • Q4 Strategic Plan Report.
Q3 (Jul 1 to Sep 30) – July Meeting	**Q4 – (Oct 1 to Dec 31) – October Meeting**
• Initiate Board of Health Risk Management & Assessment. • Review Governance Policies.	• Report on Board of Health Risk Management & Assessment. • Report on Accountability (OPHOS, OPHS, PHFAA) and Compliance (HPPA) status. • Report on Accreditation Status/Options. • Q2 Strategic Plan Report.

Board of Health Orientation and Development

Every Board of Health is must ensure that all new members receive an orientation to the role and ongoing development and education. A comprehensive orientation can support a positive board culture and enrich the members' understanding of their role and the expectations of the Board of Health.

When the board has all members appointed, board retreats may provide opportunities for improvement and identify recommendations, resulting in board goals and future education topics.

Performance Evaluations

Medical Officer of Health & Chief Executive Officer Performance Appraisal

The Medical Officer of Health & Chief Executive Officer Performance Review will be conducted annually during the first quarter of the calendar year with a report coming to the Governance Committee on the results in the April Governance Committee meeting.

Board of Health Self-Assessment

In accordance with the Ontario Public Health Organizational Standards, the Board of Health should complete a self-assessment at least every other year and provide recommendations for improvements in board effectiveness and engagement.

Terms of Reference Review

The Governance Committee Terms of Reference sets out the parameters of how authority is delegated to the committee and how the committee is accountable to the Board of Health.

It is incumbent upon the Governance Committee to review the terms of reference at least biannually to ensure that components (purpose, reporting relationship, membership, chair, term of office, duties, frequency of meetings, agenda and minutes, bylaws and review) are still relevant to the needs of the committee.

Board of Health Bylaws, Policies and Procedures Review and Development

These bylaws and policies represent the general principles that set the direction, limitations and accountability frameworks for MLHU. Governance Policies relate to bylaws, organizational structure and finances.

The Ontario Public Health Organizational Standards address bylaws that must be in place for board operation as well as suggestions for additional policies

The Board of Health Governance Committee should ensure that these policies are revised or reviewed biannually.

The Senior Leadership Team may make recommendation for additional bylaws, policies or procedures or revising to existing ones should the need arise.

Accountability

Compliance with Ontario Public Health Standards

The Ontario Public Health Standards communicate the provincial expectations in the local planning and delivery of public health programs and services by the Board of Health. They provide the minimum requirements in the assessment, planning, delivery, management and evaluation of programs and services targeting disease prevention, health protection and promotion and community health surveillance. The standards are published by the Ministry of Health and Long-Term Care under the authority of Section 7 of the Health Protection and Promotion Act.

Compliance with the Ontario Public Health Organizational Standards

The Ontario Public Health Organizational Standards are a set of organizational and governance standards that apply to all Boards of Health. They provide the basis for assessing the governance and administrative functioning of boards and Public Heath Units.

Provincial Accountability Framework (PHFAA)

The Public Health Financial and Accountability Agreements provide a framework for setting specific performance expectations, and establishing data requirements to support monitoring of these performance expectations.

Public Health Unit Audits

In 2012-2013, the Ministry of Health and Long-Term Care began an auditing process for health units under Article 8.3 of the Accountability Agreement and an assessment of the board of health under section 82 of the Health Protection and Promotion Act. Its goal is to audit at least two public health units per year as efforts to ensure compliance with three main areas: the Ontario Public Health Organizational Standards, Public Health Accountability Agreement, and the Smoke-Free Ontario Agreement.

With respect to the Organizational Standards, the province will audit the BOH's structure, operations, leadership, trusteeship, community engagement and responsiveness, and management operations.

Strategic Planning

In approving major decisions, the Board of Health must be aware of the big picture and understand how their decisions will shape an organization over the long-term. . Board members do not generally participate in the creation and formulation of strategy. This is the responsibility of the MOH/CEO and the Senior Leadership Team. However, Board Members must understand and approve the strategy proposed by the leadership team for long-term value creation. Once approved, Board Members should continually monitor the execution and results of the strategic plan. For these purposes, directors must know the key value and risk drivers of the organization.

A strategic plan is required by each health unit in accordance the Ontario Public Health Organizational Standards.

Accreditation and Quality

While it is not mandatory for Public Health Units to be accredited, slightly more than half choose to participate in the accreditation process. Accreditation is an ongoing, voluntary process used to assess and improve the quality of programs and services to stakeholders.

Accreditation also provides a process for quality assurance by identifying areas for improvements in efficiency and performance related to leadership, management and delivery of services.

Risk Management and Assessment

Risk Management Planning

The Board of Health should have a risk management strategy that is monitored and evaluated on a regular basis. This means have to identify and assess potential risks, determining appropriate health unit responses. A risk management strategy would also necessitate a common understanding of risk, the impact or consequences that each risk may have on the organization and the probability of occurrence that the risk may have.

Board of Health Liability

A report commissioned by alPHa and its legal counsel that outlines the legal obligations that the Board of Health members have to the Public Health Unit and the community. It is recommended that if the board of health has not already done so that a standing item on the board's reporting calendar be the receipt of a

report from the Medical Officer of Health on the status of compliance with required obligations under the HPPA. This links with accountability role that the Board of Health is responsible for.

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FINANCE & FACILITIES COMMITTEE

PURPOSE

The committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health /Chief Executive Officer (MOH/CEO), and the Associate Director, Finance in the administration and risk management of matters related to the finances and facilities of the organization.

REPORTING RELATIONSHIP

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

MEMBERSHIP

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

The Secretary-Treasurer will be an ex-officio member

Staff support:

- Associate Director, Finance
- Executive Assistant to the Board of Health and Communications or the Executive Assistant to the Medical Officer of Health depending on availability.

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

CHAIR

The Finance & Facilities Committee will elect a Chair at the first meeting of the year to serve for a one or two year term. The Chair of the Committee may be appointed for additional terms following the completion of an appointment to enhance continuity of the Committee.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as he or she remains a Board of Health member.

DUTIES

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

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

FREQUENCY OF MEETINGS

The Committee will meet monthly between Board of Health meetings, if a meeting is deemed to be not required it shall be cancelled at the call of the Chair of the Committee.

AGENDA & MINUTES

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

BYLAWS:

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

REVIEW

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

Implementation Date: June 20, 2013
Revision Date: April 7, 2016

Finance & Facilities Committee
Reporting Calendar

Q1 (Jan 1 to Mar 31)	Q2 (Apr 1 to Jun 30)
• Q4 Financial and Factual Certificate Update • Review and Approve Annual Reporting Calendar • Review and Recommend 2016 Board of Health Budget • Public Sector Salary Disclosure • Review Funding & Service Level Agreements • 50 King St. Lease Update	• Q1 Financial and Factual Certificate Update • Visa and Accounts Payable Update • Review and Recommend - Audited 2015 Financial Statements for MLHU • Recommend Budget Parameters & Planning Assumptions for 2017 • Recommend Guidelines for Municipal Budget Targets • Review and Recommend 2016 Board of Health Remuneration • Strathroy Office Lease Update • Organizational Structure and Location Update • Living Wage Initiative Update
Q3 (Jul 1 to Sep 30)	**Q4 – (Oct 1 to Dec 31)**
• Q2 Financial and Factual Certificate Update • Review and Recommend – Audited Financial Statements for April 1 to March 31 Programs • Review and Recommend Program Budgeting Marginal Analysis (PBMA) Process, Criteria and Weighting • Queens St. Lease Update	• Q3 Financial and Factual Certificate Update • Review and Recommend PBMA Proposed Resource Reallocation • Review Insurance Policies • Initiate Terms of Reference Review (biannually)

The items on the reporting calendar are 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, monitoring of facilities, risk management and administration and to align the budget to the strategic priorities of the Board of Health.

Accountability

Audited Financial Statements Review

The preparation of the financial statements is the responsibility of the Health Unit's management and is prepared in compliance with legislation and in accordance with Canadian public sector accounting standards. The Finance & Facilities Committee meets with management and the external auditors to review the financial statements and discuss any significant financial reporting or internal control matters prior to their approval of the financial statements.

It is a requirement of the Board of Health is to provide audited financial reports to various funding agencies for programs that are funded from April 1st – March 31st each year. The purpose of this audited report is to provide the agencies with assurance that the funds were expended for the intended purpose. The agencies use this information for confirmation and as a part of their settlement process.

These programs are also reported in the main audited financial statements of the Middlesex-London Health Unit which was approved by the Board of Health in June, however this report includes program revenues and expenditures of these programs during the period of January 1st to December 31st, which does not coincide with the reporting requirements of the funding agencies. Therefore, a separate audited statement is required.

Board of Health Remuneration

Section 49 of the Health Protection & Promotion Act (HPPA) speaks to the composition, term, and remuneration of Board of Health members. Subsections (4), (5), (6), & (11) relate specifically to remuneration and expenses. This is to be reviewed by the Finance & Facilities Committee who makes recommendations to the Board of Health each year.

Public Sector Salary Disclosure

The Public Sector Salary Disclosure Act, 1996 makes Ontario's public sector more open and accountable to taxpayers. The act requires organizations that receive public funding from the Province of Ontario to disclose annually the names, positions, salaries and total taxable benefits of employees paid $100,000 or more in a calendar year.

The main requirement for organizations covered by the act is to make their disclosure or if applicable to make their statement of no employee salaries to disclose available to the public by March 31st each year. Organizations covered by the act are also required to send their disclosure or statement to their funding ministry or ministries by the fifth business day of March.

Funding & Service Level Agreements

The Middlesex-London Health Unit receives grant funding, both one-time and ongoing from a variety of different sources. It is incumbent upon the Finance & Facilities Committee to annually, or as deemed necessary, review all service level and funding agreements.

Budget Process

Board of Health Budget Cycle

The Board of Health budget cycle consists of a defined set of tools and key deliverable dates that the management of the Middlesex-London Health Unit are accountable to meet. The budget cycle intends to align planning processes with resource allocation and facilitate meeting the needs of the programs and services.

Budget Parameters & Planning Assumptions

Developing high level planning parameters is an integral part of any budget process. They help guide and inform planning and resource allocation decisions. Ideally the parameters should be linked to the organization's strategic direction, key budget planning assumptions and take into consideration municipal and provincial outlooks.

Strategic and financial targets can also be considered during the Budget Parameters & Planning Assumptions deliberations at the Finance & Facilities Committee.

Guidelines for Municipal Budgets

While the Municipal funders can set targets for the Board, the final decision regarding budget requirements rests with the Board of Health. It is therefore essential that the Board of Health determine its approach to the development of the budget and provide the Municipalities of intended changes to the budget.

Reserve and Reserve Funds

The Board of Health maintains the following Reserve and Reserve Funds: Funding Stabilization Reserve, Dental Treatment Reserve Fund, Sick Leave Reserve Fund, Environmental Reserve – Septic Tank Inspections, Technology & Infrastructure Reserve Fund, and Employment Cost Reserve Fund.

Planned contributions and drawdowns to the reserves or reserve funds will be included in the annual operating budget approved by the Board of Health. Any unplanned drawdowns will be approved by resolution of the Board of Health. Each year a report is provided to the obligated municipalities outlining the transactions of the reserve and reserve funds.

Program Budgeting Marginal Analysis

Program Budgeting Marginal Analysis (PBMA) is a criteria-based budgeting process that facilitates reallocation of resources based on maximizing service. This is done through the transparent application of pre-defined criteria and decision-making processes to prioritize where proposed funding investments and disinvestments are made.

Board of Health Budget

The Board of Health Budget is presented to the Finance & Facilities Committee through the use of Program Budget Templates which integrates: (A) A summary of the team program, (B) Applicable health standards, legislation or regulations, (C) Components of the team program, (D) Performance/service level measures, (E) Staffing costs, (F) Expenditures, (G) Funding Sources, (H) Key highlights planned, (I) Pressures and challenges, and (J) Recommended enhancements, reductions and efficiencies.

Communications

Quarterly Financial Updates

Health Unit staff provide financial analysis for each quarter and report the actual and projected budget variance as well as any budget adjustments, or noteworthy items that that have arisen since the previous financial update that could impact the Middlesex-London Health Unit budget.

Visa & Accounts Payable Updates

In accordance with Section 5.17 of the Procurement Policy, the Associate Director of Finance is to report annually the suppliers who have invoiced a cumulative total value of $100,000 or more in a calendar year.

The Finance & Facilities Committee also requested to report annually a summary of purchases made with corporate purchase cards.

Facilities, Risk Management & Administration

Factual Certificate

Health Unit Management completes a factual certificate to increase oversight in key areas of financial and risk management. The certificate process ensures that the Committee has done its due diligence. The certificate is reviewed on a quarterly basis alongside financial updates.

Physical Asset and Facilities Monitoring

The Finance & Facilities Committee is responsible for monitoring the Middlesex-London Health Unit's physical assets and facilities. This entails a review of space needs, property leases and acquisitions.

Policy Development & Review

Bylaws and policies represent the general principles that set the direction, limitations and accountability frameworks for the Middlesex-London Health Unit. The Finance & Facilities Committee is responsible for reviewing the governance and administration policies relating to the financial management of the organization, including but not limited to, procurement, investments, and signing authority.

These requirements are outlined by the Ontario Public Health Organizational Standards and should be reviewed by the Finance & Facilities Committee at least biannually.

The Senior Leadership Team may also make recommendations for additional finance bylaws, policies or revisions should the need arise.

Insurance Coverage Review

The Finance & Facilities Committee is responsible for an annual review of the types and amounts of insurance carried by the Health Unit. Staff are responsible for preparing a review of the insurance needs of the Health Unit and providing recommendation to the Finance & Facilities Committee in regards to the level and types of insurance the Middlesex-London Health Unit should purchase.

Other

Benefits Provider Review

Group insurance for the Middlesex-London Health Unit is reviewed at the completion of a service agreement. Staff are responsible for preparing a review of the needs of the Health Unit following appropriate market analysis and providing recommendation to the Finance & Facilities Committee.

Review Terms of Reference

The Finance & Facilities Committee Terms of Reference sets out the parameters of how authority is delegated to the committee and how the committee is accountable to the Board of Health.

It is incumbent upon the Finance & Facilities Committee to review the terms of reference at least biannually to ensure that components (purpose, reporting relationship, membership, chair, term of office, duties, frequency of meetings, agenda and minutes, bylaws and review) are still relevant to the needs of the committee.

Living Wage Certification Update

The Middlesex-London Health Unit is in the process of becoming a Living Wage Employer. Experience elsewhere indicates that the business impacts would include reduced employee turnover, increased job satisfaction and loyalty, and increased performance. This would also establish the Health Unit as a leader in this area, and enhance the Health Unit's ability to influence others to take on Living Wage policies.

SUBJECT:	Board of Health Self-Assessment	**POLICY NUMBER:**	**G-300**
SECTION:	Board Effectiveness	**PAGE:**	1 of 2

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

The purpose of the Board of Health Self-Assessment is to provide all board members an opportunity to evaluate and discuss the performance of the board and to understand the barriers to and drivers of board effectiveness and engagement. Results of the self-assessment are helpful in planning board development opportunities and enhancing generative governance.

POLICY

It is important to recognize that board effectiveness must be continuously monitored and evaluated with regards to performance, processes and practices. The Board of Health believes that regular self-assessment is essential in supporting the health unit's vision, mission and values, improving leadership and improving public health outcomes.

The Board of Health is required to complete a self-assessment at least every other year as per the requirements of the Ontario Public Health Organizational Standards (OPHOS).

PROCEDURE

The Governance Committee of the Board of Health is responsible for the initiation of the Board of Health Self-Assessment and to assist and advise staff in its administration. The process for the self-assessment is as follows:

1. Governance Committee reviews and approves the Board of Health Self-Assessment Tool (Appendix A)
2. The Governance Committee Report informs the Board of Health that this process is being initiated.
3. The survey is distributed via email following the February Board of Health meeting for completion prior to the March Board of Health meeting.
4. Completed hard copies can be submitted in a sealed envelope to the Executive Assistant to the Board of Health and Communications.

APPLICABLE LEGISLATION

Ontario Public Health Organizational Standards

RELATED POLICIES

REVISION DATES (* = major revision)**:**

Board of Health Self-Assessment

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

As part of the Board's commitment to good governance and continuous quality improvement, all Board members are invited to complete this self-assessment survey. High-level results of the survey will be reported to the Governance Committee of the Board in an anonymous form without any identifying information. They will be used to inform recommendations for improvements in Board effectiveness and engagement.

Your participation is voluntary and you may choose not to participate or not to respond to any question. The questionnaires will be kept confidential in our records for seven years to comply with our Middlesex-London Health Unit Retention Schedule.

You can complete the survey online or on paper. If you complete the paper version please return it in a sealed envelope to Executive Assistant to the Board of Health and Communications.

If you have any questions please contact the Executive Assistant to the Board of Health and Communications via email or telephone.

Please check Yes, No or Don't know for each question. If your response is No, please provide an explanation in the comment box that appears. This information is key to identifying areas for improvement.

1. Is the Board of Health structured properly (i.e membership, size, terms of office, reporting relationships)?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

2. Am I getting sufficient information to make informed decisions at Board of Health meetings?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

3. Am I learning enough, both at Board of Health meetings and elsewhere, about current best practices in public health and governance in order to be an effective Board member?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

4. Does the Board of Health take all relevant information into consideration when making decisions?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

5. Is MLHU accomplishing our strategic outcomes as outlined in our strategic plan?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

6. In the past year, has the Board of Health adequately responded to serious complaints of wrongdoing or irregularities?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

7. Does the current relationship between the Board of Health and senior staff result in effective and efficient management of the public health unit?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

8. Are you satisfied with the reports to the Board of Health made by MLHU staff?

For instance, do you think the reports are relevant and provide the correct information?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

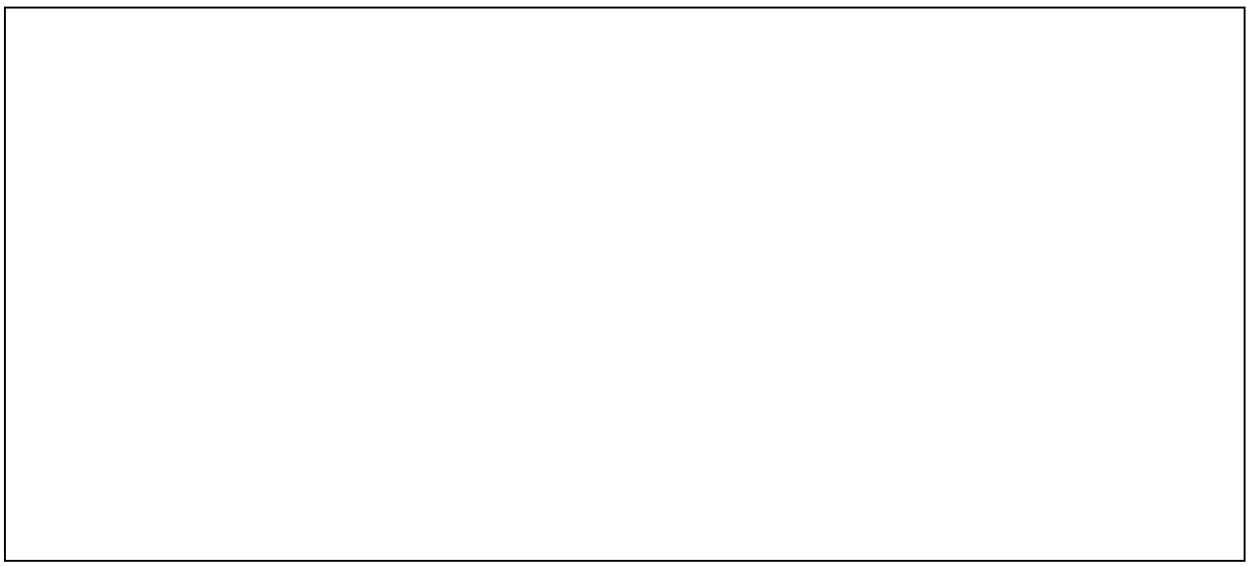
9. Are you satisfied with the presentations made to the Board of Health by MLHU staff?

For instance, do you think the time taken for presentations and question and answer sessions is appropriate?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

10. What is the most important thing that you could recommend for discussion or action in order to improve the Board's performance?



Thank you for taking the time to complete this survey.

SUBJECT:	Nominations and Appointments to the Board of Health	**POLICY NUMBER:**	**G-350**
SECTION:	Board Effectiveness	**PAGE:**	1 of 3

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

Well-defined nomination and appointment processes help to ensure a high-performing Board of Health by articulating the need for balance within the Board, board member skills, expertise, qualities and competencies that are desired and clear steps that can be followed.

POLICY

This policy articulates the requirements, criteria and process s the Board of Health nominations, appointments and reappointments. This policy is applicable to provincial appointees, and where relevant, to municipal appointees.

PROCEDURE

Notification

Incumbent appointees who are eligible for reappointment will notify the Chair of their intentions with respect to requesting reappointment not less than six months prior to the expiration of their term. The Secretary-Treasurer of the Board will provide a listing of all Board Members with term expiration dates annually, usually at the first meeting of the year.

Term of Appointment

The term of appointment for provincial appointees is set by the Public Appointments Secretariat and may be for one, two or three years. The term of appointment for a municipal appointee is the term of office of the council unless otherwise specified by the Council.

Criteria to be Considered

In considering the appointment and reappointment endorsement/recommendation, the Board of Health will consider

a) Commitment to the Mission, Vision and goals of the Middlesex-London Health Unit (MLHU);
b) Commitment to and an understanding of the policies and programs of the MLHU;
c) Ability to work collegially with other Board Members and the Medical Officer of Health/CEO;
d) Diversity and skill composition of current Board of Health members;
e) Representation of MLHU in the community;
f) Regularity of attendance at Board of Health meetings;
g) Participation in and contribution at Board of Health meetings; and
h) Ability to make a continued commitment to monthly involvement in Board of Health meetings and related activities.

Term Limits
The Ministry of Health and Long-Term Care adheres to the Provincial Appointments Secretariat's ten-year limit for appointees. There is no limit to length of service for municipal representatives, however, it is recognized that best practices in governance include term limits in the range of ten years.

Consideration of Reappointment Requests
The Board of Health will consider endorsements/recommendations relating to Board reappointment in a closed session, under Board of Health Bylaw No. 3 section 7.2, Criteria for in-camera meetings, subsection (b) personal matters about an identifiable individual, including Board employees.

The Governance Committee shall consider offering interviews to applicants in order to advise the Board on appropriateness of recommending applicants to the Ministry.

A Board member being considered for reappointment will absent themself from the portion of the session during which their reappointment request is considered. The remaining members may, at their discretion, request the member to return to provide information or answer questions. A motion regarding endorsement/recommendation, if any, will be made in camera.

Letter of Endorsement/Recommendation
For municipal appointments or reappointments, the Chair will submit a letter of endorsement by regular mail addressed to the Mayor of the City of London and the Warden for Middlesex County listing the current diversity and skill requirements for their consideration in the appointment or reappointment process.

For provincial appointment or reappointments, the Chair will submit a letter of endorsement by regular mail addressed to the Minister of Health and Long Term Care listing the names of all interested appointees that are being supported for appointment or reappointment along with the completed Reappointment Information Form(s) to:

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

Or by email or fax to
Minister's Special Assistant for Public Appointments
Fax: 416-326-1571

A copy of all above-mentioned documentation must also be sent to the Manager, Public Appointments Unit, Ministry of Health and Long Term Care, by fax to 416-327-8496 or by email.

For municipal appointments or reappointments, the Chair will submit a letter of endorsement by regular mail addressed to the Mayor of the City of London and the Warden for Middlesex County.

APPLICABLE LEGISLATION

Health Protection and Promotion Act, R.S.O., 1990, c H.7.
Municipal Act, 2001, S.O. 2001, c. 25.

RELATED POLICIES

Board of Health By-law No.3

REVISION DATES (* = major revision)**:**

SUBJECT:	Board of Health Orientation and Development	**POLICY NUMBER:**	**G-370**
SECTION:	Board Effectiveness	**PAGE:**	1 of 2

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

To ensure that members of the Board have the knowledge necessary to effectively discharge their duties, as members of the Board of Health.

POLICY

Board members shall receive an orientation to their role and responsibilities as Board members and to Middlesex-London Health Unit as an organization as soon as practical, following their appointments.

Additionally, the Board of Health will participate in development opportunities based on priorities identified in the Board of Health Self-Assessment.

PROCEDURE

Required Pre-Orientation Training
Members of the Board of Health are required to complete training for the Accessibility for Ontarians with Disabilities Act (AODA) prior to the on-site orientation. Those who have already completed AODA training can forward a confirmation of participation to the Executive Assistant to the Board of Health rather than completing the training again. The training can be accessed using a link to be provided to new Board members.

On-Site Orientation
This will include a staff overview and tour of the Middlesex-London Health Unit sites which details the programs and services of the Corporate Services, the Office of the Medical Officer of Health, Environmental Health and Infectious Disease, Foundational Standard, Healthy Living and Healthy Start divisions.

Online Self-Paced Learning
Additional content for the Board of Health is available online including:
- Essential reading list;
- Recommended Priority reading list;
- Legislation specific to public health;
- Provincial public health reports;
- Middlesex-London Health Unit Program Budgeting Templates;
- Middlesex-London Health Unit documents; and

- Other web-based resources for Board of Health Members.

These materials can be accessed by going to: https://www.healthunit.com/board-of-health-orientation.

Board of Health Development
The Governance Committee is responsible for setting parameters on Board of Health development activities, which may be informed by the Board of Health Self-Assessment results. Board development sessions are to be held on an annual basis.

APPLICABLE LEGISLATION

Ontario Public Health Organizational Standards.

RELATED POLICIES

REVISION DATES (* = major revision)**:**

SUBJECT:	Conflict of Interest and Declaration	**POLICY NUMBER:**	**G-380**
SECTION:	Board Effectiveness	**PAGE:**	1 of 3

IMPLEMENTATION:	November 17, 2016	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

Members of the Board of Health are called to observe the highest ethical standards in their conduct as members. This policy described potential conflicts of interest in seeks annual declaration.

POLICY

The standard of behaviour of members of the Board of Health is that each member must scrupulously avoid conflicts of interest between the interest of the health unit on one hand and personal, professional, and business financial interests on the other. This includes avoiding potential and actual conflicts of interest, as well as perceptions of conflicts of interest.

PROCEDURE

Types of Conflict

Conflicts of interest could arise that are:

- actual or real, where the person's official duties are or will be influenced by the person's private or personal interests;
- perceived or apparent, where the person's official duties appear to be influenced by the person's private or personal interest; or
- foreseeable or potential, where the person's official duties may be influenced in the future by the person's private or personal interests

Examples of Conflict of Interest Situations

Interest in a Transaction

A Director has a direct or indirect interest in a transaction or contract with the health unit.

Interest of a Relative

The health unit conducts business with suppliers of goods or services or any other party of which spouse of an officer of the health unit is a principal or officer.

Gifts

A Director, or the Director's adult child, accepts gifts, payments, services or anything else of more than a token or nominal value from a party that hopes to transact business with the Health unit (including a supplier of goods or services) for the purposes of (or that maybe perceived to be for the purposes of) influencing an act or decision of the Board.

"Two Hats"

A Director is also a director of another corporation (even a not-for-profit corporation) proposing

to enter into a transaction with the Health unit.

Appropriation of Corporate Opportunity
An employee diverts an opportunity or advantage that belongs to the Health unit to himself or herself.

Responsibility
Board members must declare any conflict of interest as soon as it has been identified. The declaration should be made to the Board Chair. The declaration shall disclose the nature and extent of the stakeholder's interest. Disclosure shall be made at the earliest possible time and prior to any discussion, vote or decision making on the matter (unless such discussion, vote or decision making has occurred before the conflict was discovered). The Board members shall not attempt in any way to influence and such vote or decision.

As the identification of a conflict of interest is sometimes difficult, Board members are encouraged to consult the Board Chair regarding those matters that the member considers could constitute a conflict of interest. It is the responsibility of the Board Chair to determine whether a conflict of interest exists. In making that determination, the Board Chair may be guided by advice from the member and the other members of the Board and the Medical Officer of Health / Chief Executive Officer and by the advice of counsel, if sought. Board Chair should resolve any uncertainty as to whether a conflict of interest exists on the side of its existence. Once the Board Chair has determined that the member is in a conflict of interest position, the member should formally declare the conflict of interest in the manner set forth in this policy.

Special Role for the Board Chair
The Board Chair is the key person to establish an ethical climate for the health unit and the Board, and for ongoing attention to conflict of interest issues on the Board. The Board Chair is also responsible for the resolution of conflict of interest situations, and related disputes, among the Board members. The Vice Chair will, together with the Board, deal with conflict of interest situations that may arise with respect to the Board Chair. The Board bears great responsibility for maintaining the reputation of the health and such has special responsibility for ethical matters.

Annual Responsibilities
In addition to complying with the ongoing responsibilities set forth above, the Board members are required to complete an Annual Declaration Form (Appendix A).

APPLICABLE LEGISLATION

RELATED POLICIES

REVISION DATES (* = major revision)**:**

Middlesex-London Health Unit
Conflict of Interest
Annual Declaration Form

Introduction:
Members of the Board of Directors are required to complete, sign and deliver this Annual Declaration Form to the Chair of the Board. If you have any questions concerning this Form or the Conflict of Interest policy, please contact the Board Chair or Medical Officer of Health / Chief Executive Officer.

Declaration:
I declare that:

a) I have read the attached Conflict of Interest policy.
b) I acknowledge that I am bound by the Conflict of Interest policy, including the disclosure requirements that apply to me.
c) At the present time, [Check the appropriate box]
d) Neither I, nor any of my Board colleagues, are in a conflict of interest situation nor am I aware of any fact situation which could give rise to a conflict of interest.
e) I, or one of my Board colleagues, is in a conflict of interest situation or a potential conflict of interest situation and I have notified the Board chair as set out in the Conflict of Interest policy.
f) I understand and acknowledge that my failure to comply with the Conflict of Interest policy will be considered a breach of my obligations to the health and may result in my removal from the Board.

Name	Signature	Date (Month, Day, Year)

SUBJECT:	Code of Conduct	**POLICY NUMBER:**	**G-390**
SECTION:	Board Effectiveness	**PAGE:**	1 of 2

IMPLEMENTATION:	November 15, 2007	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

To enact a Corporate Code of Conduct (Appendix A) that promotes integrity, respect, responsibility, fairness, caring and citizenship in the workplace. As well as the Board of Health Code of Conduct (Appendix B) which supports good governance practices and compliance with Organizational Standards.

To demonstrate accountability and commitment to our stakeholders by ensuring that public health programs and services are delivered in a manner consistent with the Corporate Code of Conduct (hereafter referred to as “the Code”).

POLICY

All individuals involved in the planning, delivery, administration and governance of public health services on behalf of the Health Unit are aware of and comply with the Code. This includes; Board members, staff, students and volunteers.

Resources regarding conflict resolution will be made available as appropriate.

Any reported circumstances that are inconsistent with the Code are investigated in a timely manner and where possible, resolved.

PROCEDURE

Roles and Responsibilities

The Board of Health will:

- Comply with the Codes;
- Support and encourage management in their administration of the Codes;
- Disclose any situations or activities that are not in compliance with the Codes.

The Senior Leadership Team will:

- Comply with the Code;
- Establish a process that clearly communicates the Code to all staff, students and volunteers and provides all incumbents to the Health Unit with appropriate orientation to the Code;
- Demonstrate an on-going commitment to the spirit and intent of the Code by ensuring that the Code is regularly reviewed with staff, students, and volunteers (e.g., as part of the performance review);
- Provide opportunities for all Board Members, staff, students and volunteers to acquire the knowledge, skills and attitudes necessary to adhere to the Code;
- Provide an effective intervention strategy and response to all reported infractions of the Code.

Staff, students and volunteers will:

- Comply with the Code;
- Work collaboratively with management, colleagues, students and volunteers to acquire the knowledge, skills and attitudes necessary to adhere to the Code;
- Disclose any situations or activities that are not in compliance with the Code.

Accountability

Initially, a Board member, staff, student or volunteer becomes aware of or experiences circumstances that are inconsistent with the Code, is encouraged, whenever appropriate, to address the issue in a timely manner by communicating directly with the involved person(s).

If this approach is not appropriate or does not resolve the concern, the individual is encouraged to review the concern with a colleague or Manager. Board members should discuss the issue with the Board Chair and/or Medical Officer of Health.

Should the concern still not be resolved as a result of those discussions, or if the individual is uncomfortable discussing the concern with his/her Manager, the individual may choose to communicate with one of the following individuals to determine the appropriate follow up:

- The Director;
- The Director, Corporate Service; or
- The Medical Officer of Health/CEO.

The persons involved in the resolution process will determine if the appropriate remedies and follow up may be found under another policy (e.g. Progressive Discipline or Harassment).

Confidentiality

If the concern requires confidential treatment, including keeping the identity of the individual(s) concerned anonymous, all reasonable efforts will be made to keep that confidentiality, except to the extent necessary to conduct the appropriate follow up.

APPLICABLE LEGISLATION

RELATED POLICIES

REVISION DATES (* = major revision)**:**

MIDDLESEX-LONDON HEALTH UNIT

CORPORATE CODE OF CONDUCT

The Middlesex-London Health Unit Corporate Code of Conduct demonstrates the commitment of the Board members, staff, students, volunteers and our stakeholders (i.e. the public, clients and funding bodies) to provide public health programs and services with integrity, respect, responsibility, fairness, caring and citizenship.

Expectations and Guiding Principles

It is expected that employees will comply with the Laws of Canada; all professional regulatory codes and requirements; and the administrative policies of the Health Unit. Therefore, the Code does not itemize prohibitions of illicit behaviours (e.g. theft, fraud, drug use, etc.) but rather extends beyond rules and regulations to promote notions of integrity, respect, responsibility, fairness, caring and citizenship in the workplace. Follow the Golden Rule: Treat others as you would have them treat you.

Follow the Golden Rule: Treat others as you would have them treat you.

If ever in doubt about the acceptability of a particular course of action, ask the following question: Assuming full public disclosure of the action, would both you and the Health Unit be comfortable from a moral, ethical and legal standpoint? If the answer is "yes," then the action is probably consistent with the Code.

The Code

As a Board Member, Staff, Student or Volunteer of the Health Unit, I will:

- ✓ maintain the highest level of professional standards as an employee of the Health Unit and conduct myself with honesty and integrity at all times towards all people.
- ✓ show respect for my work and contribution to the Health Unit and offer my best efforts every day by presenting pertinent, accurate, and objective information.
- ✓ keep confidences about the Health Unit's business; I will avoid gossip and harsh criticism of others and consistently offer an attitude of understanding toward all people.
- ✓ listen carefully and allow people to give me information without interrupting them or arguing with them.
- ✓ honour the Health Unit and its resources and not squander, steal, or damage its assets; and be punctual and honour the value of time.
- ✓ accept responsibility for the duties that have been assigned to me each day and collaborate with others in a spirit of teamwork to accomplish defined goals.
- ✓ continually improve my skills as a person and as an employee through educational enhancement programs to perform my job in a timely way at a high level of excellence.
- ✓ exhibit high moral character as an individual and not engage in any illegal behaviors that might reduce my value to the Health Unit in the eyes of my employer.
- ✓ offer praise and encouragement to my co-workers when appropriate and be pleasant to people in my business dealings.
- ✓ show respect to all people in the workplace and honour diversity in all areas including age, gender, disability, sexual orientation, ethnic background, nationality, and religion.

Middlesex-London Board of Health
Code of Conduct

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

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

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

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

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

5. Conduct at Meetings:
- Regularly attend and be prepared for meetings.
- Conduct themselves with decorum.

6. Media Interactions and Public Discussions:

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

7. Interactions with Staff Members:

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

8. Election Campaigns:

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

9. Post-Board of Health Membership:

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

10. Legal Advice:

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

11. Compliance:

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

Middlesex-London Board of Health
Code of Conduct Details

BACKGROUND:

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

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

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

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

EXPLANATION:

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

Board of Health members shall always:

- act in the best interests of the Board of Health and Health Unit to support the delivery of public health programs and services;
- when making decisions relating to the business of the Board of Health, do so in compliance with each Board of Health Member's duty of care, loyalty and good faith to the Board of Health;
- serve (and be seen to serve) the Board of Health in a conscientious and diligent manner;
- be committed to performing their functions with integrity and shall avoid conflicts of interest, both perceived and real;

- perform their duties and arrange their private affairs in a manner that promotes public confidence;
- seek to serve the Board of Health's interest and the public's interest by upholding the intent and the spirit of all laws applicable to the Board of Health;

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

2) Public Meetings and Confidential Information:

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

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

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

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

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

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

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

3) Real and Perceived Conflicts of Interest

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

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

Therefore, Board of Health members shall:

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

4) Serving on Other Boards / Councils:

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

Board of Health members do not have a conflict of interest solely as a result of being appointed to the Board of Health by any particular organization, even if the appointing organization takes a position on a matter before the Board of Health. However, where a

Board of Health member is not prepared to consider Board of Health business in a manner that is consistent with the best interests of the Board of Health, the member has contravened their duty to act in the best interest of the Board of Health. Further, where a Board of Health member uses his or her position as a Board of Health member for the purpose of advancing the interests of any other entity (whether or not they were appointed by that entity), the Board of Health member has contravened their duty to act in the best interest of the Board of Health.

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

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

Therefore, Board of Health members shall:

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

5) Conduct at Meetings:

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

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

Therefore, Board of Health members shall:

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

6) Media Contact Interactions and Public Discussions:

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

Therefore, Board of Health members shall:

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

7) Interactions with Staff Members:

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

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

of Health members also have the right and the obligation to request clarification and further information from Health Unit staff.

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

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

8) Election Campaigns:

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

Therefore, Board of Health members shall:
- Not use Health Unit resources or Board of Health meetings to advance an election campaign.

9) Post-Board of Health Membership:

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

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

10) Legal Advice:

Outside legal advice is occasionally necessary given the complex nature of public health practice and governance. However, in the interest of resolving issues and

conflicts effectively without unnecessary expense, Board of Health members seeking legal advice will make a request through the Secretary-Treasurer.

Therefore, Board of Health members shall:
- Make a request through the Secretary-Treasurer when legal advice is necessary.

11) Compliance:

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

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

IN THE EVENT OF NON-COMPLIANCE:

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

I. Informal Complaints:

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

a) Advise the Board of Health member that their behaviour or activity contravenes the Code of Conduct;
b) Encourage the Board of Health member to stop the prohibited behaviour or activity;
c) If applicable, confirm to the Board of Health member your satisfaction or dissatisfaction with his or her response to the concern identified;
d) Keep a written record of the incident(s), including date, time, location, other persons present or any other relevant information, including steps taken to resolve the matter.

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

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

II. Formal Complaints:

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

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

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

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

In the event that the Board of Health Chair and the Secretary-Treasurer agree that there has been a contravention of the Code of Conduct or, alternatively, cannot unanimously agree that there has not been a contravention of the Code of Conduct, the matter shall be referred to the Board of Health with a full report to determine whether there has been a contravention of the Code of Conduct and, if so, what if any action might be appropriate in the circumstances.
The complaint and the full report shall be presented to a meeting of the Board of Health. As this matter may involve an identifiable individual, this discussion is permitted to occur in closed session. If the Board of Health determines that there has not been a contravention of the Code of Conduct, no action shall be taken. If the Board of Health determines that there has been a contravention of the Code of Conduct, the Board has the right, in its sole and absolute discretion, to recommend and/or take the following actions:

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

b) A request for a public apology from the offending member, failing which other options will be considered;
c) A public reprimand by the Board of Health of the offending member; and
d) All other remedies that may be available to the Board of Health at law.

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

a) The Board of Health member's past conduct;
b) The severity of the contravention of the Code of Conduct;
c) The implications of the Code of Conduct contravention to the Board of Health and the Health Unit;
d) The Board of Health member's co-operation in addressing the contravention;
e) The Board of Health member's general level of remorse that the contravention of the Code of Conduct has occurred; and
f) Such further and other criteria that may reasonably be considered by the Board of Health.

SUBJECT:	Annual Report	**POLICY NUMBER:**	**G-470**
SECTION:	Communications and External Relations	**PAGE:**	1 of 2

IMPLEMENTATION:	September 23, 1992	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	April 19, 2012

PURPOSE

To ensure that Health Unit activities are summarized annually and are available for review by key stakeholders and the general public as a means to document accountability.

POLICY

The Health Unit will have an annual report that demonstrates the impact of health unit services on the health of the community and to meet the requirements set forth by the Ontario Public Health Organizational Standards.

Information will be gathered from all Divisions in order to highlight the program activities and fiscal accountabilities for the previous year.

The annual report for MLHU is to be posted in a readily accessible manner of the health unit's website.

PROCEDURE

Development of the Annual Report
The Manager, Communications coordinates the development of the report.

Distribution of the Report
The Medical Officer of Health will present the report to the Board of Health and the report shall be posted to the health unit website by the Online Communications Coordinator.

Contents of the Report
The report shall be addressed to the public; include annual financial information; include a description of the mission, roles, processes, programs and operation of the public health unit; and include performance indicators that ensure transparency and accountability.

APPLICABLE LEGISLATION

Ontario Public Health Organization Standards

RELATED POLICIES

REVISION DATES (* = major revision)**:**
June 1 1995
July 12 2000
October 13 2004
April 19 2012

SUBJECT:	Media Relations	**POLICY NUMBER:**	**G-480**
SECTION:	Communications and External Relations	**PAGE:**	1 of 3

IMPLEMENTATION:	September 23, 1992	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	July 27, 2011

PURPOSE

To maximize the media's interest in and coverage of public health issues, programs, activities and services and to ensure that information is accurate, timely, relevant and maintains client confidentiality.

POLICY

The media plays an important role in the Health Unit's efforts to inform and raise awareness regarding public health issues, programs and services in Middlesex-London. Staff's prompt response to media requests allows the Health Unit to maintain strong and open lines of communication with both the media and the residents of Middlesex-London.

A Health Unit spokesperson is to be designated through consultation with the Manager, Communications or their designate. The type of request and its potential implications will be taken into consideration.

The Manager, Communications should be contacted to coordinate media requests and to provide guidance, advice or assistance to staff in how to respond to media inquiries.

Staff should inform the Manager, Communications promptly when they are approached directly by the media.

The Manager, Communications is to be consulted in the development of media messages and approaches when crisis communications are required.

The Health Unit has a legal obligation to keep medical information private and confidential. Information about patients/clients must not be released without the permission of the patient/client unless deemed essential to protect the health of the community.

PROCEDURE

Media Enquiries

All media requests should be directed to and cleared by the Manager, Communications who will act as media liaison and ask the appropriate Director/Manager/staff to respond to a media request. S/he will offer Health Unit staff advice, guidance or assistance as needed. In the event of a public health emergency/crisis all media requests are to be referred to and coordinated by the Manager, Communications as outlined below. The Online Communications Coordinator will act as media liaison in the absence of the Manager, Communications.

Staff contacted directly by the media should refer the call to the Manager, Communications, unless the staff person is the designated spokesperson on a media release. Members of the media are to be met by a staff person in the main reception area, on the first floor and must be escorted by a staff person at all times when on Health Unit premises. The Health Unit has the right to prohibit members of the media from interviewing patients/clients and staff, taking photographs or otherwise invading the privacy of individuals or staff.

MLHU-Initiated Media Communications

In order to ensure that Health Unit media projects or approaches are not compromised, all staff must consult with the Manager, Communications before initiating contact with the media. All complaints or rebuttals regarding media coverage or the conduct of a member of the media must be handled by the Manager, Communications. Media Releases are issued by the Office of the Medical Officer of Health and approved by the Manager, Communications prior to release.

When sending out a Media Release the Manager, Communications will:

- work with staff to develop effective media messages;
- edits releases;
- distributes the release to appropriate media outlets;
- send a copy of the media release to the MOH, the Management Team, the designated spokesperson and posts the media release on the MLHU website; releases will be distributed to all staff via e-mail
- monitor, evaluate, and track media coverage and, if needed, advise/respond to media coverage.

Crisis Media Communications

Procedure(s) for this response are described in the Emergency Response Plan that is maintained by the Manager, Emergency Management.

Staff Training

The Manager, Communications educates staff about media relations and provides media training as required.

APPLICABLE LEGISLATION

RELATED POLICIES

REVISION DATES (* = major revision)**:**
November 6 1996
July 12 2000
October 13 2004
July 28 2011

SUBJECT:	Board of Health Reports	**POLICY NUMBER:**	**G-490**
SECTION:	Communications and External Relations	**PAGE:**	1 of 2

IMPLEMENTATION:	June 15, 1994	**APPROVAL:**	Board of Health
SPONSOR:	Medical Officer of Health	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	November 17, 2016

PURPOSE

To ensure reports to the Board of Health are prepared and processed in a standardized format.

POLICY

All reports submitted by staff to the Board of Health must be addressed and formatted as per the MLHU Corporate Identity and Graphic Standards Manual and in accordance with the procedure in this policy.

PROCEDURE

General
Board of Health reports are initiated and prepared by appropriate Health Unit staff. Preparation of the agenda is the responsibility of the Medical Officer of Health and Chief Executive Officer in order to maintain a coordinated Board meeting agenda and to handle the inclusion of urgent issues.

Format
The Board Report template (Appendix A) must be used to prepare board reports. Referencing will follow the most current version of the American Psychological Association (APA). Additional formatting details are in the MLHU Corporate Identity and Graphic Standards Manual. Additional templates for Governance Committee and Finance and Facilities Committee can be found as Appendix B and C.

Submission Protocol
After the agenda has been set, reports will be numbered sequentially from January 1 to December 31 with a two-digit reference to the year the report appeared before the Board. The Executive Assistant to the Medical Officer of Health maintains a register of Board reports by report number, meeting date, subject matter and author(s).

Draft reports are to be reviewed by the Director and Manager before proceeding to the next step in the submission protocol.

Ten working days prior to the Board meeting, the following information must be submitted to the EA to the MOH for review by the MOH: an electronic version of the draft report and the relevant

appendices. The EA to the MOH will provide an updated schedule of Board meeting dates and report submission deadlines to all staff.

The draft electronic version of the report is sent as an attachment through outlook to the EA of the MOH who will maintain computer files of the board reports in order to expedite minor revisions and to provide centralized management of the reports.

Major revisions to the draft reports by the MOH will be discussed with the author(s)/appropriate manager. If time permits the author is responsible for completing major revisions and resubmitting the report.

The final version of the report must be approved and signed by the MOH.

Distribution
Board reports will be incorporated into packages for distribution to Board members by the EA to the MOH. The EA to the MOH will arrange for the delivery of packages to Board members to be received no later than the Friday of the week before the scheduled Board meeting.

The EA to the MOH will distribute Board meeting packages, including in-camera reports, where appropriate to all members of the Senior Leadership Team; Manager, Communications; and Manager, Strategic Projects, prior to the Board meeting. Directors circulate Board agenda, reports and minutes to staff in accordance with Divisional practices.

The EA to the MOH will send an electronic copy of the final Board Report to each of the Director(s)/Manager(s) who originally submitted them.

Board packages, excluding in-camera reports, will be made available to the Media by the Manager, Communications prior to the scheduled Board meeting. The EA will also provide the Online Communications Coordinator with a copy of the Board agenda package (excluding in-camera reports) to be posted to the Health Unit website.

APPLICABLE LEGISLATION

RELATED POLICIES

REVISION DATES (* = major revision)**:**
February 12 1997;
July 20 2000;
June 17 2004

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. X

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: YYYY Month DD

TITLE

Recommendation

Key Points

-
-
-

Background

Heading 1

Heading 2

Next Steps

This report was prepared by Name, Title, Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. X

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: YYYY Month DD

TITLE

Recommendation

Key Points

-
-
-

Background

Heading 1

Heading 2

Next Steps

This report was prepared by Name, Title, Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. X

TO: Chair and Members of the Finance & Facilities Committee

FROM: Christopher Mackie, Medical Officer of Health

DATE: YYYY Month DD

TITLE

Recommendation

Key Points

-
-
-

Background

Heading 1

Heading 2

Next Steps

This report was prepared by Name, Title, Division.

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

Appendix C to Report No. 018-16GC

November 2016	
By-law, Policy and Procedures By-law #1 - Management of Property By-law #2 - Banking & Finance By-law #3 - Proceedings of the Board of Health By-law #4 - Duties of the Auditor Strategic Planning MOH/CEO Direction MOH/CEO Position Description MOH/CEO Performance Appraisal Approval and Signing Authority Contractual Services	Procurement Roles and Responsibilities of the Board of Health Board Size and Composition Standing and Ad Hoc Committees Board of Health Self- Assessment Nominations and Appointments to the Board of Health Board of Health Orientation and Development Conflicts of Interest & Declaration Annual Report Media Relations Board of Health Reports
Q4 - 2016	
Jordan's Principle	

Q1 – 2017	**Q2 – 2017**
Privacy & Security of Information Risk Management Governance Principles and Board Accountability Board of Health Corporate Sponsorship Board of Health Donations Board of Health Gifts and Honorariums Board Member Remuneration Board Member Reimbursement and Travel	MOH/CEO Selection and Succession Planning Occupational Health and Safety – Framework Financial Objectives Financial Planning and Performance Asset Protection Borrowing Tangible Capital Assets Reserve and Reserve Funds
Q3 – 2017	**Q4 - 2017**
Complaints Resignation and Removal of Board Members Performance Monitoring Code of Conduct Respect for Diversity Ethics	Quality Improvement – Framework Advocacy Community Engagement Relationship with the Ministry of Health and Long-Term Care and Local Health Integration Network Relationships with Other Health Service Providers and Key Stakeholders