AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, April 20 2017 6:00 p.m.

1. DISCLOSURE OF CONFLICTS OF INTEREST

2. APPROVAL OF AGENDA

3. APPROVAL OF MINUTES – March 16, 2017

4. NEW BUSINESS

4.1 2016 Medical Officer of Health and Chief Executive Officer Performance Appraisal (Report No. 006-17GC)

5. OTHER BUSINESS

5.1 Policy Review Continued

5.2 Next meeting: Thursday June 15, 2017

6. ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, March 16, 2017 6:00 p.m.

Committee Members Present:	**Mr. Trevor Hunter (Chair)** Mr. Ian Peer Mr. Kurtis Smith Mr. Jesse Helmer
Regrets:	Ms. Maureen Cassidy
Others Present:	Mr. Marcel Meyer Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Laura Di Cesare, Director, Corporate Services

Chair Hunter called the meeting to order at 6:02 p.m.

DISCLOSURE OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Mr. Helmer, seconded by Mr. Smith, *that the AGENDA for the March 16, 2017 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Smith, *that the MINUTES of the January 19, 2017 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 2017 BOH Self-Assessment Results (Report No. 004-17GC)

Discussion ensued about the following items:

- The process used this year, including sending it out to be completed digitally and ranking items in question 19.
- Where efforts should be focused for Board development in the next year and how the committee will hone in and provide direction to staff for future Board education and development sessions such as regular education regarding the various programs and governing aspects such as policy or standards at each Board meeting.

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

1) *Recommend that the Board of Health receive Report No. 004-17GC re: Board of Health Self-Assessment Results for information; and*
2) *Consider the survey results and incorporate the feedback into Board development planning for 2017.*

Carried

4.2 Strategic Plan Update (Report No. 005-17GC)

Ms. Di Cesare provided a summary of the Strategic Plan Update and Balanced Scorecard, which included an update on projects that did not start in 2016 and those that will continue into 2017. Ms. Di Cesare advised that staff will endeavour to bring an update to the Committee semi-annually, versus at year end only. Ms. Di Cesare

also noted some recent announcements that may require some realignment of items identified on the 2017 scorecard. These challenges include the Ontario Pubic Health Standards Modernization work and the potential value for money audit which could impact and the work currently being done.

Discussion ensued about the following items:

- The feasibility of continuing to pursue the e-agenda software in the scorecard and the issues experienced in completing this item in 2016.

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

1. *The Governance Committee receive Report No. 005-17 re: Strategic Plan Update for information; and,*
2. *The Board of Health approve the 2017 Middlesex-London Health Unit Balanced Scorecard.*

Carried

OTHER BUSINESS

5.1 Policy Review (Continued)

Mr. Jordan Banninga, Manager, Strategic Projects provided a summary of and changes made to policies G-270, G-280, G-290, G-300, G-350, G-370, G-470, G-480, and G-490. Discussion ensued about the updates made to these policies, and that policy G-380 will be taken back to staff for a review of wording around declaration of conflict of interest and the possible removal of Appendix A to this policy.

It was moved by Mr. Helmer, seconded by Mr. Smith *that the Governance Committee recommend that the Board of Health approve policies G-270, G-280, G-290, G-300, G-350, G-370, G-470, G-480, and G-490.*

Carried

It was moved by Mr. Smith, seconded by Mr. Helmer, *that the Governance Committee forward policies G-310, G-320, G-330, G-410 and G-420 to the Finance and Facilities Committee to review and provide amendments.*

Carried

Discussion ensued about sharing the updated policy manual on the website, once finalized. The Committee agreed that it belongs in the public purview.

It was moved by Mr. Helmer, seconded by Mr. Smith *that the Governance Committee recommend the Board of Health consider putting the Governance Policy Manual on the Health Unit's website once finalized.*

Carried

Ms. Di Cesare thanked and recognized Mr. Banninga's efforts in preparing the Governance Reports for this evening's meeting.

The Governance Committee will review the remaining policies at its next meeting (G-120 and G-260). Any questions about the remaining policies for review will be forwarded to Mr. Banninga to clarify.

5.2 **Next Meeting:** Thursday, April 20, 2017

ADJOURNMENT

At 6:56 p.m. it was moved by Mr. Smith, seconded by Mr. Helmer, *that the meeting be adjourned.*

Carried

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TREVOR HUNTER
Chair

LAURA DI CESARE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-17GC

TO: Chair and Members of the Governance Committee

FROM: Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 April 20

2016 MEDICAL OFFICER OF HEALTH AND CHIEF EXECUTIVE OFFICER PERFORMANCE APPRAISAL

Recommendations

It is recommended that:

1) ***The Governance Committee receive Report 006-17GC; and***
2) ***The Governance Committee form a sub-committee to initiate the performance appraisal process for the Medical Officer of Health and Chief Executive Officer.***

Key Points

- The 2015 performance appraisal was initiated in January 2016 with the appraisal being completed in April.
- The Governance Committee Terms of Reference and the 2017 reporting calendar highlights that the MOH & CEO performance appraisal will be initiated in the second quarter of the calendar year.
- A sub-committee is necessary for the administration of the 2016 performance appraisal.
- The appraisal completion date will be delayed until the MOH & CEO has returned to work following his leave.

Background

The Governance Committee is responsible for initiating the annual performance appraisal process for the Medical Officer of Health and Chief Executive Officer (MOH & CEO). The most recent performance appraisal of the MOH & CEO was initiated in the first quarter of 2016 by a sub-committee consisting of Mr. Jesse Helmer, Mr. Marcel Meyer, Mr. Ian Peer, Mr. Kurtis Smith and Mr. Mark Studenny.

A Performance Appraisal Tool for the Middlesex-London Health Unit's MOH & CEO was developed in 2015 following a review of the Ontario Public Health Organizational Standards, templates provided by the Association of Local Public Health Agencies, best practices for performance appraisals and input from the Governance Committee. In 2016, the process of collecting feedback to inform the appraisal was simplified utilizing available technology in the form of an on-line 360-degree feedback tool. The Board of Health recently renewed its approval of this appraisal process when it approved Policy G-050 Medical Officer of Health and Chief Executive Officer Performance Appraisal at the December 2016 board meeting.

2016 Performance Appraisal Process

1. The Governance Committee Report informs the Board of Health that this process is being initiated.
2. The Governance Committee strikes a performance appraisal sub-committee.
3. The sub-committee reviews and approves the performance appraisal tool from policy G-050 (Appendix A) and timeline (Appendix B).
4. The sub-committee informs the Board of Health of the start of the process and invites Board members to provide comments to the sub-committee.
5. The MOH & CEO is requested to complete the same performance appraisal tool and given a date to submit appraisal tool to the subcommittee.
6. The sub-committee gathers supporting documentation covering the appraisal timeframe including position description (policy G-030), MOH & CEO Monthly Activity Reports and listings of Board of Health Report Titles both public and in-camera.
7. The sub-committee meets with the Board to complete the Board of Health portion of the performance appraisal.
8. The sub-committee can then meet with the MOH & CEO to discuss any questions or concerns that they may have with the performance appraisal.
9. Once the sub-committee has concluded their review of the material, a summary document is drafted by the sub-committee and presented in-camera to the entire Board for their review and approval.
10. The Board Members reach agreement on all contents of the performance appraisal.
11. The Board Chair and a representative of the sub-committee then meet with the MOH & CEO to discuss the results of the appraisal and the goals for the next year.
12. The performance appraisal is signed and filed in a sealed envelope with Human Resources.

Additional tools to assist with the completion of the MOH & CEO performance appraisal (checklist, process outline and sample emails) are available as appendices to policy G-050.

This report was prepared by the Corporate Services Division.

Laura Di Cesare, CHRE
Acting Chief Executive Officer

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.					

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
• 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 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.					

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
• 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 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

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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**

Middlesex-London Health Unit
Medical Officer of Health and Chief Executive Officer
Performance Appraisal Process Timeline 2017

Date	Activities
April 20, 2017	• Governance Report initiates the appraisal process • Governance Committee strikes a performance appraisal sub-committee • Sub-committee reviews performance appraisal tool • Update to the Board of Health on the process
After April 20, 2017 meeting	• Request the Medical Officer of Health and Chief Executive Officer complete the appraisal tool and return to sub-committee upon his return • Collect supporting documentation required for performance appraisal • Invite stakeholder feedback
May 18, 2017 and as required	• Status update to the Board of Health
TBD	• Review and consolidate all feedback into one document • Once MOH & CEO self-appraisal is received the sub-committee and Medical Officer of Health and Chief Executive Officer may meet if there are any questions regarding the self-appraisal • Sub-committee prepares recommendations for the Board of Health regarding the performance appraisal and goals for next performance appraisal period
Tentatively June 15, 2017	• Governance Committee convenes an in-camera session of the Board of Health to discuss and reach agreement on final appraisal results and goals identified for the next performance appraisal period.
TBD	• The Board of Health Chair and a representative of the sub-committee meet with the Medical Officer of Health and Chief Executive Officer to discuss the final appraisal results and the goals identified for the next performance appraisal period

FOR REVIEW

Governance Manual By-laws & Policies

April 20, 2017

Policy #	Section	Policy & Appendices	Status	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	Approved	• To be reviewed before December 2018
G-B10	**By-Laws**	By-law #1 - Management of Property	Approved	• To be reviewed before December 2018
G-B20	**By-Laws**	By-law #2 - Banking & Finance	Approved	• To be reviewed before December 2018
G-B30	**By-Laws**	By-law #3 - Proceedings of the Board of Health	Approved	• To be reviewed before December 2018
G-B40	**By-Laws**	By-law #4 - Duties of the Auditor	Approved	• To be reviewed before December 2018
G-010	**Strategic Direction**	Strategic Planning	Approved	• To be reviewed before December 2018
G-020	**Leadership and Board Management**	MOH / CEO Direction	Approved	• To be reviewed before December 2018
G-030	**Leadership and Board Management**	MOH / CEO Position Description ➢ Appendix A – MOH / CEO Position Description	Approved	• To be reviewed before December 2018
G-040	**Leadership and Board Management**	MOH / CEO Selection and Succession Planning	Defer	• To be reviewed by governance at June meeting • Requires additional background work and research
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	Approved	• To be reviewed before December 2018

Policy #	Section	Policy & Appendices	Status	Summary of Changes / Next Steps
		➢ Appendix G - Sample email and performance appraisal questions for Community Partners		
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	Defer	• To be reviewed by governance at June meeting • Requires additional background work and research
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	For Review	• New policy
G-110	**Program Quality and Effectiveness**	Performance Monitoring	Q3 – 2017	• TBD
G-120	**Program Quality and Effectiveness**	Risk Management	For Review	• New policy
G-130	**Program Quality and Effectiveness**	Ethics	Q3 – 2017	• TBD
G-140	**Program Quality and Effectiveness**	Respect for Diversity	Q3 – 2017	• TBD
G-150	**Program Quality and Effectiveness**	Complaints	Q3 - 2017	• TBD
G-160	**Program Quality and Effectiveness**	Jordan's Principle	Approved	• To be reviewed before December 2018
G-170	**Financial and Organizational Accountability**	Financial Objectives	-	• Content for this policy has been detailed in G-180 and is no longer necessary

Policy #	Section	Policy & Appendices	Status	Summary of Changes / Next Steps
G-180	**Financial and Organizational Accountability**	Financial Planning and Performance	For Review	• New policy
G-190	**Financial and Organizational Accountability**	Asset Protection	For Review	• Revised from previously existing administrative policy • Recommend for FFC review
G-200	**Financial and Organizational Accountability**	Approval and Signing Authority	Approved	• To be reviewed before December 2018
G-210	**Financial and Organizational Accountability**	Borrowing and Investing	For Review	• New policy • Recommend for FFC review
G-220	**Financial and Organizational Accountability**	Contractual Services ➢ Appendix A – Approval Directory	Approved	• To be reviewed before December 2018
G-230	**Financial and Organizational Accountability**	Procurement ➢ Procurement Protocols	Approved	• To be reviewed before December 2018
G-240	**Financial and Organizational Accountability**	Tangible Capital Assets	For Review	• Revised from previously existing administrative policy • Recommend for FFC review
G-250	**Financial and Organizational Accountability**	Reserve and Reserve Funds	For Review	• Revised from previously existing administrative policy • Recommend for FFC review
G-310	**Financial and Organizational Accountability**	Corporate Sponsorship	To FFC	• Replaces policy 4-070
G-320	**Financial and Organizational Accountability**	Donations	To FFC	• Replaces policy 4-160
G-330	**Financial and Organizational Accountability**	Gifts and Honorariums	To FFC	• Replaces policy 4-055
G-410	**Financial and Organizational Accountability**	Board Member Remuneration	To FFC	• TBD

Policy #	Section	Policy & Appendices	Status	Summary of Changes / Next Steps
G-420	**Financial and Organizational Accountability**	Travel Reimbursement	To FFC	• TBD
G-260	**Board Effectiveness**	Governance Principles and Board Accountability	For Review	• New policy
G-270	**Board Effectiveness**	Roles and Responsibilities of the Board of Health ➢ Appendix A- Board of Health Members ➢ Appendix B- Board of Health Chair & Vice Chair ➢ Appendix C- Board of Health Secretary-Treasurer	Approved	• To be reviewed before March 2019
G-280	**Board Effectiveness**	Board Size and Composition	Approved	• To be reviewed before March 2019
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	Approved	• To be reviewed before March 2019
G-300	**Board Effectiveness**	Board of Health Self- Assessment ➢ Appendix A – Board of Health Self-Assessment Tool	Approved	• To be reviewed before March 2019
G-350	**Board Effectiveness**	Nominations and Appointments to the Board of Health	Approved	• To be reviewed before March 2019
G-360	**Board Effectiveness**	Resignation and Removal of Board Members	Q3 - 2016	• TBD
G-370	**Board Effectiveness**	Board of Health Orientation and Development	Approved	• To be reviewed before March 2019
G-380	**Board Effectiveness**	Conflicts of Interest & Declaration ➢ Declaration Form	Being reviewed by legal	• New policy
G-390	**Board Effectiveness**	Code of Conduct ➢ Appendix A – Corporate Code of Conduct	Q3 – 2017	• TBD

Policy #	Section	Policy & Appendices	Status	Summary of Changes / Next Steps
		➢ Appendix B – BOH Code of Conduct		
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	Approved	• To be reviewed before March 2019
G-480	**Communications and External Relations**	Media Relations	Approved	• To be reviewed before March 2019
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	Approved	• To be reviewed before March 2019

SUBJECT:	Information Privacy and Confidentiality	**POLICY NUMBER:**	**G-100**
SECTION:	Program Quality and Effectiveness	**PAGE:**	1 of 6

IMPLEMENTATION:		**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	

PURPOSE

To facilitate the Board of Health's compliance with certain governance and accountability requirements outlined within *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA) and the *Personal Health Information Protection Act* (PHIPA). with respect to the security of Personal Information (PI) and/or Personal Health Information (PHI).

To outline the responsible information handling practices (IHPs) expected of Board Members as it relates to PI, PHI and Confidential Information (CI).

POLICY

Through the publication of this policy, the Board of Health: (1) recognizes information Privacy as a human right protected by law; and (2) formalizes its commitment to ensuring the Privacy and Confidentiality of the PI, PHI and CI under the custody and control of the Health Unit.

The BOH is accountable for the lawful Collection, Use, Disclosure and Security of PI, PHI that is under the custody and control of the Health Unit.

Board Members are accountable for maintaining the Confidentiality and Security of CI that they gain access to for the purpose of discharging their duties and responsibilities as a member of the Board of Health.

The Board shall be informed of all significant privacy risks.

The Board shall be informed of all significant privacy breaches.

PROCEDURES

1.0 Board of Health Accountabilities Under MFIPPA

1.1 Designation of Head (MFIPPA, S.3)
Through the approval and publication of this policy, the Board of Health confirms, in writing, that it designates from among its members, the Board Chair to serve as the "Head" of the institution for the purposes of MFIPPA; and further

1.2 The Board Chair delegates the duties and responsibilities of the Head outlined in MFIPPA to the Medical Officer of Health and Chief Executive Officer (MOH/CEO). The day-to-day administration and management of the Health Unit's information privacy program is facilitated by the Heath Unit's Privacy Officer, who reports to the Director of Corporate Services.

2.0 Board of Health Accountabilities Under PHIPA

Health Information Custodian – PHIPA, S. 3(6)

2.1 The medical officer of health of a board of health within the meaning of the *Health Protection and Promotion Act* serves the HIC for the purposes of PHIPA.

Contact Person – PHIPA, S. 15

2.2 The Privacy Officer serves as an Agent of the HIC to:

(a) Facilitate the HIC's compliance with PHIPA;

(b) Ensure that all Agents of the HIC are appropriately informed of their duties under PHIPA;

(c) Respond to requests of an individual for access to or correction of a record of personal health information that is in the custody or under the control of the HIC; and

(d) Receive complaints from the public about the HIC's alleged contravention of PHIPA or its regulations (S. 15(3)).

Written Public Statement – PHIPA S. 16

2.3 The Health Unit makes a written statement (APPENDIX A) with respect to its information privacy practices publicly available.

Privacy Breach Notification – PHIPA S. 12, and PHIPA Regulations

2.4 The HIC shall inform the Board of all significant privacy breaches, involving any Agents of the HIC, that require mandatory notification:

(a) the Information Privacy Commission (IPC) of Ontario in accordance with Section 12(3) of PHIPA and the prescribed regulations;

(b) a regulatory college within the meaning of the Regulated Health Professionals Act or the Canadian Institute of Public Health Inspectors as required and/or appropriate; and/or

(c) a police service; and/or

(d) the media.

3.0 Board Member Confidentiality Awareness and Attestation

3.1 Board Members will be provided with a copy of this policy upon orientation to the Board of Health.

3.2 As part of the annual development plan, all Board Members shall be required to confirm their awareness of their confidentiality obligations under the applicable privacy legislation and the governance policies of the Board by signing the Annual Confidentiality Attestation (APPENDIX B).

DEFINITIONS

In this Policy,

1. "**Agents**", in relation to the Health Information Custodian (hereafter referred to as the HIC or the Custodian), means a person that, with the authorization of the Custodian, acts for or on behalf of the Custodian in respect of Personal Health Information for the purposes of the Custodian, and not the Agent's own purposes, whether or not the Agent has the authority to bind the Custodian, whether or not the Agent is employed by the Custodian and whether or not the Agent is being remunerated (PHIPA S. 2).

2. "**Collection**" means to gather, acquire, receive or obtain the information by any means from any source.

3. "**Confidentiality**" means the nondisclosure of PI or PHI except to another authorized person. (Adapted from *Mosby's Medical Dictionary*, 9th edition. 2009, Elsevier.)

4. "**Confidential Information**" means Personal Information, Personal Health Information or any other information, whether in written, visual or oral form, that either alone or in the context of other information, could reasonably be considered information that is of a sensitive nature to the organization or institution, including employee, financial, organizational information, and would also include information that is evaluative or opinion material compiled solely for the purpose of determining suitability, eligibility or qualifications for the awarding of contracts and other benefits by the organization or institution in circumstances where it may reasonably have been assumed that the identity of the source would be held in confidence [s. 38(c), *MFIPPA*]. For clarity, Confidential Information would be any information that would fall within the foregoing definition, whether this information emanates from or is about MLHU, or another organization or institution.

5. "**Disclosure**" means to make the information available or to release it to another health information custodian or to another person, but does not include to use the information.

6. "**Head**" means the individual designated, in writing, by the Board of Health from among themselves, to act as head of the institution for the purposes of MFIPPA.

7. "**Health Information Custodian**" means a person or organization as defined and described in *PHIPA* who has custody or control of Personal Health Information as a result of or in connection with performing the person's or organization's powers or duties. The HIC for the Middlesex-London Health Unit is the Medical Officer of Health (See *PHIPA* S. 3 (1) for the complete definition).

8. "**Identifying Information**" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual. (PHIPA S. 4 (2)).

9. "**Institution**" means a board of health. (MFIPPA, S. 2 (1).

10. "**Personal Information**" means recorded information about an identifiable individual, including:
    (a) Information relating to the race, national or ethnic origin, colour, religion, age, sex, sexual orientation or marital or family status of the individual;
    (b) Information relating to the education or the medical, psychiatric, psychological, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved;
    (c) Any identifying number, symbol or other particular assigned to the individual;
    (d) The address, telephone number, fingerprints or blood type of the individual;
    (e) The personal opinions or views of the individual except if they relate to another individual;
    (f) Correspondence sent to an institution by the individual that is implicitly or explicitly of a private or confidential nature, and replies to that correspondence that would reveal the contents of the original correspondence;
    (g) The views or opinions of another individual about the individual; and/or
    (h) The individual's name if it appears with other personal information relating to the individual or where the disclosure of the name would reveal other personal information about the individual. (*MFIPPA, S. 2(1)*)

11. "**Personal Health Information**" means identifying information about an individual in oral or recorded form, if the information:

    (a) Relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family;
    (b) Relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual;
    (c) Is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the individual;
    (d) Relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual;
    (e) Relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance;
    (f) Is the individual's health number; and/or
    (g) Identifies an individual's substitute decision-maker. PHIPA S. 4(1)

12. "**Privacy**" means the qualified right of individual citizens to exercise control over the collection, use and disclosure, of their Personal Information and Personal Health Information, unless the collection, use and/or disclosure of the information is permitted or required by law.

13. "**Privacy breach**" means the loss of custody or control of Personal Information or Personal Health Information. This includes, but is not limited to the: theft, loss, unauthorized use, unauthorized disclosure, unauthorized copying or records, unauthorized modification or records, the insecure transfer or transmission of records and/or the insecure disposal/destruction of records.

14. "**Privacy Officer**" means the individual designated by the Medical Officer of Health and Chief Executive Officer as the individual primarily accountable for the implementation and management of the Health Unit's Privacy and information handling practices. The Privacy Officer for the Health Unit is the Manager, Privacy and Occupational Health and Safety.

15. "**Records**" means any record of information in any form or in any medium, whether in oral, written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record. (MFIPPA S. 2 and PHIPA, S. 2)

16. "**Security**" means a system of safeguards and precautions established to preserve confidentiality. These means may be legislative, administrative/procedural and/or technical.

17. "**Use**" means to view, handle or otherwise deal with the information.

APPLICABLE LEGISLATION

Municipal Freedom of Information and Protection of Privacy Act
Personal Health Information Protection Act

RELATED POLICIES

In addition to this governance policy, the Health Unit's program for the protection of PI, PHI and CI is comprised of the following administrative policies:

Policy 6-010 Confidential Information
Policy 6-020 Access to Information Requests
Policy 6-030 Records Management
Policy 6-040 Security of Personal Information and Personal Health Information
Policy 6-050 Privacy Breach Identification and Management

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

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT PRIVACY STATEMENT

Introduction

Protecting your privacy is important to the Middlesex-London Health Unit. In providing health services and health protection and promotion programs, information we collect about you is governed by one or more of the following three laws:

- *Health Protection and Promotion Act,* R.S.O. 1990, c. H.7 *(HPPA)*
- *Municipal Freedom of Information and Protection of Privacy Act,* R.S.O. 1990, c. M56 *(MFIPPA)*
- *Personal Health Information Protection Act,* S.O. 2004, c. 3, Sch. A *(PHIPA)*

When Is Your Consent Required to Collect, Use, Keep Or Give Out Your Personal Information?

When you seek health-related services from the Health Unit we assume we have your permission to collect, use and share your Personal Health Information as required to carry out our job, unless you specifically tell us otherwise. If some other health care provider needs this information to provide your care, we can give it to them unless you specifically tell us not to. You may change or withdraw your consent to the use and sharing of your information at any time by telling us in writing. If others who are not directly involved in your care want your information, we must ask your permission. Please note the laws listed above contain some exceptions to this requirement for your consent. If you have any questions about these exceptions, please contact our Privacy Officer. Contact information for the Privacy Officer is provided below.

When we require your Personal Information for participating in a program offered by the Health Unit, we will tell you verbally or in writing what information we are collecting, under what law we are allowed to collect this information, and who you can speak to if you have any questions. This is called “Notice of Collection”.

Sharing Personal Information with Family and Others

The Health Unit will not share your Personal or Personal Health Information with family members or others who are not health care providers involved in your care, unless you consent to this or the law requires it. For a young child, consent is obtained from a legal parent or guardian. Under the law, we are not allowed to get consent from or give information to a parent who is not the legal guardian (such as those who only have right of access) unless we have the consent of the legal guardian. If an older child or youth has consented to her or his own care, then the Health Unit must get the older child or youth’s consent to release health information to a family member or others who are not health care providers involved in their care. The Health Unit determines the age of consent under the *Health Care Consent Act* at the time of providing health-related services to the older child or youth.

Your Health Card Number

The number on your Ontario Health Insurance Plan (“OHIP”) card is your “Health Card Number”. You will need to provide your Health Card Number to the Health Unit in order to receive certain health services. This information will not be shared with another institution or individual without your consent.

Research

Your Personal or Personal Health Information may be used for research projects that the Health Unit is conducting, either alone or with other organizations. Before we collect any information, we will tell you the purpose(s) the information is being collected and used for. Any information used in our research will be expressed solely in statistical terms. This means no information that could be identifiable to you will be in any report generated from the research.

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Access to Personal and Personal Health Information

You have a right to see and get a copy of the information in your file, unless the law restricts access. You can request information verbally or in writing. Depending upon the amount of information you ask for, or additional actions that the Health Unit needs to take to provide the information, the law allows MLHU to charge you a fee. The Health Unit may waive this fee.

The Health Unit will respond to your request for information within 30 calendar days. If there is a delay in providing the information, we will notify you and respond as quickly as possible. When all or a part of a record cannot be provided, we will inform you why access is restricted and give the Health Unit's legal authority for this refusal. For instance, the Health Unit is not permitted to disclose information that identifies another person, or that is the subject of a police investigation.

Correction of Your Information or Record

If your personal information changes or you notice a mistake or information is missing in your record, you have a right to ask us to correct your record. The Health Unit is required to respond within 30 days and will change the information or record if we can verify that the new information is correct. If we refuse to make the correction we will explain why we made this decision. You have the right to give us a letter objecting to our decision. This letter will be kept in your file. As well, you have a right to complain to the Information and Privacy Commissioner of Ontario. Contact information for the Information and Privacy Commissioner of Ontario is provided below.

Who to Contact at Middlesex-London Health Unit Regarding Privacy and Access to Information

The Health Unit's Privacy Officer is the Manager, Privacy and Occupational Health & Safety. If you have a question about this privacy statement, the Health Unit's privacy policy and procedure, or about any of the Health Unit's information handling practices, please contact

Privacy Officer
Middlesex-London Health Unit
50 King Street, London, Ontario N6A 5L7
(519) 663-5317, Ext. 2251
Email: privacy@mlhu.on.ca

Information and Privacy Commissioner of Ontario ("IPC/O")

If you do not agree with how the Health Unit has responded to your request for access to a record or correction of a record, you have the right to make a complaint to the Information and Privacy Commissioner of Ontario. For more information about how to make a complaint, please see the Information and Privacy Commissioner's website at www.ipc.on.ca, or you may write to them at:

Information and Privacy Commissioner/Ontario
2 Bloor Street East
Suite 1400
Toronto, Ontario M4W 1A8

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Web Privacy Statement

When you visit Middlesex-London Health Unit's websites, you do so anonymously - there is no need to tell us who you are. If you make an enquiry to Healthunit.com, we will ask you to give your name and mailing address or email address for the purpose of responding to your enquiry. Only those who "need to know" will have access to the personal information provided.

Healthunit.com provides links to other websites. The Health Unit cannot ensure the privacy practices of other sites and encourages you to read their privacy policy before you provide any Personal or Personal Health Information.

Middlesex-London Health Unit's public or “Internet” web server does not retain personal information collected beyond the time it takes to forward it on to a secure internal system for processing. Any email that you send to us through the Internet is unencrypted – so please do not send confidential information via email. In the event that you send an email to Middlesex-London Health Unit, the Health Unit may retain your e-mail address, as well as any information contained in the email, on a secure internal system for responding to your request and tracking any follow-up action.

Encryption technology protects personal information you provide during transmission. When you are in an encrypted session, the web page will contain a notice stating "you are in a secure site". A security icon will also appear in either the lower left corner or the lower right corner of your browser window, depending on your browser. If encryption is not available through a Middlesex-London Health Unit website, an alternative means of communication is recommended (e.g. telephone call).

Personal and Personal Health Information is disposed of according to Middlesex-London Health Unit's record retention schedule. To ensure Personal and Personal Health Information is unrecoverable, any paper records generated are shredded, and electronic media is wiped prior to disposal using a utility program or by physical destruction of the media.

Logging Practices

Middlesex-London Health Unit logs the IP (Internet Protocol) address and clickstream data of site visitors. An IP address is the number automatically assigned to the computer or to the Internet Service Provider requesting a web address. Clickstream data, sometimes called “clickstream analytics”, is the process of collecting and analyzing statistical information about how visitors interact with a website. The information may include things such as the general location of the visitor’s computer, the pages visited while on the Health Unit website and for how long they were visited. Other actions the visitor completes, for instance filling in an online form or downloading a brochure, may also be recorded. Clickstream data may also include certain basic information about the visitor’s computer, such as screen resolution and operating system.

Logged information and clickstream data may be recorded by the Middlesex-London Health Unit and its authorized Agents only and is recorded in non-identifiable form. The information we collect is used for website evaluation, systems analysis and maintenance. Middlesex-London Health Unit's clickstream data is anonymous. The Health Unit will not sell or share clickstream data and/or web log information to third parties.

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SUBJECT:	Risk Management	**POLICY NUMBER:**	**G-120**
SECTION:	Program Quality and Effectiveness	**PAGE:**	1 of 2

IMPLEMENTATION:		**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	

PURPOSE

To ensure that an appropriate and effective risk management process is in place to monitor and to respond to emerging issues and potential threats to the agency, from both internal and external sources.

POLICY

The Middlesex-London Health Unit engages in a wide range of activities, in its facilities and in the community, all of which are subject to some level of uncertainty. It is the policy of the agency:

- To embed risk management into the culture and operations of the agency;
- To integrate risk management into strategic planning, program planning, performance management and resource allocation decisions;
- To manage threats and leverage opportunities as appropriate and in accordance with best practices;
- To re-assess regularly and to report on the agency's risks and the effectiveness of existing risk mitigation strategies;
- To anticipate and respond to changing social, environmental and legislative requirements;
- To support the development of risk management competencies across the agency; and
- To encourage all staff to report risks and to ensure that no person who in good faith reports a risk is subjected to any form of retribution, retaliation or reprisal.

PROCEDURE

The Board of Health shall be responsible for providing risk oversight and ensuring that the agency takes a risk-based approach to establishing a sound system of internal control that is integrated with the agency's planning processes. The Board shall obtain an understanding of the risks inherent in the agency's strategies and the risk appetite of management in executing these strategies, shall apprise itself of useful information from internal and external sources about the critical assumptions underlying the strategies, shall be alert for organizational behaviour that can lead to excessive risk taking or insufficient risk taking, and shall provide advice to management regarding critical risk issues. The Board shall also provide direction on the extent and categories of risk that it regards as acceptable and define the scope and frequency of risk management reporting.

The MLHU Risk Management Process is based on the Ontario Public Service Risk Management Framework and includes the following steps:

1. Establish objectives
2. Identify risks and controls
3. Assess risks and controls
4. Evaluate and take action
5. Monitor and report

Management shall ensure that policies are carried out and processes are executed in accordance with objectives and identified risk tolerances, as well as actively embrace an integrated approach to risk management, sharing risk information transparently throughout the agency and promoting a culture in which risk management permeates all levels of the organization.

The Medical Officer of Health / Chief Executive Officer shall have overall responsibility for risk management, ensuring the effective execution of the agency risk management process and that no significant risk is overlooked. The Director, Corporate Services shall be responsible for the development, implementation, and review of a systematic risk management process.

All employees, students, and volunteers shall consider risk management as an integral and ongoing part of their role in the agency. They shall have an inherent responsibility to identify, assess, manage and communicate risks associated with their work to assist in developing and implementing risk management plans and actions.

APPLICABLE LEGISLATION

Ontario Public Health Organizational Standards

RELATED POLICIES

REVISION DATES (* = major revision)

SUBJECT:	Financial Planning and Performance	**POLICY NUMBER:**	**G-180**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 3

IMPLEMENTATION:		**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	

PURPOSE

To ensure that Health Unit budgeting and financial practices are performed in a fiscally responsible manner and that processes are in place that allow for responsible financial controls and the ability to demonstrate organizational performance.

POLICY

The Secretary-Treasurer prepares and controls the Annual Budget under the jurisdiction of the Board of Health and prepares financial and operating statements for the Board of Health in accordance with Ministry of Health and Long-Term Care policies and Public Sector Accounting Board Guidelines. The Finance and Facilities Committee (FFC) of the Board of Health reviews and recommends the annual budget for Board of Health approval. Additional financial planning and performance tools and processes include Planning and Budget Templates (PBTs), Program Budgeting Marginal Analysis (PBMA), quarterly financial reporting, one-time funding requests, and the factual certificate.

PROCEDURE

Fiscal Year

The fiscal year of the Health Unit is January 1 to December 31 for all mandatory programs and any programs funded in whole or in part, by municipalities. For programs funded by other agencies, the fiscal year shall be determined by the agency providing funding.

Annual Budget Preparation

The annual budget will be developed based on a variety of factors including strategic directions, provincial and / or municipal guidance, previous years' base budgets, community need, new funding or legislative requirements. Budget planning and performance reporting is the responsibility of the Directors, Managers and other staff who manage budgets. The budget planning and approval cycle is attached as Appendix A. The planning and approval cycle has the following components:

1. **Planning and Budget Templates**

These templates integrate: (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.

2. 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.

3. Quarterly Financial Reporting

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.

4. One-time Funding Requests

One-time funding request may be used for to non-reoccurring expenditures or to temporarily enhance program objectives. Requests should be made during the budget preparation process or in certain circumstances within the budget year, by making application to the provincial government for one-time funding. If the request is made after budget preparation and approval, the divisional Director must agree to the need for the request before the application process is initiated. Once the need is established, the approval of the request will follow the policy G-200 Signing Authority based on the total value of the request.

5. 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.

6. Audited Financial Statements

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 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 is approved by the Board of Health. This report includes program

revenues and expenditures of these programs during the period of January 1st to December 31st.

RELATED POLICIES

G-200 Approval & Signing Authority

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

Appendix A

Annual Budget Planning and Reporting Cycle

January	• Annual budget submission to FFC
February	• Annual budget approved by Board of Health • Q4 Variance Reporting and Factual Certificate to FFC
March	• Budget submission to the Ministry of Health and Long-Term Care
April	
May	• Q1 Variance Reporting and Factual Certificate to FFC
June	• January 1 to December 31 – Audited Financial Statements to FFC • High-level planning parameters for upcoming year recommended to FFC
July	• PBMA criteria recommended to FFC
August	• Q2 Variance Reporting and Factual Certificate to FFC
September	• April 1 to March 31 Consolidated Financial Statements to FFC
October	
November	• Q3 Variance Reporting and Factual Certificate to FFC • PBMA proposals recommended to FFC
December	

SUBJECT:	Asset Protection	**POLICY NUMBER:**	**G-190**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 2

IMPLEMENTATION:		**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	

PURPOSE

To ensure that Health Unit assets, Board of Health members, employees, students, volunteers and any other persons legally engaged on the behalf of the Health Unit are adequately insured against physical damage and / or injury and errors and omissions.

POLICY

The Board of Health shall ensure that assets are reasonably protected and not placed at unnecessary risk or liability.

PROCEDURE

The Board of Health shall ensure that:

- Reasonable insurance coverage against fire, theft, casualty losses, with an appropriate deductible is maintained.
- Reasonable insurance coverage against liability losses for Board of Health members, employees, students, volunteers and any other persons legally engaged on the behalf of the Health Unit is maintained.
- Reasonable insurance coverage against losses due to errors and omissions for Board of Health members, employees, students, volunteers and any other persons legally engaged on the behalf of the Health Unit is maintained.
- Where risks are known, the Health Unit actively mitigates these risks through planning and policy development (e.g. building security planning).

Review of Insurance Coverage
The Associate Director, Finance or designate reviews all insurance policies annually with insurance professionals representing the Board of Health. The Associate Director, Finance or designate presents any substantive changes in these policies to the Finance and Facilities Committee of the Board of Health for their approval.

Request for Proof of Insurance – Insurance Certificates
From time to time, staff may be required to provide proof of the Health Unit's insurance, for example for renting facilities and equipment.

Staff must submit the request to the Associate Director, Finance or designate 10 business days prior to the date required by the 3rd party. The request should detail the following:

- Date of the event
- The location and description of the event
- The 3rd party contact information including name, address and fax number

The Associate Director, Finance or designate will liaise with the insurance agent to fill the request, and ensure the 3rd party receives a copy of the insurance certificate.

The Associate Director, Finance or designate will keep all Insurance Certificates, and may provide a copy to the requestor if required.

REVISION DATES (* = major revision)**:**
1992-09-23
1997-09-25
2000-06-31
2005-03-02
2008-10-30
2014-06-01

SUBJECT:	Borrowing and Investing	**POLICY NUMBER:**	**G-210**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 2

IMPLEMENTATION:		**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	

PURPOSE

The purpose of the investment and borrowing policy is to set out a framework for investing and borrowing activities of public health funds while meeting the objectives of the Board of Health and related statutory and contractual requirements.

POLICY

The Board of Health may borrow funds to meet expenditures of the Health Unit when deemed necessary. In regards to investments, the Health Unit shall adhere to the following guiding principles in the consideration, purchase, disposal and administration of any Board of Health held investments: a) Adherence to statutory requirements, b) Preservation of capital, c) Liquidity, d) Diversification and e) Yield.

PROCEDURE

Borrowing

The Chair of the Board and the Secretary-Treasurer, following a majority vote of the Board of Health, are authorized on behalf of the Board to borrow, from time to time, by way of promissory note, mortgage, or other suitable debt instrument from a registered chartered bank, trust company or credit union to meet Health Unit expenditures. The Board may delegate to the Medical Officer of Health / Chief Executive Officer the exercise of this power on the behalf of the Board in such manner as the Board may determine by Board resolution.

Investing

The following principles will be considered for the purchase, disposal, and administration of Health Unit investments:

a) **Adhere to Statutory Requirements**

All investment activities shall be in compliance with the relevant sections of any applicable legislation, related regulations, and applicable funding agreements.

b) **Preservation of Capital**

Safety of principal is a primary objective of the investment portfolio. Investments shall be undertaken in a manner that seeks to ensure the preservation of capital in the overall portfolio.

c) **Liquidity**

The investment portfolio shall remain sufficiently liquid to meet all operating or cash flow requirements and limit temporary borrowing requirements. Furthermore, since all possible cash

demands cannot be anticipated, the portfolio shall consist largely of securities with active secondary or resale markets.

d) **Diversification**
The portfolio shall be diversified by asset class, issuer type, credit rating and by term to the extent possible, given legal and regulatory constraints.

e) **Yield**
The Health Unit shall maximize the net rate of return earned on the investment portfolio, without compromising the other objectives listed previously. Investments are generally limited to relatively low risk securities in anticipation of earning a fair return relative to the assumed risk.

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 #2 Banking and Finance

SUBJECT: Tangible Capital Assets
SECTION: Financial and Organizational Accountability
POLICY NUMBER: G-240
PAGE: 1 of 5

IMPLEMENTATION:
SPONSOR: MOH / CEO
REVIEWED BY: Finance and Facilities Committee
APPROVAL: Board of Health
SIGNATURE:
DATE:

PURPOSE

The purpose of this policy is to prescribe the accounting treatment for tangible capital assets so that investments in property, plant and equipment are reflected on the Health Unit's financial statements in order to comply with Section 3150 of the Public Sector Accounting Board (PSAB) Handbook.

POLICY

The principle issue regarding tangible capital assets (TCA) is the recognition of the assets and the determination of amortization charges. This policy sets forth how the Health Unit gathers and maintains information needed to prepare financial statements in regards to tangible capital assets.

PROCEDURE

Capitalization and Asset Categories:
Tangible capital assets should be capitalized (recorded in the fixed asset sub-ledger) according to the following thresholds per year:

Categories	***Useful Life***	***Thresholds***
Land	Capitalize Only	All
Buildings	40 years	$50,000
Building Betterments • Roof • Interior Renovations • Heating, Ventilation and Cooling Systems	 20 years 10 years 10 years	 $15,000 $5,000 $5,000
Computer Systems (pooled hardware, software)	4 years	$10,000
Motor Vehicle	5 years	$10,000
Furniture and Equipment (pooled)	7 years	$10,000

*The Health Unit must have legal title to the assets in order for the asset to qualify as a capital asset.

Valuation of Assets
Tangible capital assets should be recorded at cost plus all ancillary charges necessary to place the asset in its intended location and condition for use.

1. **Purchased assets**
The cost is the gross amount paid to acquire the asset and includes all non-refundable taxes and duties, freight and delivery charges, installation and site preparation costs etc., net of any trade discounts or rebates.

The cost of land includes purchase price plus legal fees, land registration fees, transfer taxes etc. Costs would include any costs to make the land suitable for intended use such as demolition and site improvements that become part of the land.

2. **Acquired, Constructed or Developed Assets**
The cost includes all costs directly attributable (e.g. construction, architectural and other professional fees) to the acquisition, construction or development of the asset. Capitalization of general administrative overhead is not permitted.

3. **Donated or Contributed Assets**
The cost of donated or contributed assets is equal to the fair value at the date of construction or contribution. Fair value may be determined using market or appraisal values. Cost may be determined by an estimate of replacement cost.

Componentization
Tangible capital assets may be accounted for using either the single asset or component approach. Whether the component approach is to be used will be determined by the usefulness of the information versus the cost of collecting and maintaining information at the component level.

Factors to consider when determining whether to use a component approach include:

a) Major components have significantly different useful lives and consumption patterns than the related tangible capital asset.
b) The value of the components in relation to the related capital tangible capital asset.

Amortization
The cost, less any residual value, of a tangible capital asset with a limited life should be amortized over its useful life in a rational and systematic manner appropriate to its nature and use. (PSAB 3150.22)

Amortization should be accounted for as an expense in the statement of operations. A record is still required for assets still in use, but already fully amortized. Amortization does not commence until the asset is available for use. In the year an asset is put into service, half of the applicable amortization is expensed. The method of asset amortization, threshold levels and estimated useful life will be reviewed on an annual basis.

Disposal
Managers should notify the Associate Director, Finance when assets become surplus to operations. Disposal procedures for capital assets will be in accordance with Health Unit Procurement Policy.

Capital Leases
Any capital lease shall be accounted for in the same manner as acquiring a capital asset.

Reporting
PSAB 3150.40 requires that the financial statements should disclose, for each major category of tangible capital assets and in total:

a) Cost at the beginning of the period
b) Additions in the period
c) Disposals in the period
d) The amount of any write-downs in the period
e) The amount of amortization of the costs of tangible capital assets for the period
f) Accumulated amortization at the beginning and end of the period and
g) Net carrying amount at the beginning and end of the period.

Method for determining initial cost of each asset category:
Where feasible, an inventory of all assets will be conducted. A master list of assets will be created, identified by category and updated as assets are acquired or disposed of. Assets which are old and still in use past their normal amortization period will still be recorded.

Other Valuation:
Where possible and where the age of the capital asset is identified as being within 7 years (legislated retention period) historical cost will be determined from accounting records. In the absence of historical records, or where the cost and effort required to perform the appropriate research may outweigh the benefits, current replacement costs, discounted to the year of acquisition or construction, will be used. CPI rates will be used for discounting purposes. For buildings, historical values will be determined by a professional engineering firm. A consistent method of estimating the costs will be applied except where it can be demonstrated that a different method would provide a more accurate estimate of the cost.

Future capital assets will be recorded at cost. Contributed capital assets will be recorded at fair value at the time of contribution.

Definitions

Tangible Capital Assets: are non-financial assets having physical substance that:

a) Are used on a continuing basis in the Health Unit's operations
b) Have useful lives extending beyond one year
c) Are not held for re-sale in the ordinary course of operations.

Amortization: is the accounting process of allocating the cost less the residual value of a tangible capital asset to operating periods as an expense over its useful life. (Also referred to as depreciation.)

Betterments: are subsequent expenditures on tangible capital assets that:

- Increase service capacity
- Lower associated operating costs
- Extend the useful life of the asset
- Improve the quality of the asset

These costs are included in the tangible capital asset's cost. Any other expenditure would be considered a repair or maintenance and expensed in the period in which the expense was incurred.

Capital lease: is a lease with contractual terms that transfer substantially all the benefits and risks inherent in ownership of property to the Health Unit. One or more of the following conditions must be met:

a) There is reasonable assurance that the Health Unit will obtain ownership of the leased property by the end of the lease term
b) The lease term is of such duration that the Health Unit will receive substantially all of the economic benefits expected to be derived from the use of the leased property over its life span.
c) The lessor would be assured of recovering the investment in the leased property and of earning a return on the investment as a result of the lease agreement.

Capitalization threshold: is the minimum amount that expenditures must exceed before they are capitalized and are reported on the balance sheet of the financial statements. Items not meeting the threshold would be recorded as an expense in the period in which the expense was incurred.

Group Assets (pooling): have an individual value below the capitalization threshold but have a material value as a group. Although recorded in the financial systems as a single asset, each unit may be recorded in the asset sub-ledger for monitoring and control of its use and maintenance. Examples could include computers, furniture and fixtures, small moveable equipment etc.

Useful Life: is the shortest of the asset's physical, technological, commercial or legal life.

APPLICABLE LEGISLATION

Public Sector Accounting Board (PSAB) Handbook

REVISION DATES (* = major revision)**:**
2010-01-01

SUBJECT:	Reserve and Reserve Funds	**POLICY NUMBER:**	**G-250**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 2

IMPLEMENTATION:		**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	

PURPOSE

The purpose of this policy is to provide a process for establishing, maintaining, and using reserves and reserve funds.

POLICY

The maintenance of a reserve and reserve funds is an acceptable business practice, and will help protect the Health Unit and its funders from future funding liabilities. In order for the Health Unit to address one-time or short-term expenditures, either planned or unplanned, which arise, it is necessary to maintain reserve and/or reserve funds.

PROCEDURE

The Health Unit will attempt to offset any unexpected expenditures within the annual operating budget for all Heath Unit programs where possible without jeopardizing programs.

The Health Unit will, where possible, leverage the use of reserve and reserve funds for requesting funding grants from provincial funders or other sources.

Establishment of Reserves and Reserve Funds
Any reserve and reserve fund will be established by resolution of the Board of Health which will provide the purpose or use, maximum contributions, and expected timelines for contributions and drawdowns. A list of Health Unit reserve and reserve funds is attached as Appendix A

Any reserve or reserve fund is to be held in accordance to Policy G-210 Investment and Borrowing with the same signing officers as other Health Unit bank accounts.

Contributions / Drawdowns
Any planned contributions and drawdowns to the reserve or reserve funds will be included in the annual operating budget approved by the Board of Health. Any audited unexpended municipal funds are eligible for transfer to a reserve or reserve fund by resolution of the Board of Health subject to consultation with municipal councils.

Any unplanned withdrawals from the reserve or reserve funds will be approved by resolution of the Board of Health.

Any contributions to or drawdowns from reserve or reserve funds that include funding from municipal sources will be made using the same municipal apportionment used for funding public health programs.

Limits
The maximum contributions to a reserve fund shall be the amount required to fulfill the specific requirement.

The maximum contributions to reserves for any particular operating year shall be 2% of gross revenues found on the annual statement of operations of the audited financial statements.

The maximum cumulative reserves shall be 10% of gross revenues found on the annual statement of operations of the audited financial statements.

Annual Reporting
An annual report will be provided to the obligated municipalities outlining the transactions of the reserve and reserve funds during the previous year. Where possible, planned or future contributions and drawdowns will be included.

DEFINITIONS
Reserves: are amounts set aside by resolution of the Board of Health that are carried year to year mainly as contingencies against unforeseen events or emergencies.

Reserve Funds: are amounts set aside for specific purposes by resolution of the Board of Health. They are carried from year to year unless consumed or formally closed.

REVISION DATES (* = major revision)**:**
2014-11-20

Middlesex-London Health Unit

Reserve / Reserve Fund Summary

Funding Stabilization Reserve

Purpose:

The Funding Stabilization Reserve Fund is required to ensure the ongoing financial stability and fiscal health of the Board. Generally, the use of these funds falls within these three categories:

1) ***Operating and Environmental Emergencies*** – highest priority and are based on public safety and demand nature of the expenditure.
2) ***Revenue Stability and Operating Contingency*** - intended to stabilize the impacts of cyclical revenue downturns and operating cost increases that are largely temporary and not within the Health Unit's ability to adjust in the short-term.
3) ***Innovation*** – incentive to encourage creativity and innovation, funds maybe be used to explore innovative and creative solutions directed towards making the Health Unit more efficient and effective.

Fund Limit:

Total fund balance not to exceed 10% of gross revenues in any given year.

Maximum Yearly Contribution:

Annual contributions to the fund should not exceed 2% of gross revenues in the year the contribution is made.

Expected Contribution / Withdrawals:

None.

Dental Treatment Reserve Fund

Purpose:

The reserve fund was established with proceeds from the sales of assets as a result of closure of the various clinics throughout the City of London as a result in a change in policy from the Ontario Works program. The purpose of the fund are to fund annual deficits (if any) from operations and ultimately for future obligations relating to a closure of the Dental Treatment Clinic.

Fund Limit:

Total fund balance should not exceed the anticipated closing costs for the dental clinic. It is estimated to be $250,000 (2014).

Maximum Yearly Contribution:

Maximum yearly contribution is set at the annual surplus from operations (if any).

Expected Contribution / Withdrawals:

- Potentially the annual amount of any operating shortfall.

Sick Leave Reserve Fund

Purpose:

The reserve fund was established and contributions made, as a result of the OMERS rate holiday. Employees hired prior to January 1, 1982 are entitled to accumulate and receive payment upon retirement of up to six month's salary of unused sick leave credits. Funds are to be applied to payment of this obligation or liability.

Fund Limit:

The total fund balance should equal the estimated liability as per the audited financial statements for the Middlesex-London Health Unit.

Maximum Yearly Contribution:

Annually contributions may be required for increases in the liability due to salary increases and accumulation of additional sick credits for employees with balances less than the maximum payout.

Expected Contributions / Withdrawals:

Withdrawals occur from time to time when qualified employees retire.

Environmental Reserve – Septic Tank Inspections

Purpose:

This reserve funds was established to cover possible future settlements of outstanding lawsuits against the Middlesex-London Health Unit due to inspections of septic installations under what is now the Part 8 of the Building Code.

The lawsuits generally relate to the claim of faulty septic tank installations. Often Middlesex-London Health Unit was named in the lawsuit as the Public Health Inspector inspected the installation. Middlesex-London Health Unit has not performed this work since around 1994.

Fund Limit

The total fund balance should equal the estimated liability as per the audited financial statements for the Middlesex-London Health Unit.

Maximum Yearly Contribution:

Annually contributions would be restricted to the increase in the liability.

Expected Contributions / Withdrawals:

None.

Technology & Infrastructure Reserve Fund

Purpose:

The Technology and Infrastructure Reserve is established to create a funding source for buildings and infrastructure capital projects, new equipment purchases and capital replacement programs. Use of the reserve is restricted to the following types of purchases:

- Major construction, acquisition, or renovation activities as approved by the Board of Health
- Major purchases of Information Technology software or hardware.
- Vehicle, furniture and/or equipment replacement

Fund Limit:

$ 2 million

Maximum Yearly Contribution:

Annual contributions = $250,000

Expected Contributions / Withdrawals:

$250,000 (Contribution)

Employment Costs Reserve Fund

Purpose:

Contributions are available to maintain services by alleviating the impact of the growth of wages and/or benefits and other related employment costs.

Fund Limit:

$200,000

Maximum Yearly Contribution:

Annual contributions = $200,000

Expected Contributions / Withdrawals:

None

SUBJECT:	Governance Principles and Board Accountability	**POLICY NUMBER:**	**G-260**
SECTION:	Board Effectiveness	**PAGE:**	1 of 2

IMPLEMENTATION:		**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	

PURPOSE

As part of the Board of Health's responsibility for ensuring Board effectiveness, the Board will establish, approve and at least biannually review their Governance Principles and Board Accountability Statement. This statement addresses the overarching philosophy and approach to its governance responsibilities, including its governance model and accountabilities.

POLICY

The Middlesex-London Board of Health is an autonomous board of health as established under section 49 of the Health Protection and Promotion Act (HPPA), meaning it is separate from any municipal organization but with municipal representation, including council members and / or citizen representatives appointed by municipalities and citizen representatives appointed by the province.

MLHU's governance principles are based on Dr. Graham Scott's Critical Elements for Effective Governance which was developed using a Modified Pointer and Orlikoff Framework, the Ontario Public Health Organizational Standards, OHA Guide to Good Governance and several other influencers. These Critical Elements for Effective Governance also take into consideration the unique context for boards of health.

The Middlesex-London Board of Health is accountable to the Middlesex-London Health Unit, the individuals and communities it serves, and the Government of Ontario and local municipalities for the efficient and effective delivery of public health programs and services.

PROCEDURE

The governance principles and board accountabilities form a distinctive set of governance structures with responsibilities and processes that are consistent with one another.

Structures refer to the parameters for selection and operation of the Board of Health as established by legislation, regulation, by-laws and policies.

Responsibilities refer to how governance functions are exercised and how responsibilities are distributed between the Board of Health, and the Medical Officer of Health / Chief Executive Officer.

Processes refer to those practices relating to board development, management and decision-making.

These structures, responsibilities and processes are articulated and supported by:

- Governance Policy Manual;
- Board agendas;
- Board and Committee reporting calendars; and
- Board self-assessments.

APPLICABLE LEGISLATION

Ontario Public Health Organizational Standards

RELATED POLICIES

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