AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2017 June 15

MISSION – MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Maureen Cassidy
Mr. Michael Clarke
Ms. Patricia Fulton
Mr. Jesse Helmer (Chair)
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden (Vice-Chair)

SECRETARY-TREASURER

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

Board of Health meeting, May 18, 2017.

DELEGATIONS

7:05 – 7:15 p.m.	Mr. John Millson, Associate Director, Finance and Mr. Ian Jeffreys, Partner, KPMG re: Item #3, 2016 Draft Financial Statements
7:15 – 7:25 p.m.	Mr. Jesse Helmer, Vice-Chair, Finance & Facilities Committee, re: Item #1, FFC meeting update, June 8, 2017.
	Receive: May 18, 2017, May 19, 2017 and June 8, 2017 Finance & Facilities Committee meeting minutes
7:25 – 7:35	Mr. Trevor Hunter, Chair, Governance Committee re: Item #2 Governance Committee Meeting, June 15, 2017 (verbal update).
	Receive: April 20, 2017 Governance Committee meeting minutes

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance & Facilities Committee Meeting June 8, 2017 (Report No. 031-17)	Agenda: June 8, 2017 Minutes: June 8, 2017	x	x		To receive a verbal update from the June 8, 2017 Finance & Facilities Committee (FFC) meeting.
2	Governance Committee Meeting June 15, 2017 (Verbal Update)	Agenda: June 15, 2017	x	x		To receive a verbal update from the June 15, 2017 Governance Committee (GC) meeting.
Delegation and Recommendation Reports						
3	2016 Draft Financial Statements (Report No. 032-17)	Appendix A Appendix B	x	x		To approve the audited Financial Statements for the Middlesex-London Health Unit.
4	Smoke-Free Clauses in the Standard Lease Under the Residential Tenancies Act (RTA) (Report No. 033-17)	Appendix A Appendix B		x		To communicate support for the inclusion of smoke-free clauses in the standard lease under the RTA and direct staff to participate in a consultation process to inform regulatory changes to increase the availability and enforceability of smoke-free clauses within tenancy agreements.
Information Reports						
5	Summary Information Report, June 2017 (Report No. 034-17)				x	To provide an update on Health Unit programs and services for June 2017.
6	Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, June 2017 (Report No. 035-17)				x	To provide an update on the activities of the Acting MOH / Acting CEO for June 2017.

OTHER BUSINESS

- Next Finance & Facilities Committee meeting: July 6, 2017 @ 9:00 a.m.
- Next Board of Health meeting: July 20, 2017 @ 7:00 p.m.
- Next Governance Committee meeting: September 21, 2017 @ 6:00 p.m.

CORRESPONDENCE

a) Date: 2017 May 1
Topic: a1) OPHS Modernization
a2) Low-Income Dental Program for Adults and Seniors
From: Porcupine Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
The Porcupine Health Unit passed resolutions regarding Ontario Public Health Standards Modernization and Low-Income Dental Programs for Adults and Seniors.
Board

The Middlesex-London Board of Health approved a motion to submit feedback to the Ministry of Health and Long-Term Care regarding the Ontario Public Health Modernization at its meeting in May.

The Board also passed a motion at the January 2014 meeting to send a letter to the Minister of Health and Long-Term Care and local Members of Provincial Parliament, copied to the Association of Local Public Health Agencies and all Ontario Boards of Health to advocate for a program that provides both publicly-funded dental treatment and prevention to low-income adults, including seniors.

Recommendation:
Receive

b) Date: 2017 May 2
Topic: Tobacco Endgame Strategies
From: Peterborough Public Health
To: The Honourable Dr. Jane Philpott and The Honourable Dr. Eric Hoskins

Background:
Peterborough Public Health endorsed a motion passed by Simcoe Muskoka District Health Unit (SMDHU) to support the federal government's proposal to have less than 5% of people using tobacco by 2035. This proposal includes approaches that were identified at the 2016 summit, A Tobacco End Game. SMDHU also included a motion to encourage alignment of the Smoke Free Ontario Strategy with federal plans. The tobacco end game approach includes enhance taxation, enhanced smoking cessation, reduction in the production, supply and distribution of tobacco, litigation, and new funding streams for tobacco control.

Recommendation:
Receive

c) Date: 2017 May 2
Topic: Regulations to restrict the sale of caffeinated energy drinks to children and youth
From: Sudbury & District Health Unit
To: The Honourable Jane Philpott

Background:
The Sudbury and District Health Unit passed a resolution urging provincial and federal Ministers of Health to advance regulation prohibiting the sale of caffeinated energy drinks to children and youth under the age of majority in venues where they frequent.

Recommendation:
Receive

d) Date: 2017 May 4
Topic: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Personal Service Settings Under the HPPA
From: Grey Bruce Health Unit
To: The Honourable Kathleen Wynne

Background:
The Grey Bruce Health Unit supports a previous Wellington-Dufferin Guelph recommendation that the Government of Ontario enact legislation to support inspection and enforcement activities within personal services settings.

Recommendation:
Receive

e) Date: 2017 May 5
Topic: Stop Marketing to Kids Coalition's Ottawa's Principles and Further Action On Sugary Drinks
From: Peterborough Public Health
To: The Honourable Dr. Jane Philpott

Background:
At the February 2017 Middlesex-London Board of Health meeting, the Board of Health endorsed a motion to communicate support for STOP M2K's Ottawa Principles by sending Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks, and its appendices to other Boards of Health in Ontario.

Peterborough Public Health endorsed correspondence from the Middlesex-London Health Unit regarding the Marketing to Kids Coalition's Ottawa Principles, and Further Action on Sugary Drinks

Recommendation:
Receive

f) Date: 2017 May 3 – rec'd May 5, 2017
Topic: Human Papillomavirus (HPV) Catch-up for Boys
From: Wellington Dufferin Guelph Public Health
To: The Honourable Dr. Eric Hoskins

Background:
Wellington Dufferin Guelph Public Health submitted correspondence to the Ontario Minister of Health to implement a publicly-funded human papillomavirus (HPV) immunization program for boys. The program was most recently expanded to Grade 8 boys beginning in the 2016-17 school year.

Recommendation:
Receive

g) Date: 2017 May 3 – rec'd may 5, 2017
Topic: Provincial Alcohol Strategy
From: Wellington Dufferin Guelph Public Health
To: The Honourable Dr. Eric Hoskins

Background:
Wellington Dufferin Guelph Public Health submitted correspondence to the Ontario Minister of Health to develop a comprehensive, province-wide strategy to support the safe consumption of alcohol.

At the July 2016 Middlesex-London Board of Health meeting, the Board received a report regarding the Middlesex-London Community Drug and Alcohol Strategy which also addressed this issue.

Recommendation:
Receive

h) Date: May 10, 2017
Topic: Report - Alcohol in Our Communities: A Report on Alcohol Use in Northwestern Ontario
From: Northwestern Health Unit
To: Boards of Health, MOH and Senior PH Directors and Managers

Background:
The Northwest Health Unit approved a resolution to receive the report, titled Alcohol in *Our Communities: A Report on Alcohol Use in Northwestern Ontario* and that it be shared with regional and local agencies, and provincial and federal ministries in order to allow for informed decision making and planning. The report suggests the need to focus on healthy public policy, education and skills development and creating supportive environments.

Recommendation:
Receive

i) Date: May 3, 2017 (rec'd May 5)
Topic: Fluoride Varnish Programs for Children at Risk for Dental Caries
From: Wellington-Dufferin-Guelph Public Health
To: alPHa and Board of Health Chairs

Background:

Wellington Dufferin Guelph Public Health passed a motion to ask the Association of Local Public Health Agencies (alPHa) to petition the Ontario Government to provide funding for fluoride varnish programs through Healthy Smiles Ontario for implementation in school and community-based programs and to urge other Boards of Health to conduct this treatment if not already underway.

The Middlesex-London Health Unit currently provides fluoride varnish on our community.

Recommendation:

Receive

j) Date: May 3, 2017
Topic: HBHC Program Targets and Funding
From: Wellington-Dufferin-Guelph Public Health
To: The Honourable Michael Coteau

Background:

Wellington Dufferin Guelph Public Health passed a motion to advocate to the Ministry of Children and Youth Services to commit to aligning program service delivery expectations for Healthy Babies Healthy Children with the annual budget and that it be fully funded for all program costs, including staffing, operation, administration and annual increases in costs to deliver services.

Recommendation:

Receive

k) Date: May 5, 2017
Topic: Local Poverty Reduction Fund
From: alPHa
To: all Health Units

Background:

alPHa offered congratulation to the Middlesex-London Health Unit and Sudbury and District Health Unit for previous successful applications to the Local Poverty Reduction Fund and announced the next round of funding. Funding is available for projects that tackle food security, homelessness, and indigenous-led projects. Other announcements included the development of Ontario's first Food Security Strategy, Basic Income Pilot and the 2016 Annual Report.

Recommendation:

Receive.

l) Date: May 2, 2017 (rec'd May 16, 2017)
Topic: Opioid Strategies
From: Algoma Public Health
To: Minister Dr. Eric Hoskins

Background:

Algoma Public Health passed a resolution regarding the provincial and federal opioid strategies. This endorsed a previous resolution from the Sudbury & District Health Unit. The resolution congratulates the Ontario Minister of Health and Long-Term Care and Chief Medical Officer on signing a joint statement of action committing to address the burden of opioid-related harms and the provincial opioid strategy. It also requested that plans be developed with targets, deliverables and timelines that are communicated to stakeholders such as Board of Health. They further requested that the Federal Minister of Heath to communicate and promptly implement the federal opioid strategy.

Recommendation:

Receive.

m) Date: May 15, 2017 (rec'd May 19)
Topic: Marijuana controls under Bill 178, Smoke-Free Ontario Act, 2016
From: Elgin St. Thomas Public Health
To: The Honourable Dr. Eric Hoskins

Background:

Elgin St. Thomas Public Health drafted correspondence to the Ontario Minister of Health regarding the inclusion of marijuana under Bill 178, Smoke-Free Ontario Act and supports the positions of Simcoe Muskoka District and Windsor-Essex County Health Units recommending an amendment to include marijuana as a prescribed substance.

Recommendation:

Receive

n) Date: May 24, 2017
Topic: South West CCAC and South West LHIN amalgamation
From: Michael Barrette, CEO South West LHIN
To: Health Service Provider Board Chairs, CEOs/EDs and System Partners

Background:

As of May 24, the South West Community Care Access Centre and the Souh West Local Health Integration Network are now one organization: the South West LHIN. This communication included a Q&A document, appropriate contacts and next steps to occur in the transition.

Recommendation:

Receive.

o) Date: May 15, 2017
Topic: Next Steps, Modernization of OPH Standards
From: Roselle Martino, Assistant Deputy Minister, MOHLTC
To: Board Chairs, Medical Officers of Health, and Chief Executive Officers

Background:

The Ministry of Health and Long-Term Care sent correspondence regarding the next steps in the Ontario Public Health Standards Modernization process. They are now reviewing the submissions from Boards of Health and will be working on protocols, guidelines and indicators, establishing a Standards Implementation Task Force, reviewing an Accountability Framework and draft proposed organizational requirements, establishing an Accountability Implementation Task Force and lastly, holding a series of summits in Toronto.

The Accountability Framework, draft organizational requirements and a summary of the feedback received at the consultations sessions were also attached.

Recommendation:

Receive.

p) Date: May 29, 2017
Topic: Association of Local Public Health Agencies current and incoming presidents
From: Association of Local Public Health Agencies
To: Board of Health Members

Background:

The alPHa Board of Directors announced Linda Stewart, Executive Director of alPHa, will be retiring effective November 4, 2017. Looking ahead, a search committee has been established for the purposes of finding a successor before Linda retires.

Recommendation:

Receive.

q) Date: May 30, 2017
Topic: Energy Drinks
From: Association of Local Public Health Agencies
To: Board of Health, Medical Officer of Health & Chair of the Board of Health

Background:

Correspondence was submitted to alPHa by Jim Shepherd, a father who lost his son due to an unexplained arrhythmic event which followed the consumption of an energy drink. A report was submitted with this correspondence detailing measures that boards of health can take to mitigate risks to children. These include banning sale to those under the age of 19, regulations of advertising to minors, and fostering awareness and education programs.

Recommendation:

Receive.

r) Date: June 1, 2017
Topic: Municipal Levy
From: Leeds, Grenville, Lanark District Health Unit
To: The Honourable Eric Hoskins, all Health Units

Background:

The Health Protection and Promotion Act stipulates that municipalities must decide how to apportion the municipal component of the expenses of the Board of Health among obligated municipalities. All of the obligated municipalities will have to agree with this change before it can be implemented according to the Health Protection and Promotion Act, and Ontario Regulation 489/97. The Leeds, Grenville & Lanark District Health Unit is seeking guidance from the Ministry of Health and Long-Term Care on whether to use Municipal Property Assessment Corporations Ontario Population Report or the most recent census data from Statistics Canada.

Recommendation:

Receive.

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

CONFIDENTIAL

The Board of Health will move in-camera to discuss matters regarding identifiable individuals, employee negotiations, a proposed or pending acquisition of land by the Middlesex-London Board of Health and to consider minutes from the May 18, 19, and June 8, 2017 Finance and Facilities Committee meeting and its May 18, 2017 Board of Health meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, May 18, 2017 7:00 p.m.

MEMBERS PRESENT:
Ms. Maureen Cassidy
Mr. Michael Clarke
Ms. Patricia Fulton
Mr. Jesse Helmer (Chair)
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden (Vice-Chair)

OTHERS PRESENT:
Ms. Laura Di Cesare, Secretary-Treasurer
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder)
Ms. Shaya Dhinsa, Manager, Sexual Health
Ms. Laura Dueck, Public Health Nurse, BFI Lead
Mr. Dan Flaherty, Communications Manager
Ms. Tracey Gordon, Manager, Reproductive Health Team
Ms. Shannon Hunt, Public Health Nurse, Reproductive Health Team
Ms. Donna Kosmack, Manager, South West Tobacco Control Area Network
Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Ms. Heather Lokko, Manager, Healthy Start
Mr. John Millson, Associate Director, Finance
Ms. Debbie Shugar, Manager, Screening, Assessment and Intervention
Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Director, Healthy Living

Chair Helmer called the meeting to order at 7:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Helmer inquired if there were any disclosures of pecuniary interest. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Vanderheyden, seconded by Mr. Smith, *that the **AGENDA** for the May 18, 2017 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that the **MINUTES** of the April 20, 2017 Board of Health meeting be approved.*

Carried

DELEGATIONS

Ms. Laura Dueck, Public Health Nurse, Baby Friendly Initiative Lead, provided an update and background on the implementation of the Baby-Friendly Initiative at the Middlesex-London Health Unit, outlining the requirements as they relate to the BFI policy, Board membership and questions about the policy.

Discussion ensued about demand and access to services for breastfeeding and post-partum care, as well as support and clarification of support provided to mothers who are unable to breastfeed.

Baby-Friendly Initiative Update and Annual Board of Health Orientation (Report No. 026-17)

It was moved by Mr. Clarke, seconded by Ms. Vanderheyden, *that the Board of Health receive Report No. 026-17 re: Baby-Friendly Initiative Update for information.*

Carried

COMMITTEE REPORTS

1) Finance & Facilities Committee (FFC) Meeting, May 4, 2017 (Report No. 025-17)

Ms. Fulton made note of an amendment to the May 4, 2017 FFC meeting minutes on page 2, where program targets are discussed. The answer was the reverse of the minutes: program targets are set based on program capacity, rather than on best practices, as indicated in the minutes. The May 4 minutes will be adjusted accordingly.

It was moved by Ms. Fulton, seconded by Mr. Peer, *that the Board of Health receive the minutes from the May 4, 2017 Finance & Facilities Committee meeting as amended.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Peer, *that the Board of Health write a letter to Minister Michael Coteau advocating for increased Preschool Speech and Language funding to avoid reduced services and longer wait times.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that the Board of Health close the Family Health Clinic as of June 30, 2017, as outlined in Report No. 022-17FFC.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Smith, *that the Board of Health:*

1) *Review the 2017–18 Transfer Payment Agreement (attached as Appendix A to Report No. 015-17FFC) and authorize the Board Chair to sign the agreement; and*
2) *Increase the 2017–18 Shared Library Services Partnership (SLSP) operating budget by $4,210.75 to reflect the increased grant amount.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Peer, *that the Board of Health:*

1) *Receive Report No. 016-17FFC for information; and*
2) *Recommend that the Board Chair sign Amending Agreement No. 6 to the Public Health Funding and Accountability Agreement as appended.*

Carried

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden, *that the Board of Health:*

1) *Authorize the Board Chair to sign the Contribution Agreement when it is received; and*

2) *Approve the revision of the 2017 operating budget to include $82,924 in one-hundred-percent funding received from the Public Health Agency of Canada to help address the high-risk injection drug use in Middlesex-London, as outlined in Appendix A.*

Carried

Discussion ensued about coordination of activities between all agencies that will be receiving funding from the shared grant.

Ms. Shaya Dhinsa answered questions about the coordination of work with other agencies that are receiving funds, such as the Regional HIV/AIDS Connection (RHAC) and the London InterCommunity Health Centre (LIHC). Ms. Dhinsa explained how these agencies with work with MLHU to address gaps, coordinate outreach work and sit together at the HIV leadership table.

It was moved by Ms. Fulton, seconded by Ms. Cassidy, *that the Board of Health approve the renewal of the group insurance rates administered by Great-West Life as described in Report No. 018-17FFC.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that the Board of Health receive the verbal Dental Clinic report for information.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Peer, *that the Board of Health increase the Board member compensation rate for a half-day meeting to $151.49 retroactively to January 1, 2017.*

Carried

It was moved by Ms. Fulton, seconded by Ms. Cassidy, *that the Board of Health receive Report No. 020-17FFC re: Q1 Financial Update and Factual Certificate for information.*

Carried

Ms. Fulton informed the Board of Health that the FFC reviewed Report No. 021-17FFC, which included governance policies for the Committee's feedback. Staff will forward this feedback to the Governance Committee.

The FFC will resume its confidential meeting regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health tomorrow at 10:45 a.m. All Board members are welcome to attend.

The next regularly scheduled FFC meeting will be on Thursday, June 8, 2017, at 10:00 a.m.

Ms. Fulton mentioned that the Auditor's report, which would normally come to FFC, will come directly to the June 15, 2017 Board of Health meeting, since the Auditor is unable to attend the rescheduled FFC meeting.

DELEGATION AND RECOMMENDATION REPORTS

3) Enhancing Harm-Reduction Services to Increase Access to Clean Needles and Other Supplies (Report No. 027-17)

Discussion ensued on the following items:

- Clarification of the report's purpose, and whether RHAC is following the best practices.
- Dr. Hovhannisyan trusts that RHAC follows the best practices, namely provincially recognized sites for harm reduction and piloting various products for harm reduction.
- There are still gaps and unsafe injection practices happening across the city.
- What does and does not work in addressing safe injection and harm reduction for people who inject drugs.

- London has a high rate of daily injectors; the official number may in fact be low, given what we know about what's happening in terms of injection drug use.

It was moved by Mr. Meyer, seconded by Mr. Clarke, *that the Board of Health:*

1) *Receive Report No. 027-17 re: Enhancing Harm Reduction Services to Increase Access to Clean Needles and Other Supplies for information; and*
2) *Endorse the Regional HIV/AIDS Connection (RHAC) funding submission to the AIDS Bureau, Ministry of Health and Long-Term Care (MOHLTC), to request additional support to enhance harm-reduction services and direct staff to forward the endorsement to the MOHLTC.*

Carried

INFORMATION REPORTS

4) Summary Information Report, May 2017 (Report No. 028-17)

It was moved by Mr. Smith, seconded by Mr. Hunter, *that the Board of Health receive Report No. 028-17 re: Summary Information Report, May 2017 for information.*

Carried

Ms. Heather Lokko answered questions. Discussion ensued on the length of the current wait list.

5) Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, May 2017 (Report No. 029-17)

Ms. Vanderheyden thanked staff for attending Middlesex Municipal Day in April.

It was moved by Mr. Smith, seconded by Mr. Hunter, *that the Board of Health receive Report No. 029-17 re: Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, May 2017.*

Carried

OTHER BUSINESS

Next meetings:

- Next Finance & Facilities Committee meetings:
  - Friday, May 19, at 10:45 a.m.
  - Thursday, June 8, 2017, at 10:00 a.m.
- Next Board of Health meeting: Thursday, June 15, 2017, at 7:00 p.m.
- Next Governance Committee meeting: Thursday, June 15, 2017, at 6:00 p.m.

CORRESPONDENCE

It was moved by Mr. Clarke, seconded by Ms. Fulton, *that the Board of Health receive items a) through c) and e) through n).*

Carried

It was moved by Mr. Clarke, seconded by Ms. Fulton, *that the Board of Health endorse item d).*

Carried

CONFIDENTIAL

At 7:57 p.m., Chair Helmer invited a motion to move in-camera to discuss matters regarding labour negotiations, identifiable individuals, and to consider confidential minutes from its April 20 meeting and May 4 Finance & Facilities Committee meeting.

At 7:58 p.m., it was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health move in-camera to discuss matters regarding labour relations and employee negotiations, identifiable individuals, and to consider confidential minutes from its April 20 meeting and May 4 Finance & Facilities Committee meeting.*

Carried

At 7:58 p.m., all visitors and Health Unit staff except for Ms. Laura Di Cesare, Dr. Gayane Hovhannisyan, Ms. Elizabeth Milne, Mr. John Millson, Ms. Heather Lokko, Ms. Suzanne Vandervoort, Mr. Stephen Turner and Ms. Debbie Shugar left the meeting.

At 9:00 p.m., it was moved by Mr. Smith, seconded by Ms. Vanderheyden, *that the Board of Health rise and return to public session.*

Carried

At 9:00 p.m., the Board of Health returned to public session.

Chair Helmer reminded the Board about the upcoming Association of Local Public Health Agencies (alPHa) annual general meeting from June 11 to 13, and invited any Board members wishing to attend to contact Elizabeth Milne to register. Chair Helmer also directed Board members to contact Ms. Milne if they are interested in playing in the Health Unit's Annual Charity Golf Tournament on June 22, in support of the United Way of London & Middlesex.

ADJOURNMENT

At 9:01 p.m., it was moved by Ms. Vanderheyden, seconded by Mr. Smith, *that the meeting be adjourned.*

Carried

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JESSE HELMER
Chair

LAURA DI CESARE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street North, London
Middlesex-London Board of Health Boardroom
Thursday, May 18, 2017 9:30 a.m.

COMMITTEE MEMBERS PRESENT:
Ms. Patricia Fulton (Chair)
Mr. Jesse Helmer
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Joanne Vanderheyden

OTHERS PRESENT:
Ms. Maureen Cassidy, Board member
Mr. Michael Clarke, Board member
Mr. Trevor Hunter, Board member
Mr. Kurtis Smith, Board member
Ms. Laura Di Cesare, Secretary-Treasurer
Dr. Christopher Mackie, Medical Officer of Health & CEO
Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Mr. James Adas, Supervisor, Operations & Procurement
Mr. Jordan Banninga, Manager, Strategic Projects
Mr. John Millson, Associate Director, Finance
Ms. Tania Krysa, MTE Consultant
Mr. Carlos Henriquez, MTE Consultant
Mr. Guy Bellehumeur, GB Architect
Ms. Anne Classens, GB Architect
Mr. Alex Maehle, GB Architect
Mr. Don Bryant, Partner, McKenzie Lake

Chair Fulton called the meeting to order and welcomed those in attendance, making note that the purpose of the meeting was to discuss a proposed or pending acquisition of land by the Middlesex-London Board of Health. Chair Fulton invited a motion to move in-camera to begin the meeting.

CONFIDENTIAL

At 9:34 a.m., it was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee move in-camera to discuss matters regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

Disclosure of Conflicts of Interest were requested and declared in Confidential session.

At 4:42 p.m., it was moved by Mr. Helmer seconded by Mr. Peer *that the Finance & Facilities Committee return to public session.*

Carried

OTHER BUSINESS

The next Finance & Facilities Committee will be Friday May 19, 2017 to continue to discuss matters regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health.

ADJOURNMENT

It was moved by Mr. Helmer, seconded by Mr. Peer *that the Finance & Facilities Committee adjourn the meeting.*

Carried

At 4:42 p.m., Chair Fulton *adjourned the meeting*.

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TRISH FULTON
Chair, Finance & Facilities Committee

LAURA DI CESARE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street North, London
Middlesex-London Board of Health Boardroom
Thursday, May 19, 2017 10:45 a.m.

COMMITTEE MEMBERS PRESENT:
Ms. Patricia Fulton (Chair)
Mr. Jesse Helmer
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Joanne Vanderheyden

OTHERS PRESENT:
Ms. Maureen Cassidy, Board member
Mr. Michael Clarke, Board member
Mr. Trevor Hunter, Board member
Mr. Kurtis Smith, Board member
Ms. Laura Di Cesare, Secretary-Treasurer
Dr. Christopher Mackie, Medical Officer of Health & CEO
Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Mr. James Adas, Supervisor, Operations & Procurement
Mr. Jordan Banninga, Manager, Strategic Projects
Mr. John Millson, Associate Director, Finance
Ms. Tania Krysa, MTE Consultant
Mr. Richard Simms, KPMG
Mr. Igor Verechaka, KPMG

At 10:47 a.m., Chair Fulton called the meeting to order and advised that the Committee would go in-camera to discuss a proposed or pending acquisition of land by the Middlesex-London Board of Health.

Disclosure of conflict(s) of interest were requested and declared in-camera.

At 3:05 p.m., it was moved by Mr. Helmer seconded by Ms. Vanderheyden *that the Finance & Facilities Committee return to public session.*

Carried

ADJOURNMENT

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer *that the Finance & Facilities Committee adjourn the meeting.*

Carried

At 3:05 p.m., Chair Fulton *adjourned the meeting*.

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TRISH FULTON
Chair, Finance & Facilities Committee

LAURA DI CESARE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
MIDDLESEX-LONDON BOARD OF HEALTH
50 King Street, London
Middlesex-London Health Unit – Room 3A
2017 June 8, 10:00 a.m.

COMMITTEE MEMBERS PRESENT:	Mr. Jesse Helmer Mr. Marcel Meyer Mr. Ian Peer Ms. Joanne Vanderheyden
Regrets:	Ms. Trish Fulton
OTHERS PRESENT:	Mr. Michael Clarke, Board member Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Ms. Laura Di Cesare, Secretary-Treasurer Dr. Christopher Mackie, Medical Officer of Health Mr. Jordan Banninga, Manager, Strategic Projects Dr. Gayane Hovhannisyan, Acting Medical Officer of Health Mr. John Millson, Associate Director, Finance

At 10:00 a.m., Chair Helmer called the meeting to order and made note of the Committee's sympathies to Ms. Fulton regarding her regrets for the meeting.

DISCLOSURES OF CONFLICTS OF INTEREST

Chair Helmer inquired if there were any conflicts of interest. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Vanderheyden *that the AGENDA for the June 8, 2017 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the MINUTES of the May 4, 2017 Finance & Facilities Committee meeting be approved.*

Carried

It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the MINUTES of the May 18, 2017 Finance & Facilities Committee meeting be approved.*

Carried

It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the MINUTES of the May 19, 2017 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 2016 Reserve / Reserve Fund Balances (Report No. 024-17FFC)

Mr. Millson introduced the report and summarized Appendix A, appended to this report.

Discussion ensued about the balance for accumulated sick leave.

It was moved by Mr. Peer, seconded by Joanne, *that the Finance & Facilities Committee recommend that the Board of Health:*

1) *Approve a $55,914 drawdown from the Sick Leave Reserve Fund to fund the 2016 sick leave payments to eligible staff;*
2) *Receive the 2016–17 Reserve / Reserve Fund Overview (Appendix A) for information; and*
3) *Forward Report No. 024–17FFC re: 2016 Reserve / Reserve Fund Balances to the City of London and the County of Middlesex for information.*

Carried

4.2 Funding Apportionment (Report No. 025-17FFC)

Mr. Millson provided context to how the adjustments were made in funding apportionment.

The consideration of applying the funding apportionment to the nearest 1/4 percent was discussed. For future budgeting, incorporating census data into the budget could lead to making smaller adjustments to the funding by each partner rather than one large adjustment if the data requires it. It was noted that funding from municipalities has not increased since 2004 and any changes would need to be carefully considered and communicated through the budgeting process.

Ms. Di Cesare arrived at 10:09 a.m.

It was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee recommend that the Board of Health:*

1) *Maintain the current funding apportionment for municipally funded programs at 84% for the City of London and 16% for the County of Middlesex; and*
2) *Forward Report No. 025-17FFC re: Funding Apportionment to the Councils of the City of London and County of Middlesex for information.*

Carried

4.3 Pending Funding Contracts (Report No. 026-17FFC)

Mr. Millson drew the Committee's attention to the addition of Appendix D, regarding the receipt of funding for the London Community Consultation for Supervised Injection Services (SIS)

It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the Finance & Facilities Committee recommend to the Board of Health:*

1) *To authorize the Board Chair to sign the amended three year FoodNet agreement when it has been received from the Public Health Agency of Canada; and*
2) *That Report No. 026-17FFC, "Pending funding Contracts" be received for information.*

Carried

4.4 Governance Policies – Part II (Governance Policy Review Continued)

Mr. Banninga reviewed the policies brought forward for the Committee's consideration and review; some of which were those that staff made amendments to as per the direction of the Committee at the May 4th FFC meeting.

Policies G-180 (Financial Planning and Performance), G-210 (Investing), G-310 (Corporate Sponsorship), G-330 (Gifts and Honorariums), G-410 (Board Member Remuneration) and G-420 (Travel Reimbursement) were reviewed and discussed. Mr. Banninga walked the Committee through the changes made to each of these policies.

Mr. Meyer arrived at 10:25 a.m.

G-410 was sent to staff back for review around the conflict of interest piece.

It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the Finance & Facilities Committee approve and forward to the Governance Committee amendments to policies G-180, G-210, G-310, G-330 and G-420 and send policy G-410 back to staff for further review.*

Carried

OTHER BUSINESS

Next meeting: Thursday, July 6, 2017 at 9:00 a.m., Room 3A, 50 King Street, London

CONFIDENTIAL

At 10:29 a.m., it was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee move in-camera to discuss matters regarding identifiable individuals and a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

At 11:58 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the Finance & Facilities Committee return to public session.*

Carried

At 11:58 a.m. the Finance and Facilities Committee returned to public session.

ADJOURNMENT

It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the Finance & Facilities Committee adjourn the meeting.*

Carried

At 11:58 a.m., Chair Helmer *adjourned the meeting.*

_____ _____

JESSE HELMER
Vice-Chair, Finance & Facilities Committee

LAURA DI CESARE
Secretary-Treasurer

PUBLIC SESSION – MINUTES
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.

Committee Members Present:	**Mr. Trevor Hunter (Chair)** Mr. Ian Peer Mr. Kurtis Smith Mr. Jesse Helmer Ms. Maureen Cassidy
Others Present:	Mr. Michael Clarke, Board member Mr. Marcel Meyer, Board member Ms. Joanne Vanderheyden, Board member Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Vanessa Bell, Manager, Privacy and Occupational Health & Safety Ms. Laura Di Cesare, Director, Corporate Services Mr. Dan Flaherty, Communications Manager

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.

Mr. Clarke declared that he has a social relationship to Dr. Christopher Mackie, and advised the committee that it was being declared due to the nature of the agenda items re: 2016 Medical Officer of Health / CEO Performance Appraisal.

The Committee thanked Mr. Clarke for his declaration and Ms. Di Cesare advised that Mr. Clarke not join the Medical Officer of Health Performance Appraisal sub-committee for this reason, and remain cognisant of this declaration in future matters going forward.

APPROVAL OF AGENDA

Chair Hunter made note of some minor amendments to the Agenda which included:

- Item 4.2; a walk-on report (Request for Participation: Diversity Census Report No. 007-17GC)
- Item 4.3; a verbal update regarding a Board of Health candidate information meeting that the Governance Committee Chair, the Board of Health Chair and Ms. Di Cesare attended on April 3, 2017.

It was moved by Ms. Cassidy, seconded by Mr. Peer, *that the AGENDA for the April 20, 2017 Governance Committee meeting be approved as amended.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Smith, seconded by Mr. Peer, *that the MINUTES of the March 16, 2017 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Mr. Meyer arrived at 6:06 p.m.

4.1 Medical Officer of Health / CEO Performance Appraisal (Report No. 006-17GC)

Chair Hunter introduced and provided context to this report, outlining the recommendations and clarifying the composition of the sub-committee.

Ms. Di Cesare clarified that the Chair of the Board and the former Chair have been involved in the past.

Chair Hunter noted the completion date for the Performance Appraisal would be later than last time due to Dr. Mackie's currently leave.

It was moved by Mr. Helmer, seconded by Ms. Cassidy that the Governance Committee:

1) Receive Report No. 006-17GC; and
2) Form a sub-committee to initiate the performance appraisal process for the Medical Officer of Health and Chief Executive Officer.

Carried

The Medical Officer of Health / CEO Performance Appraisal sub-committee shall consist of:
Mr. Jesse Helmer, Mr. Trevor Hunter, Mr. Ian Peer and Mr. Marcel Meyer.

4.2 Request for Participation: Diversity Census (Report No. 007-17GC)

Mr. Banninga introduced and provided context to this walk-on report, highlighting that timelines are tight for the response period as data collection is to be completed by the end of May. All data gathering and reporting is confidential and anonymous.

Ms. Cassidy provided further context to this report and the request by the City of London to complete the census since she sits on the committee that initiated the census. The goal is to increase the participation of women and women of diverse backgrounds in municipal governance and on boards and commissions. The data collected will help to identify barriers that may prevent women and in particular women from diverse backgrounds from getting involved in boards and commissions.

Mr. Banninga advised of the two methods available to complete the survey: completing it on the paper copy and submitting to Elizabeth Milne by the end of the meeting, or completing the consent form to have a link sent from the City of London to complete the survey digitally.

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

1) *Receive Report 007-17GC for information; and*
2) *Recommends that Board of Health approve the circulation of the Diversity Census to Board of Health Members for completion.*

Carried

4.3 Verbal update re: Board of Health Candidate Meeting

Chair Hunter advised the Committee that on April 3, 2017, himself, Mr. Helmer and Ms. Di Cesare met with a candidate interested in applying to be a member of the Board of Health to provide information and discuss the application process for the Board of Health.

OTHER BUSINESS

5.1 Policy Review (Continued)

Chair Hunter made note of the policies that will be forwarded to the Finance and Facilities Committee for review and consideration. These will include policies: G-180, G-190, G-210, G-240, G-250. The policies for the Governance Committee's consideration this evening will be: G-100, G-120 and G-260.

Policy G-100

Ms. Bell provided context to policy G-100, which articulates accountability to the board of health with respect to the health unit's roles and responsibilities regarding privacy and business confidential information, including how it relates to the Board of Health. Ms. Bell made note of the openness and accountability measures that the Board of Health should be aware of, clarified that the Medical Officer of Health is the designated health information custodian and drew attention to the addition of an annual Confidentiality Attestation for Board of Health members.

Ms. Vanderheyden arrived at 6:20 p.m.

Discussion ensued about the following items related to Policy G-100:

- Highlighting the new elements included in the policy that weren't previously part of the policy when it sat at the administration level.
- How requests from legal entities are handled.
- The broad definition of "confidential information" and a request to make the language more specific.

Mr. Flaherty arrived at 6:32 p.m.

Policy G-120

Mr. Banninga reviewed and provided a detailed overview of this new policy, outlining its framework which came from the Ontario Public Sector risk management framework, and its aim, which is to establish the responsibility of authorities to carry out risk management activities at the health unit.

Policy G-260

Mr. Banninga provided a brief summary of this policy, which outlines the Board of Health Accountability in Governance Structure.

Discussion ensued about the following items:

- The reporting and accountability of the Board of Health to the Health Unit and a wording change to reflect that the Board is not accountable to the Health Unit but rather responsible for. Staff will review wording and bring this back to the Committee.
- The use of this policy, as it is based on the philosophy of Mr. Graham Scott's Risk Management presentation.
- The additional revisions required for this policy, which include adding more specifics around governance principles and revising the Board of Health accountability statement.

The Committee will refer G-100 and G-260 back to staff for further revision and wording changes and recommend that the Board of Health approve policy G-120.

Mr. Hunter noted that policies G-180, G-190, G-210, G-240, G-250 will be forwarded to the Finance & Facilities Committee (FFC) for review. The committee had no comments on these policies being sent to FFC.

It was moved by Ms. Cassidy, seconded by Mr. Helmer *that the Governance Committee recommend that the Board of Health approve policy G-120.*

Carried

5.2 Next Meeting: Thursday, June 15, 2017

ADJOURNMENT

At 6:53 p.m. it was moved by Ms. Cassidy, seconded by Mr. Helmer, *that the meeting be adjourned.*
Carried

_____ _____

TREVOR HUNTER
Chair

LAURA DI CESARE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 031-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 June 15

FINANCE AND FACILITIES COMMITTEE MEETING – JUNE 8

The Finance and Facilities Committee met at 10:00 a.m. on Thursday June 8, 2017.
A summary of the discussion can be found in the minutes.

The following reports were reviewed at the meeting and recommendations made:

Reports	Recommendations for Board of Health's Consideration and Information
2016 Reserve / Reserve Fund Balances **(Report No. 024-17FFC)**	It was moved by Mr. Peer, seconded by Joanne, *that the Finance & Facilities Committee recommend that the Board of Health:* *1) Approve a $55,914 drawdown from the Sick Leave Reserve Fund to fund the 2016 sick leave payments to eligible staff;* *2) Receive the 2016–17 Reserve / Reserve Fund Overview (Appendix A) for information; and* *3) Forward Report No. 024–17FFC re: 2016 Reserve / Reserve Fund Balances to the City of London and the County of Middlesex for information.* Carried
Funding Apportionment **(Report No. 025-17FFC)**	It was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee recommend that the Board of Health:* *1) Maintain the current funding apportionment for municipally funded programs at 84% for the City of London and 16% for the County of Middlesex; and* *2) Forward Report No. 025-17FFC re: Funding Apportionment to the Councils of the City of London and County of Middlesex for information.* Carried
Pending Funding Contracts **(Report No. 026-17FFC)**	It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the Finance & Facilities Committee recommend to the Board of Health:* *1) To authorize the Board Chair to sign the amended three year FoodNet agreement when it has been received from the Public Health Agency of Canada; and* *2) That Report No. 026-17FFC, "Pending funding Contracts" be received for information.* Carried
Governance Policies – Part II **(Governance Policy Review Continued)**	It was moved by Ms. Vanderheyden, seconded by Mr. Peer, *that the Finance & Facilities Committee approve and forward to the Governance Committee amendments to policies G-180, G-210, G-310, G-330 and G-420 and send policy G-410 back to staff for further review.* Carried

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

The next meeting will be Thursday July 6, 2017 at 9:00 a.m. in Room 3A, 50 King Street.

This report was submitted by the Office of the Medical Officer of Health.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 032-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 June 15

2016 DRAFT FINANCIAL STATEMENTS

Recommendation

It is recommended that the Board of Health review and approve the audited Financial Statements for the Middlesex-London Health Unit, December 31, 2016, as appended to Report No. 032-17.

Key Points

- The draft financial statements for the Middlesex-London Health Unit relating to the operating period January 1–December 31, 2016, are attached as Appendix A.
- Preparation of the financial statements is the responsibility of MHLU management. The financial statements have been prepared in compliance with legislation and in accordance with Canadian public sector accounting standards.
- A summary of significant accounting policies is provided in note 1 to the financial statements.

Financial Overview

This report provides an overview of the financial information found in both the Statement of Financial Position and the Statement of Operations. The Statement of Financial Position can be found on page 3 of the draft financial statements (Appendix A). The Health Unit has approximately $4.7 million in cash and near-cash financial assets to offset its $3.0 million in short-term financial liabilities and $2.2 million in long-term liabilities. As of December 31, 2016, these financial liabilities include the following:

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

1) $0.7 million in amounts owing to the Province of Ontario, the Government of Canada, The Corporation of the City of London and The Corporation of the County of Middlesex
2) $1.4 million in unpaid accounts payable and accrued liabilities
3) $0.9 million in accrued wages and benefits

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

4) $2.2 million in post-employment benefits

With regard to the $2.2 million in post-employment benefits liability, above, this is the estimated amount required to fund all future costs associated with providing post-retirement benefits. This liability is currently unfunded; however, each year an estimated amount required for the current year is included as part of the operating budget.

The non-financial assets, which total $1.6 million, include the net book value of the Health Unit's tangible capital assets, such as leasehold improvements and computer systems, and prepaid expenses.

The last amount listed on the Statement of Financial Position is the Health Unit's Accumulated Surplus. This represents the net financial and physical resources available to provide future services. The details of what makes up the balance can be found in the draft financial statements, page 14, note 7. The details of the reserve/reserve fund changes are discussed in Report No. 024-17FFC.

On page 4 of the draft financial statements is the Statement of Operations, which details the Health Unit's revenues and expenditures for 2016. As can be seen, the great majority of the total revenue of $35.5 million is comprised of $33.8 million (95.2%) in grant revenue from four sources: the Province of Ontario ($26.5 million, or 78.3 % of grant revenue), the Government of Canada ($0.3 million, or 0.9%), The Corporation of the City of London ($5.9 million, or 17.5%) and The Corporation of the County of Middlesex ($1.1 million, or 3.3%). The remaining $1.6 million (4.8% of total revenue) comes from program revenue, interest and other off-set revenues.

The revenues provided for expenditures of $35.8 million, which include a $0.7 million (1.8% of total expenditures) charge for amortization expense, which is the decreasing value of the tangible capital assets for 2016. Beginning on page 12, note 4 provides a schedule of changes to the tangible capital assets. The majority of the expenditures are salaries and benefits, which total $26.8 million (74.8%). The remaining $9.0 million (23.4%) consists of travel (0.9%), materials and supplies (3.5%), professional services (10.2%), rent and maintenance (4.6%), and other expenses (4.2%).

Audit Findings Report

KPMG's Audit Findings Report, is attached as Appendix B. A common practice in presenting the report is for the Auditor to meet in private with Committee members excluding the Chief Executive Officer, Chief Financial Officer and all other staff.

Mr. John Millson, Associate Director, Finance, and Mr. Ian Jeffreys, Partner, KPMG LLP, will be present at the June 15 Board of Health meeting to address any questions regarding this report.

This report was prepared by the Finance Team, Corporate Services Division.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

Appendix A to Report No. 032-17

DRAFT Financial Statements of

MIDDLESEX-LONDON HEALTH UNIT

Year ended December 31, 2016

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

DRAFT Financial Statements
Year ended December 31, 2016

Financial Statements

MIDDLESEX-LONDON HEALTH UNIT

DRAFT Financial Statements
Year ended December 31, 2016

Management's Responsibility for the Financial Statements

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

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

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.

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

Laura Di Cesare, CHRE
Acting Chief Executive Officer

John Millson, BA, CPA, CGA
Associate Director, Finance

Jesse Helmer, Chair
Board of Health

INDEPENDENT AUDITORS' REPORT

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

We have audited the accompanying financial statements of Middlesex-London Health Unit, which comprise the statement of financial position as at December 31, 2016, the statement of operations and accumulated surplus, change in net debt, and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Middlesex-London Health Unit as at December 31, 2016, and its results of operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

"DRAFT"

Chartered Professional Accountants, Licensed Public Accountants

June 2017

London, Canada

MIDDLESEX-LONDON HEALTH UNIT

DRAFT Statement of Financial Position
December 31, 2016, with comparative information for 2015

		2016		2015
Financial Assets				
Cash	$	4,064,906	$	3,466,669
Accounts receivable		382,687		328,393
Grants receivable		296,040		345,299
		4,743,633		4,140,361
Financial Liabilities				
Province of Ontario		424,192		374,343
Government of Canada		62,999		65,107
The Corporation of the City of London		165,108		44,039
The Corporation of the County of Middlesex		31,447		8,386
Accounts payable and accrued liabilities		1,437,193		1,690,772
Accrued wages and benefits		879,974		445,010
Vested sick leave liability (note 2(a))		52,209		106,859
Post-employment benefits liability (note 2(b))		2,183,200		1,997,000
		5,236,322		4,731,516
Net Debt		(492,689)		(591,155)
Non-Financial Assets				
Tangible capital assets (note 4)		1,421,408		1,794,019
Prepaid expenses		218,051		253,981
		1,639,459		2,048,000
Commitments (note 5)				
Contingencies (note 6)				
Accumulated Surplus (note 7)	$	1,146,770	$	1,456,845

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

MIDDLESEX-LONDON HEALTH UNIT

DRAFT Statement of Operations and Accumulated Surplus
Year ended December 31, 2016, with comparative information for 2015

	2016 Budget	2016	2015
Revenue:			
Grants:			
Ministry of Health and Long-Term Care	$ 20,830,062	$ 21,159,227	$ 21,706,723
Ministry of Children and Youth Services	5,296,275	5,333,109	5,482,649
Government of Canada	312,860	290,318	329,355
The Corporation of the City of London	6,095,059	5,929,950	6,051,020
The Corporation of the County of Middlesex	1,160,961	1,129,515	1,152,575
	33,695,217	33,842,119	34,722,322
Other:			
Property search fees	3,750	2,099	3,942
Family planning	285,000	221,849	244,934
Dental service fees	277,312	190,943	179,543
Investment income	20,000	7,869	9,814
Prenatal class income	8,140	13,890	4,595
Other income (note 8)	768,531	1,167,232	1,040,235
	1,362,733	1,603,882	1,483,063
Total Revenue	35,057,950	35,446,001	36,205,385
Expenditures:			
Salaries:			
Medical Officers of Health	520,750	529,401	484,297
Public Health Nurses	9,652,127	9,395,102	9,459,278
Public Health Inspectors	2,416,884	2,475,321	2,484,829
Administrative staff	3,569,348	3,578,692	3,579,006
Dental staff	957,251	891,434	935,894
Other salaries	3,369,657	4,041,711	3,563,337
	20,486,017	20,911,661	20,506,641
Other Operating:			
Benefits	5,826,901	5,833,725	5,935,086
Travel	457,507	334,097	380,106
Materials and supplies	1,251,605	1,256,066	1,384,167
Professional services	3,510,692	3,639,207	4,473,636
Rent and maintenance	1,583,671	1,643,440	1,624,139
Amortization expense	488,027	645,575	700,706
Other expenses (note 9)	1,203,530	1,492,305	1,371,298
	14,321,933	14,844,415	15,869,138
Total Expenditures	34,807,950	35,756,076	36,375,779
Annual surplus (deficit)	250,000	(310,075)	(170,394)
Accumulated surplus, beginning of year	1,456,845	1,456,845	1,627,239
Accumulated surplus, end of year	$ 1,706,845	$ 1,146,770	$ 1,456,845

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

MIDDLESEX-LONDON HEALTH UNIT

DRAFT Statement of Change in Net Debt

Year ended December 31, 2016, with comparative information for 2015

	2016	2015
Annual deficit	$ (310,075)	$ (170,394)
Acquisition of tangible capital assets, net	(272,964)	(533,700)
Amortization of tangible capital assets	645,575	700,706
	62,536	(3,388)
Acquisition of prepaid expenses	(218,051)	(253,981)
Use of prepaid expenses	253,981	182,991
	35,930	(70,990)
Change in net debt	98,466	(74,378)
Net debt, beginning of year	(591,155)	(516,777)
Net debt, end of year	$ (492,689)	$ (591,155)

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

MIDDLESEX-LONDON HEALTH UNIT

DRAFT Statement of Cash Flows

December 31, 2016, with comparative information for 2015

	2016	2015
Cash provided by (used in):		
Operating activities:		
Annual deficit	$ (310,075)	$ (170,394)
Items not involving cash:		
Amortization	645,575	700,706
Change in employee benefits and other liabilities	131,550	107,458
Changes in non-cash assets and liabilities:		
Accounts receivable	(54,294)	42,237
Grants receivable	49,259	(746)
Prepaid expenses	35,930	(70,990)
Due to Province of Ontario	49,849	(73,046)
Due to Government of Canada	(2,108)	(33,574)
Due to The Corporation of the City of London	121,069	44,039
Due to The Corporation of the County of Middlesex	23,061	8,386
Accounts payable and accrued liabilities	(253,579)	484,764
Accrued wages and benefits	434,964	(460,114)
Net change in cash from operating activities	871,201	578,726
Capital activities:		
Cash used to acquire tangible capital assets	(272,964)	(533,700)
Net change in cash from capital activities	(272,964)	(533,700)
Net change in cash	598,237	45,026
Cash and cash equivalents, beginning of year	3,466,669	3,421,643
Cash and cash equivalents, end of year	$ 4,064,906	$ 3,466,669

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

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

1. Significant accounting policies:

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

(a) Basis of presentation:

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

Inter-departmental transactions and balances have been eliminated.

(b) Basis of accounting:

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

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

The operations of the Middlesex-London Health Unit are funded by government transfers from the Province of Ontario, The Corporation of the City of London and The Corporation of the County of Middlesex. Government transfers are recognized in the financial statements as revenue in the period in which events giving rise to the transfer occur, providing the transfers are authorized, any eligibility criteria have been met and reasonable estimates of the amounts can be made. Government transfers not received at year end are recorded as grants receivable due from the related funding organization in the statement of financial position.

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

1. Significant accounting policies (continued):

(c) Employee future benefits:

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

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

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

(d) Non-financial assets:

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

(i) Tangible capital assets

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

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

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

1. Significant accounting policies (continued):

(d) Non-financial assets (continued):

(ii) Contributions of tangible capital assets

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

(iii) Leased tangible capital assets

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

(e) Use of estimates:

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

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

Actual results could differ from these estimates.

2. Employee future benefits:

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

(a) Vested sick leave liability:

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

The liability for these accumulated days, to the extent that they have vested and could be taken in cash by an employee on termination, amounted to $52,209 (2015 - $106,859) at the end of the year.

A reserve of $82,032 has been established to meet future commitments for this liability.

(b) Post-retirement benefits liability:

The Middlesex-London Health Unit pays certain life insurance benefits on behalf of the retired employees as well as extended health and dental benefits for early retirees to age sixty-five. The Middlesex-London Health Unit recognizes these post-retirement costs in the period in which the employees render services. The most recent actuarial valuation was performed as at December 31, 2014.

	2016	2015
Accrued employee future benefit obligations	$ 2,644,600	$ 2,503,000
Unamortized net actuarial loss	(461,400)	(506,000)
Employee future benefits liability as of December 31	$ 2,183,200	$ 1,997,000

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

	2016	2015
Current year benefit cost	$ 174,800	$ 157,600
Interest on accrued benefit obligation	85,100	88,300
Amortization of net actuarial loss	44,600	35,200
Total benefit cost	$ 304,500	$ 281,100

Benefits paid during the year were $118,300 (2015 - $124,100).

2. Employee future benefits (continued):

(b) Post-retirement benefits liability (continued):

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

(i) Discount rate:

The obligation as at December 31, 2016, of the present value of future liabilities and the expense for the year ended December 31, 2016, are determined using a discount rate of 3.25% (2015 – 3.25%).

(ii) Medical costs:

Prescription drug costs are assumed to increase at the rate of 8% per year (2015 - 8%) declining to 4% per year over 20 years. Other Medical and Vision costs are assumed to increase at a rate of 4% per year, and 0% per year respectively.

(iii) Dental costs:

Dental costs are assumed to increase at the rate of 4% per year (2015 - 4%).

3. Pension agreement:

The Middlesex-London Health Unit contributes to the OMERS which is a multi-employer plan, on behalf of 314 members. The plan is a defined benefit plan which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay.

During 2016, the plan required employers to contribute 9.0% of employee earnings up to the year's maximum pensionable earnings and 14.6% thereafter. The Middlesex-London Health Unit contributed $1,974,638 (2015 - $1,992,186) to the OMERS pension plan on behalf of its employees during the year ended December 31, 2016.

4. Tangible Capital Assets:

Cost	Balance at December 31, 2015	Additions	Disposals / Transfers	Balance at December 31, 2016
Leasehold Improvements – 15 years	$ 2,672,872	$ -	$ (11,998)	$ 2,660,874
Leasehold Improvements – 5 years	181,668	3,609	(151,427)	33,850
Computer Systems	1,634,727	244,575	(569,823)	1,309,479
Motor Vehicle	5,385	-	-	5,385
Furniture & Equipment	1,991,359	36,778	(518,856)	1,509,281
Total	$ 6,486,011	$ 284,962	$ (1,252,104)	$ 5,518,869

Accumulated amortization	Balance at December 31, 2015	Amortization expense	Disposals / Transfers	Balance at December 31, 2016
Leasehold Improvements – 15 years	$ 2,170,637	$ 163,412	$ -	$ 2,334,049
Leasehold Improvements – 5 years	171,936	5,633	(151,427)	26,142
Computer Systems	1,012,461	278,782	(569,823)	721,420
Motor Vehicle	673	1,346	-	2,019
Furniture & Equipment	1,336,285	196,402	(518,856)	1,013,831
Total	$ 4,691,992	$ 645,575	$ (1,240,106)	$ 4,097,461

	Net book value December 31, 2015	Net book value December 31, 2016
Leasehold Improvements – 15 years	$ 502,235	$ 326,825
Leasehold Improvements – 5 years	9,732	7,708
Computer Systems	622,266	588,059
Motor Vehicle	4,712	3,366
Furniture & Equipment	655,074	495,450
Total	$ 1,794,019	$ 1,421,408

4. Tangible Capital Assets (continued):

Cost	Balance at December 31, 2014	Additions	Disposals / Transfers	Balance at December 31, 2015
Leasehold Improvements – 15 years	$ 2,643,847	$ 29,025	$ -	$ 2,672,872
Leasehold Improvements – 5 years	175,070	6,598	-	181,668
Computer Systems	1,520,047	384,427	(269,747)	1,634,727
Motor Vehicle	-	5,385	-	5,385
Furniture & Equipment	2,130,514	108,265	(247,420)	1,991,359
Total	$ 6,469,478	$ 533,700	$ (517,167)	$ 6,486,011

Accumulated amortization	Balance at December 31, 2014	Amortization expense	Disposals / Transfers	Balance at December 31, 2015
Leasehold Improvements – 15 years	$ 2,008,063	$ 162,574	$ -	$ 2,170,637
Leasehold Improvements – 5 years	153,815	18,121	-	171,936
Computer Systems	992,808	289,400	(269,747)	1,012,461
Motor Vehicle	-	673	-	673
Furniture & Equipment	1,353,767	229,938	(247,420)	1,336,285
Total	$ 4,508,453	$ 700,706	$ (517,167)	$ 4,691,992

	Net book value December 31, 2014	Net book value December 31, 2015
Leasehold Improvements – 15 years	$ 635,784	$ 502,235
Leasehold Improvements – 5 years	21,255	9,732
Computer Systems	527,239	622,266
Motor Vehicle	-	4,712
Furniture & Equipment	776,747	655,074
Total	$ 1,961,025	$ 1,794,019

During the year, the Middlesex-London Health Unit deemed to have disposed of fully amortized assets with a cost basis of $1,240,106 (2015 - $517,167).

5. Commitments:

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

Future minimum payments to expiry are as follows:

2017	$ 917,927
2018	911,800
2019	846,097
2020	780,394
2021	780,394

6. Contingencies:

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

7. Accumulated Surplus:

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

	2016	2015
Surpluses:		
Invested in tangible capital assets	$ 1,421,408	$ 1,794,019
Unfunded:		
Sick leave benefits	(52,209)	(106,859)
Post-employment benefits	(2,183,200)	(1,997,000)
Total Surplus	(814,001)	(309,840)
Reserves set aside by the Board:		
Accumulated sick leave	82,032	137,946
Funding stabilization	818,258	818,258
Employment Costs	176,077	176,077
Technology & Infrastructure	750,000	500,000
Environmental – septic tank	6,044	6,044
Dental Treatment reserve	128,360	128,360
Total reserves	1,960,771	1,766,685
Accumulated surplus	$ 1,146,770	$ 1,456,845

8. Other income:

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

	2016 Budget	2016 Actual	2015 Actual
Collaborative project revenues	$ 183,747	$ 372,520	$ 288,697
Food handler training	12,750	27,343	32,065
Public Fit-testing	15,000	16,528	8,124
Miscellaneous revenues	175,979	246,305	251,615
OHIP Revenue	59,130	237,420	89,755
Vaccine sales	321,925	266,345	356,787
Workshop fees	-	771	13,192
	$ 768,531	$ 1,167,232	$ 1,040,235

9. Other expenses:

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

	2016 Budget	2016 Actual	2015 Actual
Communications	$ 215,194	$ 221,283	$ 187,676
Health promotion/advertising	254,841	308,295	373,047
Miscellaneous expenses	250,626	457,211	387,005
Postage and courier	67,750	61,447	56,799
Printing	178,216	164,168	161,042
Staff development	236,903	279,901	205,729
	$ 1,203,530	$ 1,492,305	$ 1,371,298

10. Budget data:

The budget data presented in these financial statements is based upon the 2016 operating budgets approved by the Board of Health. Amortization was not contemplated on development of the budget and, as such, has not been included. The chart below reconciles the approved budget to the budget figures reported in these financial statements

Revenues:		
Operating budget	$	35,057,950
Expenses:		
Operating budget		34,319,923
Capital budget		488,027
Total expenses		34,807,950
Annual surplus, as budgeted	$	250,000

Appendix B to Report No. 032-17

KPMG

Middlesex-London Health Unit

Audit Findings Report
For the year ended December 31, 2016

KPMG LLP

Licensed Public Accountants

June 1, 2017

kpmg.ca/audit

The contacts at KPMG in connection with this report are:

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At KPMG, we are **passionate** about earning your **trust**. We take deep **personal accountability**, individually and as a team, to deliver **exceptional service and value** in all our dealings with you.

At the end of the day, we measure our success from the **only perspective that matters – yours**.

Executive summary

Purpose of this report*

The purpose of this Audit Findings Report is to assist you, as a member of the Finance and Facilities Committee, in your review of the results of our audit of the financial statements of the Middlesex-London Health Unit for the year ended December 31, 2016.

This Audit Findings Report builds on the Audit Plan that was provided to management.

Changes from the Audit Plan

There have been no significant changes regarding our audit from the Audit Planning Report previously provided.

Audit Materiality

Materiality has been determined based on total expenses. We have determined materiality to be $1,073,000 for the year ending December 31, 2016.

See page 5.

Audit risks and results

We identified at the start of the audit a significant financial reporting risk relating to the presumed fraud risk over management override of controls.

This risk has been addressed in our audit.

We have identified other areas of audit focus to discuss with you.

See pages 6-8.

Adjustments and differences

We did not identify differences that remain uncorrected.

We did not identify any adjustments that were communicated to management and subsequently corrected in the financial statements.

See page 9.

Executive summary

Finalizing the audit

As of May 17, 2017, we have completed the audit of the financial statements, with the exception of certain remaining procedures, which include amongst others:

- receipt of legal confirmations;
- completing our discussions with the Finance and Facilities Committee;
- obtaining evidence of the Board's approval of the financial statements;
- receipt of the signed management representation letter

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

Control and other observations

We did not identify any control deficiencies that we determined to be significant deficiencies in ICFR.

Significant accounting estimates

Overall, we are satisfied with the reasonability of critical accounting estimates.

- Management identifies all accounting estimates and establishes processes for making accounting estimates.
- There are no indicators of management bias as a result of our audit over estimates.
- Disclosure of estimation uncertainty in the financial statements is included in Note 1(e), Use of estimates. This note provides information on areas in the financial statements that include estimates.
- Management evaluates these estimates on a regular basis to ensure they are appropriate.

Independence

We are independent with respect to the Health Unit within the meaning of the relevant rules and related interpretations prescribed by the relevant professional bodies in Canada and any other standards or applicable legislation or regulation.

See Appendix 2.

Significant accounting policies and practices

There have been no initial selections of, or changes to, significant accounting policies and practices to bring to your attention.

Financial statement presentation and disclosure

The presentation and disclosure of the financial statements are, in all material respects, in accordance with the Health Unit's relevant financial reporting framework. The form, arrangement, and content of the financial statements is considered to be appropriate.

Materiality

Professional standards require us to re-assess materiality at the completion of our audit based on period-end results or new information in order to confirm whether the amount determined for planning purposes remains appropriate.

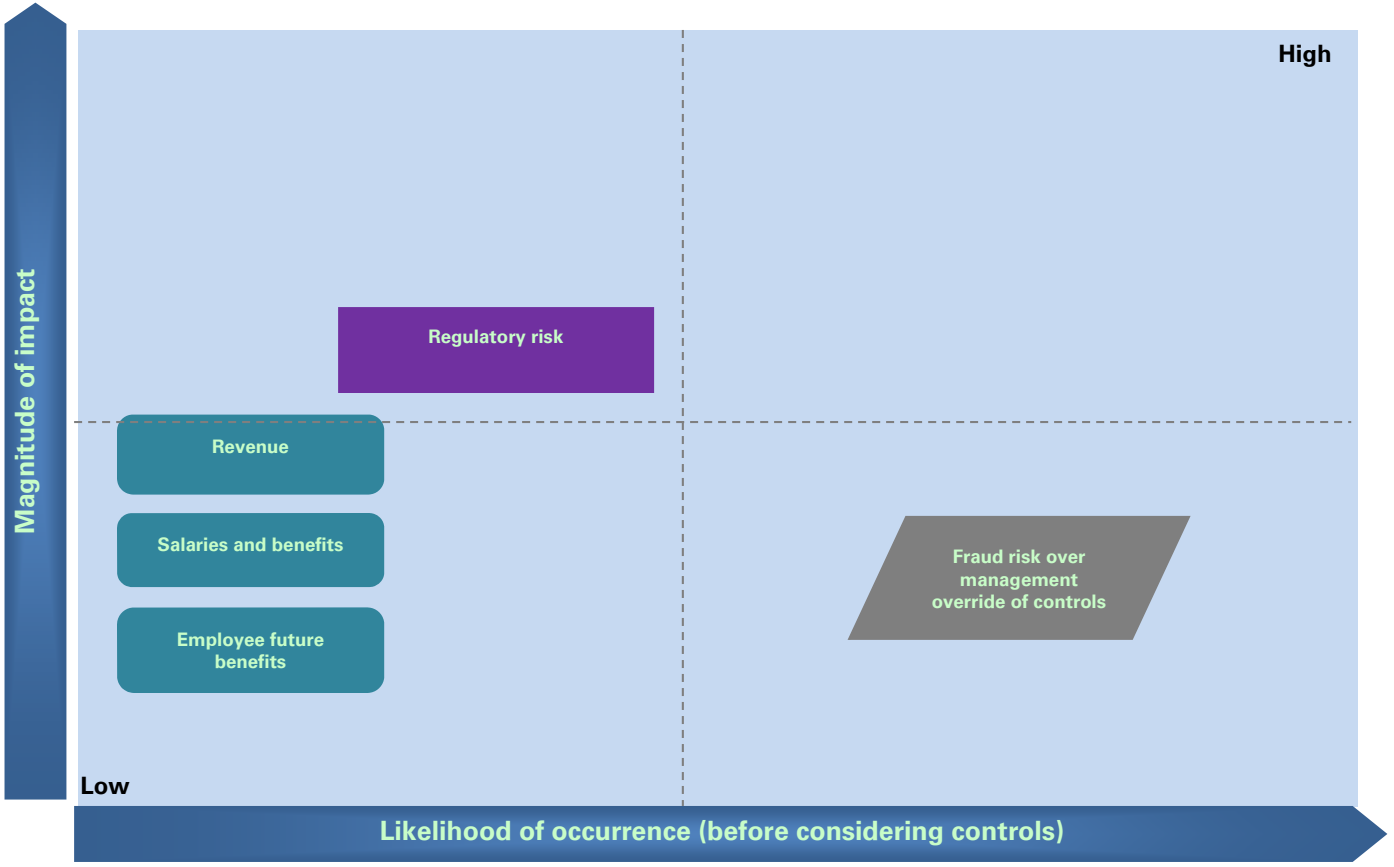
Our assessment of misstatements, if any, in amounts or disclosures at the completion of our audit will include the consideration of both quantitative and qualitative factors.

The determination of materiality requires professional judgment and is based on a combination of quantitative and qualitative assessments including the nature of account balances and financial statement disclosures.

Materiality determination	Comments	Amount
Metrics	Relevant metrics included total revenues, total expenses and net assets.	
Benchmark	Based on total expenses for the year. This benchmark is consistent with the prior year.	$35,756,078
Materiality	Determined to plan and perform the audit and to evaluate the effects of identified misstatements on the audit and of any uncorrected misstatements on the financial statements. The corresponding amount for the prior year's audit was $1,090,000.	$1,070,000
% of Benchmark	The corresponding percentage for the prior year's audit was 3%.	3%
Performance materiality	Used 75% of materiality, and used primarily to determine the nature, timing and extent of audit procedures. The corresponding amount for the prior year's audit was $817,500.	$802,500
Audit Misstatement Posting Threshold (AMPT)	Threshold used to accumulate misstatements identified during the audit. The corresponding amount for the previous year's audit was $54,500.	$53,500
Reclassification AMPT	Threshold used to accumulated reclassification misstatements. The corresponding amount for the previous year's audit was $218,000.	$214,000

Audit risks and results

This diagram is our top-down view of the financial reporting risks and their potential misstatement impact mapped against the likelihood of a misstatement occurring (before controls).



Audit risks and results

Inherent risk of material misstatement is the susceptibility of a balance or assertion to misstatement which could be material, individually or when aggregated with other misstatements, assuming that there are no related controls.

We highlight our findings in respect of significant financial reporting risks.

Significant financial reporting risks	Why	Our response and significant findings
Fraud risk from management override of controls	This is a presumed fraud risk. We have not identified any specific additional risks of management override relating to this audit.	• We selected and assessed a sample of journal entries recording as part of the year-end closing process. • We considered the appropriateness of estimates made by management in the preparation of the financial statements. *Our findings:* • No issues noted.

Audit risks and results

Our findings from the audit regarding other areas of focus are as follows:

Other areas of focus	Our response and significant findings
Revenue and deferred revenue	Substantive approach: • Substantive analytical procedures over Grants and Other revenues. • Agreed significant grants from all levels of government to funding agreements. • Obtained supporting documentation for significant deferred revenue balances at year-end. *Our findings:* • No issues noted.
Salaries and benefits	Substantive approach: • Substantive analytical procedures over salaries and benefits, including vouching new hires and terminations to supporting documentation. *Our findings:* • No issues noted.
Post-retirement benefits liability	Substantive approach: • Obtained copy of actuarial report directly from actuary. • Assessed the reasonableness of significant assumptions included in the valuation. • Reviewed financial statement disclosure relating to post-retirement benefits liability. *Our findings:* • No issues noted.

Adjustments and differences

Adjustments and differences identified during the audit have been categorized as “Corrected adjustments” or “Uncorrected differences”. These include disclosure adjustments and differences.

Professional standards require that we request of management and the audit committee that all identified differences be corrected. We have already made this request of management.

Corrected adjustments

We did not identify any adjustments that were communicated to management and subsequently corrected in the financial statements.

Uncorrected differences

We did not identify differences that remain uncorrected.

Appendices

Appendix 1: Required communications

In accordance with professional standards, there are a number of communications that are required during the course of and upon completion of our audit. These include:

- **Auditors' report** – the conclusion of our audit is set out in our draft auditors' report attached to the draft financial statements
- **Management representation letter** –In accordance with professional standards, copies of the management representation letter are provided to the Finance and Facilities Committee. The management representation letter is attached.

Appendix 2: Independence

KPMG maintains a system of quality control designed to reflect our drive and determination to deliver independent, unbiased advice and opinions, and also meet the requirements of Canadian professional standards.

We have prepared the following comments to facilitate our discussion with you regarding independence matters.

The following summarizes the professional services rendered by us to the Entity:

Description of professional services
Audit of the Middlesex-London Health Unit financial statements for the year ended December 31, 2016.
Audit of the schedule of revenue and expenditures of the Middlesex-London Health Unit for the year ended December 31, 2016.
Audit of the Middlesex-London Health Unit March 31st Programs consolidated financial statements for the year ended March 31, 2017.
Advisory assistance with respect to physical space needs.

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

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

Appendix 3: Audit Quality and Risk Management

KPMG maintains a system of quality control designed to reflect our drive and determination to deliver independent, unbiased advice and opinions, and also meet the requirements of Canadian professional standards.

Visit our Audit Quality Resources page for more information including access to our audit quality report, Audit quality: Our hands-on process.

Quality control is fundamental to our business and is the responsibility of every partner and employee. The following diagram summarises the six key elements of our quality control systems.

- Other controls include:
  - Before the firm issues its audit report, the Engagement Quality Control Reviewer reviews the appropriateness of key elements of publicly listed client audits.
  - Technical department and specialist resources provide real-time support to audit teams in the field.
- We conduct regular reviews of engagements and partners. Review teams are independent and the work of every audit partner is reviewed at least once every three years.
- We have policies and guidance to ensure that work performed by engagement personnel meets applicable professional standards, regulatory requirements and the firm's standards of quality.
- All KPMG partners and staff are required to act with integrity and objectivity and comply with applicable laws, regulations and professional standards at all times.

- We do not offer services that would impair our independence.
- The processes we employ to help retain and develop people include:
  - Assignment based on skills and experience;
  - Rotation of partners;
  - Performance evaluation;
  - Development and training; and
  - Appropriate supervision and coaching.
- We have policies and procedures for deciding whether to accept or continue a client relationship or to perform a specific engagement for that client.
- Existing audit relationships are reviewed annually and evaluated to identify instances where we should discontinue our professional association with the client.

kpmg.ca/audit

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 033-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 June 15

SMOKE-FREE CLAUSES IN THE STANDARD LEASE UNDER THE *RESIDENTIAL TENANCIES ACT*

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 033-17 re: Smoke-Free Clauses in the Standard Lease Under the Residential Tenancies Act (RTA);***
2) ***Communicate its support for the inclusion of smoke-free clauses in the Standard Lease under the RTA by sending a letter to the Honourable Chris Ballard, Minister of Housing/Minister Responsible for the Poverty Reduction Strategy;***
3) ***Forward Report No. 033-17 to Ontario Boards of Health and the Smoke-Free Housing Ontario Coalition to communicate its support for smoke-free housing policy measures; and***
4) ***Direct staff to participate in consultation processes to inform regulatory changes under the RTA to increase the availability and enforceability of smoke-free clauses within tenancy agreements.***

Key Points

- Second-hand smoke drifts between units in multi-unit housing complexes, and is especially harmful to children, the elderly, those who have chronic health problems and those who are pregnant.
- The current mechanism for enforcement of no-smoking clauses in lease agreements can be cumbersome, and has raised questions about the legality of these policies.
- The opportunity exists to prescribe smoke-free clause options by regulation in the proposed "prescribed form of tenancy agreement" (Standard Lease), under the RTA, to provide a consistent approach for the promotion and enforcement of smoke-free provisions within tenancy agreements.

Second-Hand Smoke Exposure in Rental Housing

Under the *Smoke-Free Ontario Act*, smoking is prohibited in any common area in a condominium, apartment building, or university or college residence, including elevators, hallways, parking garages, entertainment rooms, laundry facilities, lobbies and exercise areas. However, the *Act* does not prohibit smoking in private units, on balconies, or around the entrances to housing complexes. As a result, second-hand smoke exposure continues to be an issue for those living in multi-unit housing complexes. No matter how well built or maintained a building may be, second-hand smoke can seep through shared walls, ventilation systems, doors, windows, shared balconies and gaps around electrical outlets and plumbing.

While second-hand smoke exposure can cause a range of adverse health effects for anyone, it can be especially harmful to children, the elderly, those who suffer from chronic health problems and those who are pregnant. If a tenant is smoking in one unit and the smoke drifts into a neighbouring unit that is supposed to be smoke-free, often the only solution to reducing the unwanted exposure to second-hand smoke is to move and seek housing elsewhere. However, moving may not be feasible for those with disabilities, older adults and those with limited incomes. For those with greater choice and the means to move, smoke-free housing may still not be an option due to the lack of availability in Middlesex-London. Therefore, in 2015, the Board of Health endorsed the actions and priorities outlined by the Smoke-Free Housing Ontario Coalition,

attached as Appendix A, and directed staff to "encourage the Ontario Ministry of Housing to develop government policies and programs to facilitate the provision of smoke-free housing (Report 013-15)."

Enforceability of Smoke-Free Policies

No-smoking provisions within a multi-unit housing environment offer many benefits, including a healthier environment, reduced exposure to second-hand smoke, reduced risk of fire and lower cleaning and insurance costs. Therefore, smoke-free multi-unit housing should be made available for those who want it, and be offered in both the private and community/non-profit multi-unit housing markets. However, the current mechanism for enforcement of no-smoking policies can be cumbersome, and has raised questions about the legality of these policies. It is the responsibility of the landlord to ensure reasonable enjoyment for all tenants, and, if there is a breach, such as drifting second-hand smoke, there must be adequate data to demonstrate frequent and ongoing interference with normal use and enjoyment of the housing unit. According to case law analysis, although the majority of cases taken to the Landlord Tenant Board (LTB) have prevailed in favour of the landlord, LTB decisions are not bound by precedent and may not be pertinent to other situations that appear before the LTB. This means that even if a landlord follows the procedure to enforce a provision in the lease, there is no guarantee of success. If a no-smoking policy is created and cannot easily be enforced, the impact is felt by the landlord and by the tenants, who selected the housing unit based on the guarantee of a smoke-free home. Landlords and tenants desire assurance that smoke-free housing policies are enforceable.

Bill 124, the *Rental Fairness Act* and the Standard Lease

In March 2016, as part of its Long-Term Affordable Housing Strategy, the Ontario Government considered making amendments to the RTA to encourage the participation of small landlords and private homeowners in the rental housing market, while maintaining strong protections for tenants. The introduction of Bill 124, the *Rental Fairness Act*, enabled the Government to entertain amendments to the RTA to meet goals related to increasing availability and affordability of housing. During the public consultation process for Bill 124, the Smoke-Free Housing Ontario Coalition recommended that amendments be made to the RTA to enable landlords to terminate tenancy based on violations of no-smoking provisions in leases. Additionally, advice was provided that no-smoking provisions under the RTA should address smoking of all products, including tobacco, cannabis and shisha, and that the RTA should clearly define areas where no-smoking prohibitions can be prescribed to provide maximum tenant protection from second-hand smoke.

The Government chose not to include smoke-free clauses in the RTA; however, regulations under the RTA are now being developed. The opportunity exists to prescribe smoke-free clause options by regulation in the proposed "prescribed form of tenancy agreement" (Standard Lease). The Standard Lease would outline the agreement between the housing provider and the tenant, including the conditions under which occupancy can be terminated. The inclusion of smoke-free clause options to the Standard Lease would make it clear to landlords that they can include no-smoking clauses, and would provide a consistent approach for the promotion and enforcement of smoke-free provisions within tenancy agreements. It is recommended that the Board of Health communicate its support for the inclusion of smoke-free clauses in the Standard Lease by sending a letter (attached as Appendix B) to the Honourable Chris Ballard, Minister of Housing/Minister Responsible for the Poverty Reduction Strategy.

This report was prepared by the Chronic Disease Prevention and Tobacco Control Team, Environmental Health and Infectious Disease Division.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

This report addresses the following requirements of the Ontario Public Health Standards (revised May 2016): Foundations: Principles 1, 2; Comprehensive Tobacco Control: 1, 6, 7, 9.

SMOKE-FREE HOUSING ONTARIO

Appendix A to Report No. 033-17

February, 2015

Dear colleague,

Re: Act now to reduce the impact of second-hand smoke exposure in multi-unit housing in Ontario

As you are aware, tobacco use is the number one cause of preventable disease and death in Ontario. Every year, more than 13,000 people in Ontario die because of tobacco use – one person almost every 40 minutes. Tobacco is the only legal product that, when used as intended, kills half of its users prematurely. It can also kill others through involuntary exposure to second-hand smoke (SHS).

Approximately one third of Ontarians living in multi-unit housing (MUH) report regular exposure to SHS that originates in neighbouring units,and 80% of Ontarians would choose a smoke-free building if the choice existed.[1] However, many stakeholders in the housing sector erroneously believe that no-smoking policies are illegal, unenforceable or discriminatory and so many Ontarians continue to be involuntarily exposed to SHS in their home.

Studies have demonstrated that there is no safe level of exposure to SHS—all exposure is harmful and should be eliminated. According to the U.S. Department of Health and Human Services, exposure to SHS among children and adults causes a range of adverse health effects, including premature death and disease.[2] Second-hand smoke is a serious problem for many Ontario residents living in apartments and condominiums, especially those who suffer from chronic health conditions such as heart disease, asthma, allergies, diabetes, and respiratory illnesses. Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported. For many forced to breathe their neighbour's smoke, the only remedy is to move; however, moving is not always an option for people with disabilities, older adults or those with limited incomes. This is why we need to work toward making smoke-free housing in Ontario the norm, not the exception.

The 2010 Tobacco Strategy Advisory Group (TSAG) report[3] regarding Ontario's renewed Smoke-Free Ontario Strategy contains a number of recommendations pertaining to MUH. First and foremost, the report recommends continuing and intensifying a voluntary approach to smoke-free MUH. **The primary goals of the Smoke-Free Housing Ontario Coalition are to facilitate the adoption of no-smoking policies within the housing sector and to create a favourable environment to foster the adoption of those policies. We seek your endorsement in helping us achieve this end.**

Please submit a letter of endorsement of the Smoke-Free Housing Ontario Coalition to either of co-chairs Lorraine Fry at lfry@nsra-adnf.ca or Donna Kosmack at donna.kosmack@mlhu.on.ca. Endorsements are being compiled online the Smoke-Free Housing Ontario website.www.smokefreehousingon.ca. A sample statement of endorsement, and a space for your endorsement signature is attached.

Sincerely,

Lorraine Fry
Executive Director, Non-Smokers' Rights Association

Donna Kosmack
Manager, SW Tobacco Control Area Network

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1 Smoke-Free Housing Ontario. 80% of People Living in Apartments, Condos and Co-ops Want to Live Smoke Free. Press release 8 December 2011. http://www.newswire.ca/en/story/892061/80-of-people-living-in-apartments-condos-and-co-ops-want-to-live-smoke-free.

2 U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2006.

3 *Building on our Gains, Taking Action Now: Ontario's Tobacco Control Strategy for 2011-2016.* Report from the Tobacco Strategy Advisory Group to the Minister of Health Promotion and Sport, October 18, 2010. http://www.mhp.gov.on.ca/en/smoke-free/TSAG%20Report.pdf.

ENDORSEMENT OF ACTION FOR SMOKE-FREE MULTI-UNIT HOUSING

Tobacco use is the number one cause of preventable disease and death in Ontario. Leaders in public health units, local boards of health, non-governmental organizations and health charities in Ontario have a history of speaking out in favour of actions to reduce the harmful impact of tobacco use.

Whereas tobacco use is the leading cause of preventable death and disability in Canada, accounting for the deaths of approximately 13,000 people in Ontario alone each year;[4]

Whereas Second-hand smoke kills 1,000 Canadians annually.[5],[6]

Whereas Approximately one-third of Ontarians living in multi-unit housing (MUH) report regular exposure to second-hand smoke that originates in neighbouring units, and 80% would choose a smoke-free building if the choice existed.[7]

Whereas Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported.

Whereas Indoor air studies show that, depending on the age and construction of a building, up to 65% of the air in a private residence can come from elsewhere in the building[8] and no one should be unwilling exposed or forced to move due to unwanted second-hand smoke exposure.

Whereas second-hand smoke in multi-unit housing can lead to third-hand tobacco exposure as semi-volatile and volatile organic chemicals like nicotine and polycyclic aromatic hydrocarbons (carcinogens, also known as PAHs) are oily or waxy and more likely to stick to surfaces than be removed by ventilation.

Therefore be it resolved that the Middlesex-London Board of Health endorses the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

(1) Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;

(2) All future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;

(3) Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;

(4) All future public/social housing developments in Ontario should be smoke-free from the onset.

(5) Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

Ian Peer	Chair, Middlesex London Board of Health
Signatory Official (please print name and title)	Organization/Agency/Institution
Signature: Ian Peer	Date: March 19, 2015

[4] http://www.mhp.gov.on.ca/en/smoke-free/default.asp Accessed August 17 2010

[5] Health Canada, 2004. "Cigarette Smoke: It's Toxic." Second-hand Smoke: FAQs & Facts. 2004. www.hc-sc.gc.ca/hlvs/tobac-tabac/second/fact-fait/tox/index_e.html (Accessed Jan. 2006)

[6] Makomaski-Illing EM and Kaiserman MJ, 1999. Mortality attributable to tobacco use in Canada and its regions- 1998. *Canadian Journal of Public Health* 1999; 95(1):38-44. www.cpha.ca/shared/cjph/archives/abstr04.htm#38-44 (Accessed Dec. 2005)

[7] Smoke-Free Housing Ontario. 80% of People Living in Apartments, Condos and Co-ops Want to Live Smoke Free. Press release 8December 2011. http://www.newswire.ca/en/story/892061/80-of-people-living-in-apartments-condos-and-coops-want-to-live-smoke-free.

[8] "Second-hand smoke in Multi-Unit Dwellings." Non-Smokers' Rights Association (2011). Available from http://www.nsra-adnf.ca/cms/page1433.cfm.

Appendix B to Report No. 033-17

The Honourable Chris Ballard
Minister of Housing / Minister Responsible for the Poverty Reduction Strategy
17th Floor, 777 Bay Street
Toronto, Ontario, M5G 2E5

Dear Minister,

The Middlesex-London Board of Health applauds the Government of Ontario for considering possible amendments to the *Residential Tenancies Act, 2006* (RTA) to encourage the participation of small landlords and private homeowners in the rental housing market, while maintaining strong protections for tenants. The introduction of Bill 124, the *Rental Fairness Act*, enabled the Government to entertain amendments to the RTA to meet goals related to increasing the availability and the affordability of housing. Although Bill 124 does not include any amendments related to no-smoking provisions, the provision of smoke-free clause options in the proposed "prescribed form of tenancy agreement" (Standard Lease), created under Bill 124, warrants consideration.

At its June 15, 2017 meeting, the Middlesex London Board of Health considered Report No. 033-17 "**Smoke-Free Clauses in the Standard Lease Under the Residential Tenancies Act**" and voted to:

1. Receive Report No. 033-17 re: Smoke-Free Clauses in the Standard Lease Under the *Residential Tenancies Act* (RTA);
2. Communicate its support for the inclusion of smoke-free clauses in the Standard Lease under the RTA by sending a letter to the Honourable Chris Ballard, Minister of Housing/Minister Responsible for the Poverty Reduction Strategy;
3. Forward Report No. 033-17 to Ontario Boards of Health and the Smoke-Free Housing Ontario Coalition to communicate its support for smoke-free housing policy measures; and
4. Direct staff to participate in consultation processes to inform regulatory changes under the RTA to increase the availability and enforceability of smoke-free clauses within tenancy agreements.

According to an Ipsos Reid study conducted in 2010, when given a choice, 80% of multi-unit residents would choose a smoke-free building, and in 2011, data from the Rapid Risk Factor Surveillance System (RRFSS) showed nearly two-thirds of those living in multi-unit housing in Middlesex-London supported prohibiting smoking everywhere within multi-unit housing. Nonetheless, despite strong public support and demand for smoke-free accommodations, there are very few smoke-free housing options available. Low-income families have even less choice in the housing market, and often must take whatever housing is available. Those fortunate enough to find subsidized housing may not be able to relocate easily when faced with smoke infiltration from other units. As a result, individuals in our community continue to be exposed to second-hand smoke on a regular basis in their home environments.

No-smoking provisions offer many benefits, including a healthier environment, reduced exposure to second-hand smoke, reduced risk of fire, and lower cleaning[1] and insurance costs. Therefore, smoke-free multi-unit housing should be made available for those who want it, and be offered by those providing private and community/non-profit multi-unit housing.

…////1

In order to make the development of no-smoking provisions more appealing to landlords and increase the smoke-free housing options available in our community, no-smoking clause options should be added to the "Prescribed form of tenancy agreement" (Standard Lease) prescribed by regulation under Bill 124. The proposed "Prescribed form of tenancy agreement" (Standard Lease) described in Bill 124 clearly outlines the agreement between the housing provider and the tenant, including all of the conditions under which occupancy can be terminated. Inclusion of no-smoking clause options to the Standard Lease created under Bill 124 would make it clear to landlords that they can offer no-smoking provisions, and would create a consistent approach to the implementation and enforcement of no-smoking clauses within multi-unit housing tenancy agreements. This would provide landlords with the tools they need and make it as easy as possible to offer smoke-free housing, and would support landlords in ensuring compliance with this expectation between tenant and landlord. If the Standard Lease does not provide an option for smoke-free housing, most landlords and tenants will be under the impression that smoke-free clauses are not allowed. As a result, landlords will be far less inclined to include them and tenants less likely to ask for them.

The health effects from second-hand tobacco smoke exposure are widely known, and the evidence is quite clear that second-hand smoke can drift from one unit to another in multi-unit housing. In fact, the best science indicates that there is no safe level of exposure to second-hand tobacco smoke. About one in five Ontarians (21%) who live in multi-unit housing report exposure to second-hand smoke coming from outside their units. This exposure causes short-term harm, such as exacerbation of asthma or COPD, as well as longer-term health problems. However, tobacco is not the only substance that can affect the reasonable enjoyment and health of tenants within multi-unit housing.

The smoking of cannabis (recreational and medicinal) is a growing concern and a common complaint that the Middlesex-London Health Unit receives from tenants and landlords. When speaking with landlords, property management groups and condo corporations, and tenants within multi-unit housing complexes, the use of marijuana is a growing concern. The health effects from exposure to marijuana smoke is similar to the health effects from tobacco smoke. Regular marijuana smoking has been associated with chronic bronchitis and reduced lung function. The combustion of marijuana creates a smoke that contains many of the same carcinogens as tobacco smoke. While there is some evidence that marijuana smoking can be a risk factor for lung, head, neck and throat cancers, the association is unclear because of dual use of marijuana and tobacco smoking. Exposure to second-hand marijuana smoke has been studied less than second-hand tobacco smoke; however, due to the similarities in composition between tobacco and marijuana smoke, marijuana smoke is likely to be a similar public health concern. Exposure in an unventilated room can cause non-smokers to experience drug effects, including minor problems with memory and coordination, and, in some cases, testing positive for the drug in a urinalysis. The harmful health effects from exposure to second-hand marijuana smoke, regardless of whether or not the marijuana smoked is for medical purposes, warrants health protective regulations. With the coming legalization and regulation of cannabis in 2018, this issue may become even more prominent across the province.

A hookah (also known as a waterpipe, narghile, goza, or hubble-bubble) is a device used to smoke specially made tobacco and non-tobacco (herbal) products called shisha. Hookah is an alternative form of smoking whereby the shisha is heated with charcoal, the smoke from which travels down through the body of the apparatus into a water-filled chamber, which cools the smoke before it is inhaled. Hookah users will then inhale the smoke through hoses attached to the apparatus. Hookah sessions are generally longer and involve deeper inhalation than cigarette smoking. Under the *Smoke-Free Ontario Act* (SFOA), the prohibition on smoking only applies to hookah use if the shisha contains tobacco, and only applies to the common areas of multi-unit housing; however, like cigarettes, a hookah also produces second-hand

smoke that can be harmful whether or not the shisha contains tobacco or not. Studies of both tobacco-based shisha and "herbal" shisha show that the smoke from both preparations contains many of the same chemicals as cigarettes, such as carbon monoxide and other toxic agents associated with smoking-related cancer, respiratory illness and heart disease. Furthermore, a study of second-hand smoke exposure in Toronto water-pipe cafes showed that indoor air quality values for $PM_{2.5}$, ambient carbon monoxide and air nicotine are hazardous to human health.

Therefore, due to the negative health consequences from exposure to second-hand smoke, the Middlesex London Board of Health encourages the Government of Ontario to consider the need for smoke-free clause options to include tobacco, marijuana and shisha smoke. Additionally, the Middlesex-London Health Unit recommends that any no-smoking clause options indicate the maximum protection possible from second-hand smoke exposure. The language should state what provisions are covered under existing legislation, such as the *Smoke-Free Ontario Act* (SFOA), and what additional provisions are legal, permitted and enforceable under the no-smoking clause. The language should also state examples of the most protective provisions feasible, such as the entire building and property being smoke-free, and include other provisions, such as setbacks from entrances and exits, no smoking on balconies or patios, and designated outdoor smoking areas. These provisions should also state that if the landlord permits a designated outdoor smoking area on the property, it must be far enough away to ensure that second-hand smoke cannot drift into private units or balconies.

Smoke-free multi-unit housing is a critical policy issue and the Ministry of Housing is in a powerful position to signal to the housing community that smoke-free housing is a preferred option and offers tremendous health and property benefits. Adding no-smoking clause options that specify where no-smoking provisions can and cannot be made, and that include all forms of smoking in the "Prescribed form of tenancy agreement" (Standard Lease) created by regulation under Bill 124, would encourage landlords to create spaces where tenants can live without involuntary exposure to second-hand smoke from any source of smoke, whether from tobacco, marijuana, or shisha.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc. The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
The Honourable Kathleen Wynne, Premier of Ontario
Andrew Noble, Chair, Smoke-Free Housing Ontario Coalition
Ontario Boards of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 034-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 June 15

SUMMARY INFORMATION REPORT FOR JUNE

Recommendation

It is recommended that the Board of Health receive Report No. 034-17 re: Summary Information Report for June for information.

Key Points

- The Prenatal Immigrant Program (PiP), launched in July 2016, provides Arabic-speaking Newcomers with culturally mindful, accessible and relevant prenatal education and supports, with an emphasis on health and food literacy. Ongoing delivery and expansion of the program are required to meet community need.

Prenatal Immigrant Program (PiP) Update and Expansion

The Prenatal Immigrant Program (PiP), offered in partnership with the South London Neighbourhood Resource Centre (SLNRC), was launched in July 2016 in response to an identified community need (see Report No. 041-16). The weekly program is focused on providing prenatal education, nutritional skills, health literacy and psychosocial supports to Arabic-speaking Newcomers who have lived in Canada less than two years. Since it was initiated, fifty-one women and their families have participated in PiP. The majority of participating women are multiparous Syrian refugees preparing to give birth in Canada for the first time. Active promotion of PiP has not been necessary; recruitment for the program is primarily through settlement workers at SLNRC and word-of-mouth among Newcomer families. To date, thirty women who have attended the program have given birth. During early postpartum, many of these women identified the important role that PiP played in creating social supports, increasing knowledge related to the prenatal and postpartum period, and increasing understanding of and access to the healthcare system. Need for this program is greater than its current capacity, and this has created a wait list of several months, with a minimum of twelve women on the list at any given time. This is problematic, as women may be quite far into their pregnancy before they are allowed to enter the program, or may give birth and miss the opportunity to participate altogether. Current trends indicate that the number of Arabic-speaking Newcomers who would qualify for the program is increasing. Expanding the program would alleviate the wait-list issue, but must take into consideration the availability and capacity of MLHU staff and resources. To mitigate resource and capacity issues, a partnership with the Muslim Resource Centre for Social Support and Integration (MRCSSI) has been initiated. In collaboration with the MRCSSI, expansion of the program, including a second site in Northwest London, is planned for September 2017.

This report was submitted by the Reproductive Health Team, Healthy Start Division.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 035-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 June 15

ACTING MEDICAL OFFICER OF HEALTH / ACTING CHIEF EXECUTIVE OFFICER ACTIVITY REPORT – JUNE

Recommendation

It is recommended that the Board of Health receive Report No. 035-17 re: Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report – June for information.

The following report presents activities of the Acting Medical Officer of Health (Acting MOH) / Acting Chief Executive Officer (Acting CEO) for the period of May 5, 2017, to June 2, 2017.

The Acting MOH and Acting CEO attended events in honour of National Nursing Week 2017, which was celebrated this year during the week of May 8–12. During this week-long event, we celebrate the work and contributions of our Public Health Nurses. The MLHU Nursing Week Committee did wonderful work in planning the annual lunch, a cake celebration and ten great baskets for the staff raffle. All proceeds from the raffled baskets go to fund Nursing Week Events.

On May 16, the Acting MOH attended a public health information session and relationship-building workshop hosted by the Association of Iroquois and Allied Indians. The objective of this meeting was to promote mutual understanding and relationship-building between First Nation communities and public health organizations. Attendees helped to identify next steps, future planning and engagement.

From May 15 through 17, the Acting CEO and the CUPE conducted negotiation meetings. Within three days, the negotiating teams were able to arrive at a memorandum of settlement, with the new collective agreement being fully ratified within eight days.

The Acting MOH / Acting CEO also attended the following events:

May 11 — The Acting MOH and Acting CEO attended a half-day Coaching Circle Session training.
The Acting MOH and Acting CEO met with Board Chair Jesse Helmer to discuss the report to be sent to The Honourable Deb Matthews re: support from the Province to control the HIV Epidemic.

May 12 — The Acting MOH participated in a London Supervised Injection Sites (SIS) Community Advisory Committee teleconference meeting.

May 17 — The Acting MOH met with London Mayor Matt Brown and Mr. Brian Lester, Regional HIV/AIDS Connection (RHAC), to discuss SIS issues.
The Acting MOH met with Old East Village Association (OEVCA) President Peter Strack to discuss SIS community consultation.

May 18–19	The Acting CEO attended a confidential Finance & Facilities Committee meeting to review and rate the Location Proposals.
May 19	The Acting MOH participated in a phone call with Dr. Thomas Kerr, BC, regarding SIS and harm reduction.
May 23	The Acting MOH participated in two media interviews regarding harm reduction.
May 24	The Acting MOH and Acting CEO participated in a Literature Review Workshop. The Acting MOH participated in a conference call with the OPP regarding contraband tobacco. Also included on the call was Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control.
May 29	The Acting MOH participated in a phone call on the HSO program with Dianne Alexander, Director, Healthy Living Policy and Programs, MOHLTC.
May 30	The Acting MOH participated in a teleconference with the London SIS Community Advisory Group.
June 1	The Acting MOH met with Bruce Rankin, RHAC, and Anne Armstrong, London Cares, to discuss a Local Poverty Reduction Strategy Proposal. The Acting CEO attended the 7th Annual South West LHIN Quality Symposium in Stratford.
June 2	The Acting MOH participated in a call with Dr. Aiello, President, London District Dental Society.

This report was submitted by the Office of the Medical Officer of Health.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer