AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

Thursday, June 20, 2019 6:00 p.m.
399 Ridout Street North, London
Side entrance (recessed door)
MLHU Boardroom

1. DISCLOSURE OF CONFLICTS OF INTEREST

2. APPROVAL OF AGENDA

3. APPROVAL OF MINUTES – March 21, 2019

4. NEW BUSINESS

4.1 Annual Privacy Program Update (Report No. 008-19GC)
4.2 Joint Occupational Health & Safety Annual Report – June 2019 (Report No. 009-19GC)
4.3 Q2 2019 Activity Report - Strategic Projects (Report No. 010-19GC)
4.4 Governance Policy Review and Development (Report No. 011-19GC)
4.5 2019 Board of Health Self-Assessment Results (Report No. 012-19GC)
4.6 2018 Medical Officer of Health and Chief Executive Officer Performance Appraisal (Report No. 013-19GC)

5. OTHER BUSINESS

Next meeting Thursday, September 19, 2019

6. CONFIDENTIAL

The Governance Committee will move in-camera to consider confidential minutes from its March 21, 2019 meeting.

7. ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
GOVERNANCE COMMITTEE

Thursday, March 21, 2019, 6:00 p.m.
399 Ridout Street North, London, Ontario
Side Entrance, (recessed door)
MLHU Boardroom

MEMBERS PRESENT: Ms. Aina DeViet (Chair)
Ms. Maureen Cassidy
Ms. Trish Fulton
Mr. Ian Peer
Ms. Elizabeth Peloza

OTHERS PRESENT: Mr. John Brennan (Board member)
Mr. Matt Reid (Board member)
Dr. Christopher Mackie, Secretary-Treasurer
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Mr. Jordan Banninga, Manager, Program, Planning and Evaluation
Mr. Joe Belancic, Manager, Procurement and Operations
Ms. Cynthia Bos, HR Manager
Ms. Laura Di Cesare, Director, Healthy Organization
Ms. Kendra Ramer, Manager, Strategic Projects
Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance

ELECTION OF CHAIR, GOVERNANCE COMMITTEE

At 6:00 p.m., Dr. Mackie called the meeting to order and opened the floor to nominations for Chair of the Governance Committee for 2019.

It was moved by Mr. Peer seconded by Ms. Cassidy, *that Ms. DeViet be nominated for Chair of the Governance Committee for 2019.*

Carried

Ms. DeViet accepted the nomination.

Dr. Mackie invited further nominations three more times. None were forthcoming.

Therefore, it was moved by Mr. Peer, seconded by Ms. Cassidy, *that Ms. DeViet be acclaimed as Chair of the Governance Committee for 2019.*

Carried

DISCLOSURE OF CONFLICT OF INTEREST

Chair DeViet inquired if there were any disclosures of conflicts of interest to be declared.

APPROVAL OF AGENDA

It was moved by Ms. Cassidy, seconded by Ms. Peloza, *that the **AGENDA** for the March 21, 2019 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Cassidy, seconded by Mr. Peer, *that the **MINUTES** of the November 15, 2018 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Q1 2019 Activity Report – Strategic Projects (Report No. 001-19GC)

Dr. Mackie introduced and provided context to this report.

Discussion ensued about the following items:

- Projects behind schedule and reasons for the delay.
- The relocation project; how it has been received by staff and if it has impacted work in other areas.
- The issues and risks identified thought the Project Management Office and how it exists in relation to other frameworks at MLHU such as the Planning and Evaluation Framework.

It was moved by Ms. Peloza, seconded by Mr. Peer, *that the Governance Committee recommend that the Board of Health receive Report No. 001-19GC re: "Q1 2019 Activity Report – Strategic Projects" for information.*

Carried

2017 Year-end Performance on Accountability Indicators (Report No. 002-19GC)

Dr. Mackie introduced and provided context to this report.

Discussion ensued about the following items:

- The vaccination rates among school-aged children (grade 7 or 8) and the potential stigma associated with Hepatitis B and HPV vaccines for this population group.
- Clarification of reporting requirements associated with the Immunization of School Pupils Act indicator.
- How Cannabis retail will be monitored and enforced after April 1, 2019.
- The strict requirements placed on Cannabis vendors.

It was moved by Ms. Cassidy, seconded by Ms. Peloza, *that the Governance Committee receive Report No. 002-19GC re: "2017 Year-end Performance on Accountability Indicators" for information.*

Carried

Governance Policy Review and Development (Report No. 003-19GC)

Dr. Mackie thanked and recognized Ms. Gauthier for her work in modernizing the policies before the Committee this evening.

Discussion ensued about the following items:

- The summary of changes to policies outlined within Appendix A and Appendix B.
- The timeline for the policy review cycle, which is currently set at every two years, based on the Ontario Public Health Standards.
- That staff are currently working to streamline the review schedule to have a more calibrated approach to policy review going forward.

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

1) *Receive Report No. 003-19GC for information;*
2) *Recommend that the Board of Health approve the governance by-laws and policies appended to this report; and*
3) *Recommend that the Board of Health approve development of the new governance policies outlined within this report.*

Carried

Governance Committee Reporting Calendar (Report No. 004-19GC)

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

1) *Receive Report No. 004-19GC re: "Governance Committee Reporting Calendar" for information; and*
2) *Recommend that the Board of Health approve the 2019 Governance Committee Reporting Calendar.*

Carried

2019 Board Development (Report No. 005-19GC)

Ms. Fulton noted the timeline for this development activity and inquired about polling members for a date that will work for both the Board and the facilitator.

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

1) *Receive Report No. 005-19GC re: "2019 Board Development" for information; and*
2) *Recommend that the Board of Health approve the "Leading Through Transition/Change Management" session delivered by Your Latitude as a 2019 Board development opportunity.*

Carried

Board of Health Self-Assessment (Report No. 006-19GC)

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

1) *Receive Report No. 006-19GC re: "Board of Health Self-Assessment" for information;*
2) *Recommend that the Board of Health approve the Board of Health Self-Assessment Tool appended to this report; and*
3) *Approve initiation of the Board of Health self-assessment process for 2019.*

Carried

OTHER BUSINESS

Next meeting: June 20, 2019.

CONFIDENTIAL

At 6:32 p.m. it was moved by Ms. Fulton, seconded by Ms. Peloza *that the Governance Committee move in-camera to consider matters regarding identifiable individuals.*

Carried

Mr. Banninga, Ms. Gauthier, Mr. Belancic and Ms. Ramer left the meeting at 6:32 p.m.

At 6:46 p.m., it was moved by Ms. Peloza, seconded by Ms. Cassidy *that the Governance Committee rise and return to public session.*

Carried

At 6:46 p.m., the Governance Committee returned to public session.

ADJOURNMENT

At 6:46 p.m., it was moved by Mr. Peer, seconded by Ms. Fulton, *that the meeting be adjourned.*

Carried

_____
AINA DEVIET
Committee Chair

_____
CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 008-19GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / Chief Executive Officer

DATE: 2019 June 20

ANNUAL PRIVACY PROGRAM UPDATE

Recommendation

It is recommended that the Governance Committee receive Report No. 008-19GC re: "Annual Privacy Program Update" for information.

Key Points

- The Middlesex-London Health Unit is obligated under provincial privacy legislation to ensure the rights of individuals with respect to privacy; access to and correction of records of their personal information and personal health information; and access to general records that pertain to MLHU operations and governance.
- MLHU's Privacy Program supports compliance with these obligations through education and training, policy and procedure development, assessment and management of privacy risks, facilitation of access and correction requests, and management of potential and actual breaches that may occur.
- The development and implementation of enhanced privacy and information security policies and procedures are priorities for the year ahead to support implementation of MLHU's electronic client record (ECR) system and the eHealth ClinicalConnect viewer.

Background

MLHU is a "health information custodian" (HIC) in accordance with Section 3 of the *Personal Health Information Protection Act* (PHIPA) and an "institution" in accordance with Section 2 of the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA). Under these provincial privacy legislations, MLHU and the Middlesex-London Board of Health are obligated to ensure: the rights of individuals with respect to privacy; access to and correction of records of their personal information and personal health information; and access to general records that pertain to MLHU operations and governance.

MLHU Privacy Program

In accordance with Policy G-100 Privacy and Freedom of Information, the Medical Officer of Health/Chief Executive Officer (MOH/CEO) has the delegated duties and powers of the head with respect to freedom of information and protection of individual privacy under MFIPPA; and is responsible for maintaining information systems and implementing policies/procedures for privacy and security, data collection, and records management, as the designated HIC under PHIPA.

The day-to-day administration and management of MLHU's privacy program is operationalized by MLHU's Privacy Officer and includes the following components:

- Education and training
- Policy development
- Privacy impact assessment and consultation
- Response to access and correction requests under PHIPA and MFIPPA

- Breach and complaint management

MLHU's Privacy Program is continually evolving in response to internal and external drivers, including but not limited to new legislation/regulations and case law, orders issued by the provincial and federal privacy commissioners, new technologies, emerging best practices, and increasing public awareness and expectations with respect to privacy and access.

Key areas of focus and success over the past year include:

- Development of an online privacy education module for MLHU staff to support understanding of and compliance with legislative and ethical obligations;
- Updating of MLHU's public statement regarding its privacy practices;
- Privacy impact assessment and consultation to balance legislative requirements with the evolving needs and expectations of our clients and the implementation of new technologies;
- Policy development to provide clear direction with respect to Board of Health and MOH/CEO accountability;
- Progress toward becoming a partner organization with eHealth Ontario's ClinicalConnect, a web-based portal that provides health care providers with real-time access to their patients' electronic medical information from other participating regional and provincial organizations; and
- Processing of access requests (e.g., freedom of information) for personal health information and general records kept by MLHU, including collaboration with the Information and Privacy Commissioner of Ontario (IPC) to resolve complex requests.

Provincial Oversight

MLHU is required to submit annual statistical reports to the IPC with respect to: 1) confirmed privacy breaches under PHIPA (Appendix A), 2) access and correction requests under PHIPA (Appendix B), and 3) access and correction requests under MFIPPA (Appendix C). All of these reports were submitted to the IPC within the required timelines.

Next Steps

As MLHU undertakes implementation of an electronic client record (ECR) system and ClinicalConnect, development and implementation of enhanced privacy and information security policies and procedures, including an electronic health record auditing/monitoring program, are priorities for the year ahead.

This report was prepared by the Privacy, Risk and Governance Team, Healthy Organization Division.

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

The Year-End Statistical Report for the Information and Privacy Commissioner of Ontario

Statistical Report of Middlesex-London Health Unit for the Reporting Year 2018

for

Personal Health Information Privacy Breaches

Report run on: 4/10/2019 at 11:11am

Section 1: Identification

1.1	Organization Name	Middlesex-London Health Unit
	Management Contact Name & Title	Nicole Gauthier/Manager of Privacy, Risk & Governance
	Management Contact E-mail Address	nicole.gauthier@mlhu.on.ca
	Primary Contact Name & Title	Deb Turner/Program Assistant Privacy, Risk & Governance
	Primary Contact Email Address	deb.turner@mlhu.on.ca
	Primary Contact Phone Number	5196635317 ext. 2437
	Primary Contact Fax Number	5196639413
	Primary Contact Mailing Address 1	50 King Street (at Ridout)
	Primary Contact Mailing Address 2	
	Primary Contact Mailing Address 3	
	Primary Contact City	London, Ontario
	Primary Contact Postal Code	N6A 5L7
1.2	Your institution is:	Health Board

1.3 Your type of Health Information Custodian is:

○ Experienced NO health information privacy breaches during the reporting year (Survey submission will complete after this page)

⊛ Experienced one or more health information privacy breaches during the reporting year (Please continue to Section 2)

Section 2: Total Number of Health Information Privacy Breaches

2.1	Enter the total number of health information privacy breach incidents experienced during the reporting year (January – December)	2

Section 3: Stolen Personal Health Information

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
3.1	What was the total number of privacy breach incidents where personal health information was stolen?	0
3.2	**Of this total indicate the number of privacy breach incidents where:**	
3.2.1	theft was by an internal party (such as an employee, affiliated health practitioner or electronic service provider)	0
3.2.2	theft was by a stranger	0
3.2.3	theft was the result of a ransomware attack	0
3.2.4	theft was the result of another type of cyberattack	0
3.2.5	unencrypted portable electronic equipment (such as USB keys or laptops) was stolen	0
3.2.6	paper records were stolen	0
3.2.7	theft was a result of something else, by someone else or other items were stolen	0
3.2.8	TOTAL INCIDENTS	0
3.3	**Of the total on line 3.1 indicate the number of privacy breach incidents where:**	
3.3.1	one individual was affected	0
3.3.2	2 to 10 individuals were affected	0
3.3.3	11 to 50 individuals were affected	0
3.3.4	51 to 100 individuals were affected	0
3.3.5	over 100 individuals were affected	0
3.3.6	TOTAL INCIDENTS	0

Section 4: Lost Personal Health Information

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
4.1	What was the total number of privacy breach incidents where personal health information was lost?	1
4.2	**Of this total indicate the number of privacy breach incidents where:**	
4.2.1	loss was the result of a ransomware attack	0
4.2.2	loss was the result of another type of cyberattack	0
4.2.3	unencrypted portable electronic equipment (such as USB keys or laptops) was lost	0
4.2.4	paper records were lost	1
4.2.5	loss was a result of something else or other items were lost	0
4.2.6	TOTAL INCIDENTS	1
4.3	**Of the total on line 4.1 indicate the number of privacy breach incidents where:**	
4.3.1	one individual was affected	0
4.3.2	2 to 10 individuals were affected	0
4.3.3	11 to 50 individuals were affected	1
4.3.4	51 to 100 individuals were affected	0
4.3.5	over 100 individuals were affected	0
4.3.6	TOTAL INCIDENTS	1

Section 5: Used Without Authority

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
5.1	What was the total number of privacy breach incidents where personal health information was used (e.g. viewed, handled) without authority?	0
5.2	**Of this total indicate the number of privacy breach incidents where:**	
5.2.1	unauthorized use was through electronic systems	0
5.2.2	unauthorized use was through paper records	0
5.2.3	unauthorized disclosure was through other records	0
5.2.4	TOTAL INCIDENTS	0
5.3	**Of the total on line 5.1 indicate the number of privacy breach incidents where:**	
5.3.1	one individual was affected	0
5.3.2	2 to 10 individuals were affected	0
5.3.3	11 to 50 individuals were affected	0
5.3.4	51 to 100 individuals were affected	0
5.3.5	over 100 individuals were affected	0
5.3.6	TOTAL INCIDENTS	0

Section 6: Disclosed Without Authority

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
6.1	What was the total number of privacy breach incidents where personal health information was disclosed without authority?	1
6.2	**Of this total indicate the number of privacy breach incidents where:**	
6.2.1	unauthorized disclosure was through misdirected faxes	0
6.2.2	unauthorized disclosure was through misdirected emails	0
6.2.3	unauthorized disclosure was through other means	1
6.2.4	TOTAL INCIDENTS	1
6.3	**Of the total on line 6.1 indicate the number of privacy breach incidents where:**	
6.3.1	one individual was affected	1
6.3.2	2 to 10 individuals were affected	0
6.3.3	11 to 50 individuals were affected	0
6.3.4	51 to 100 individuals were affected	0
6.3.5	over 100 individuals were affected	0
6.3.6	TOTAL INCIDENTS	1

Note:

This report is for your records only and should not be faxed or mailed to the Information and Privacy Commissioner of Ontario in lieu of online submission. Faxed or mailed copies of this report will NOT be accepted. Please submit your report online at: https://statistics.ipc.on.ca.

Thank You for your cooperation!

Declaration:

I, Nicole Gauthier/Manager of Privacy, Risk & Governance, confirm that all the information provided in this report, furnished by me to the Information and Privacy Commissioner of Ontario, is true, accurate and complete in all respects.

Signature	*Date*

The Year-End Statistical Report for the Information and Privacy Commissioner of Ontario

Statistical Report of Middlesex-London Health Unit for the Reporting Year 2018

for

Personal Health Information Protection Act

Report run on: 2/14/2019 at 3:57pm

Section 1: Identification

1.1	Organization Name	Middlesex-London Health Unit
	Management Contact Name & Title	Nicole Gauthier/Manager of Privacy, Risk & Governance
	Management Contact E-mail Address	nicole.gauthier@mlhu.on.ca
	Primary Contact Name & Title	Deb Turner/Program Assistant Privacy, Risk & Governance
	Primary Contact Email Address	deb.turner@mlhu.on.ca
	Primary Contact Phone Number	5196635317 ext. 2437
	Primary Contact Fax Number	5196639413
	Primary Contact Mailing Address 1	50 King Street (at Ridout)
	Primary Contact Mailing Address 2	
	Primary Contact Mailing Address 3	
	Primary Contact City	London, Ontario
	Primary Contact Postal Code	N6A 5L7
1.2	Your institution is:	Health Board
1.3	Your type of Health Information Custodian is:	A medical officer of health or a board of health within the meaning of the *Health Protection and Promotion Act*

Section 2: Uses or Purposes of Personal Health Information

2.1	Provide the number of uses or purposes for which personal health information was disclosed where the use or purpose is not included in the written public statement of information practices under the Personal Health Information Protection Act subsection 16(1).	0

Your institution received:

- ○ Did not receive any formal written requests for access to records of personal health information or correction of personal health information.
- ◉ Received Formal written requests for access to records of personal health information.

Section 2: Uses or Purposes of Personal Health Information

Section 3: Number of Requests Completed

		Personal Health Information
3.1	Enter the number of written requests made by individuals (or by the individuals' substitute decision makers) for access to their own personal health information that were completed during the reporting year (January – December).	7

Section 4: Time to Completion

How long did your institution take to complete all requests for information? Enter the number of requests into the appropriate category.

		Personal Health Information
4.1	1-30 days	4
4.2	Over 30 days with an extension	3
4.3	Over 30 days without an extension	0
4.4	Total requests (Add Boxes 4.1 to 4.3 = 4.4)	7

BOX 4.4 must equal BOX 3.1

Section 5: Compliance with the *PHIPA*

In this section, please indicate the number of requests completed, within the statutory time limit and in excess of the statutory time limit, under each of the two different situations:

NO Time Extension Notices issued
ISSUED a Time Extension Notice (subsection 54(4))

Please note that the two different situations are mutually exclusive and the number of requests completed in each situation should add up to the total number of requests completed in Section 3.1. (Add Boxes 5.3 + 5.6 = BOX5.7. BOX 5.7 must equal BOX 3.1)

A. No Time Extension Notices Issued

		Personal Health Information
5.1	Number of requests completed within the statutory time limit (30 days) where a Time Extension Notice (subsection 54(4)) was NOT issued.	4
5.2	Number of requests completed in excess of the statutory time limit (30 days) where neither a Notice of Extension (s.27(1)) nor a Notice to Affected Person (s.28(1)) were issued.	0
5.3	Total requests (Add Boxes 5.1 + 5.2 = 5.3)	4

B. Issued a Time Extension Notice (*PHIPA* subsection 54(4))

		Personal Health Information
5.4	Number of requests completed within the time limit permitted under the Time Extension Notice (subsection 54(4))	3

Section 5: Compliance with the *PHIPA*

5.6	Total requests (Add Boxes 5.4 + 5.5 = 5.6)	3

C. Total Completed Requests (sections A and B)

		Personal Health Information
5.7	Total requests (Add Boxes 5.3 + 5.6 = 5.7)	7

BOX 5.7 must equal BOX 3.1

D. Expedited Access Requests (*PHIPA* subsection 54(5))

		Personal Health Information
5.8	Number of completed requests from the total reported in box 5.7 that were requests for expedited access and completed within the requested time period.	0
5.9	Number of completed requests from the total reported in box 5.7 that were requests for expedited access and were completed in excess of the requested time period.	0
5.10	Total requestsAdd Boxes 5.8 + 5.9 = 5.10	0

section 5a: Contributing Factors

Please outline any factors that may have contributed to your institution not meeting the 30-day time limit. If you anticipate circumstances that will improve your ability to comply with the *PHIPA* in the future, please provide details in the space below.

Large volume of records involved.

Section 6: Disposition of Requests

What course of action was taken for each of the requests completed? Please enter the number of requests into the appropriate category.

		Personal Health Information
6.1	Full access provided	4
6.2	Partial access provided: provisions applied to deny access	1
6.3	Partial access provided: no record exists or cannot be found	0
6.4	Partial access provided: record outside of *PHIPA*	0
6.5	No access provided: provisions applied to deny access	1
6.6	No access provided: no records exists or cannot be found	1
6.7	No access provided: record outside of *PHIPA*	0
6.8	Other completed requests, e.g. withdrawn or never proceeded with	0
6.9	Number of requests from box 6.8 that were not pursued following a fee estimate	0
6.10	Total requests (excluding box 6.9)Add Boxes 6.1 to 6.8 = 6.10	7

Section 6: Disposition of Requests

BOX 6.10 must be greater than or equal to BOX 3.1

Section 7: Provisions Applied to Deny Access

For the total requests where a provision was applied to deny access in full or in part, how many times did you apply each of the following? (Please note that more than one provision may be applied to each request.)

		Personal Health Information
7.1	Section 51(1)(a) - Quality of Care Information	0
7.2	Section 51(1)(b) - Quality Assurance Program (*Regulated Health Professions Act, 1991*)	0
7.3	Section 51(1)(c) - Raw Data from Psychological Test	0
7.4	Section 51(d) - Prescribed Personal Health Information	0
7.5	Section 52(1)(a) - Legal Privilege	0
7.6	Section 52(1)(b) - Other Acts or Court Order	0
7.7	Section 52(1)(c) - Proceedings that have not been concluded	0
7.8	Section 52(1)(d) - Inspection, Investigation or Similar Procedure	0
7.9	Section 52(1)(e) - Risk of Harm to or Identification of an Individual	2
7.10	Section 52(1)(f) - *MFIPPA* subsections 38(a) or (c) or *FIPPA* subsections 49 (a), (c) or (e) apply	0
7.11	Section 54(6) - Frivolous or Vexatious	0
7.12	Total requests (Add Boxes 7.1 to 7.11 = 7.12)	2

Section 8: Fees

		Personal Health Information
8.1	Number of requests for access to records of personal health information where fees were collected	0
8.2	Number of requests where fees were waived - in full	0
8.3	Number of requests where fees were waived - in part	0
8.4	Total Number of requests where fees were waived (Add Boxes 8.2 + 8.3 = 8.4)	0
8.5	Total dollar amount of fees collected	$0.00
8.6	Total dollar amount of fees waived	$0.00

Section 9: Corrections and Statements of Disagreement

		Personal Health Information
9.1	Correction requests completed	0

Section 9: Corrections and Statements of Disagreement		
9.3	Correction(s) made in part	0
9.4	Correction(s) refused	0
9.5	Correction(s) withdrawn by requester	0
9.6	Total (Add Boxes 9.2 to 9.5 = 9.6)	0
9.7	Number of correction requests with statements of disagreement attached where corrections were refused in whole or in part	0
9.8	Number of times notifications sent	0

Note:

This report is for your records only and should not be faxed or mailed to the Information and Privacy Commissioner of Ontario in lieu of online submission. Faxed or mailed copies of this report will NOT be accepted. Please submit your report online at: https://statistics.ipc.on.ca.

Thank You for your cooperation!

Declaration:

I, Nicole Gauthier/Manager of Privacy, Risk & Governance, confirm that all the information provided in this report, furnished by me to the Information and Privacy Commissioner of Ontario, is true, accurate and complete in all respects.

Signature *Date*

The Year-End Statistical Report for the Information and Privacy Commissioner of Ontario

Statistical Report of Middlesex-London Health Unit for the Reporting Year 2018

for

Municipal Freedom of Information and Protection of Privacy Act

Report run on: 2/14/2019 at 4:10pm

Section 1: Identification

1.1	Organization Name	Middlesex-London Health Unit
	Head of Institution Name & Title	Christopher Mackie, Medical Officer of Health and Chief Executive Officer
	Head of Institution E-mail Address	christopher.mackie@mlhu.on.ca
	Management Contact Name & Title	Nicole Gauthier/Manager of Privacy, Risk & Governance
	Management Contact E-mail Address	nicole.gauthier@mlhu.on.ca
	Primary Contact Name & Title	Deb Turner/Program Assistant Privacy, Risk & Governance
	Primary Contact Email Address	deb.turner@mlhu.on.ca
	Primary Contact Phone Number	5196635317 ext. 2437
	Primary Contact Fax Number	5196639413
	Primary Contact Mailing Address 1	50 King Street (at Ridout)
	Primary Contact Mailing Address 2	
	Primary Contact Mailing Address 3	
	Primary Contact City	London, Ontario
	Primary Contact Postal Code	N6A 5L7
1.2	Your institution is:	Health Board

Section 2: Inconsistent Use of Personal Information

2.1	Whenever your institution uses or discloses personal information in a way that differs from the way the information is normally used or disclosed (an inconsistent use), you must attach a record or notice of the inconsistent use to the affected information.	0

Your institution received:

○ No formal written requests for access or correction

Section 2: Inconsistent Use of Personal Information

Section 3: Number of Requests Received and Completed

Enter the number of requests that fall into each category.

		Personal Information	General Records
3.1	New Requests received during the reporting year	3	9
3.2	Total number of requests completed during the reporting year	3	9

Section 4: Source of Requests

Enter the number of requests you completed from each source.

		Personal Information	General Records
4.1	Individual/Public	0	5
4.2	Individual by Agent	3	2
4.3	Business	0	0
4.4	Academic/Researcher	0	0
4.5	Association/Group	0	0
4.6	Media	0	2
4.7	Government (all levels)	0	0
4.8	Other	0	0
4.9	Total requests (Add Boxes 4.1 to 4.8 = 4.9)	3	9

BOX 4.9 must equal BOX 3.2

Section 5: Time to Completion

How long did your institution take to complete all requests for information? Enter the number of requests into the appropriate category. How many requests were completed in:

		Personal Information	General Records
5.1	30 days or less	3	8
5.2	31 - 60 days	0	0
5.3	61 - 90 days	0	0
5.4	91 days or longer	0	1
5.5	Total requests (Add Boxes 5.1 to 5.4 = 5.5)	3	9

BOX 5.5 must equal BOX 3.2

Section 6: Compliance with the Act

Section 6: Compliance with the Act

NO notices issued;
BOTH a Notice of Extension (s.27(1)) and a Notice to Affected Person (s.28(1)) issued;
ONLY a Notice of Extension (s.27(1)) issued;
ONLY a Notice to Affected Person (s.28(1)) issued.

Please note that the four different situations are mutually exclusive and the number of requests completed in each situation should add up to the total number of requests completed in Section 3.2.(Add Boxes 6.3 + 6.6 + 6.9 + 6.12 = BOX6.13 and BOX 6.13 must equal BOX 3.2)

A. No Notices Issued

		Personal Information	General Records
6.1	Number of requests completed within the statutory time limit (30 days) where neither a Notice of Extension (s.27(1)) nor a Notice to Affected Person (s.28(1)) were issued.	3	8
6.2	Number of requests completed in excess of the statutory time limit (30 days) where neither a Notice of Extension (s.27(1)) nor a Notice to Affected Person (s.28(1)) were issued.	0	0
6.3	Total requests (Add Boxes 6.1 + 6.2 = 6.3)	3	8

B. Both a Notice of Extension (s.27(1)) and a Notice to Affected Person (s.28(1)) Issued

		Personal Information	General Records
6.4	Number of requests completed within the time limits permitted under both the Notice of Extension (s.27(1)) and a Notice to Affected Person (s.28(1)).	0	1
6.5	Number of requests completed in excess of the time limit permitted by the Notice of Extension (s.27(1)) and the time limit permitted by the Notice to Affected Person (s.28(1)).	0	0
6.6	Total requests (Add Boxes 6.4 + 6.5 = 6.6)	0	1

C. Only a Notice of Extension (s.27(1)) Issued

		Personal Information	General Records
6.7	Number of requests completed within the time limits permitted under both the Notice of Extension (s.27(1)).	0	0
6.8	Number of requests completed in excess of the time limit permitted by the Notice of Extension (s.27(1)).	0	0
6.9	Total requests (Add Boxes 6.7 + 6.8 = 6.9)	0	0

D. Only a Notice to Affected Person (s.28(1)) Issued

		Personal Information	General Records
6.10	Number of requests completed within the time limits permitted under both the Notice to Affected Person (s.28(1)).	0	0
6.11	Number of requests completed in excess of the time limit permitted by the Notice to Affected Person (s.28(1)).	0	0
6.12	Total requests (Add Boxes 6.10 + 6.11 = 6.12)	0	0

E. Total Completed Requests (sections A to D)

	Personal	General Records

Section 6a: Contributing Factors

Please outline any factors which may have contributed to your institution not meeting the statutory time limit. If you anticipate circumstances that will improve your ability to comply with the Act in the future, please provide details in the space below.

Section 7: Disposition of Requests

What course of action was taken with each of the completed requests? Enter the number of requests into the appropriate category.

		Personal Information	General Records
7.1	All information disclosed	3	6
7.2	Information disclosed in part	0	3
7.3	No information disclosed	0	0
7.4	No responsive records exists	0	0
7.5	Request withdrawn, abandoned or non-jurisdictional	0	2
7.6	Total requests (Add Boxes 7.1 to 7.5 = 7.6)	3	11

BOX 7.6 must be greater than or equal to BOX 3.2

Section 8: Exemptions & Exclusions Applied

For the Total Requests with Exemptions/Exclusions/Frivolous or Vexatious Requests, how many times did your institution apply each of the following? (More than one exemption may be applied to each request)

		Personal Information	General Records
8.1	Section 6 — Draft Bylaws, etc.	0	0
8.2	Section 7 — Advice or Recommendations	0	0
8.3	Section 8 — Law Enforcement[1]	0	0
8.4	Section 8(3) — Refusal to Confirm or Deny	0	0
8.5	Section 8.1 — Civil Remedies Act, 2001	0	0
8.6	Section 8.2 — Prohibiting Profiting from Recounting Crimes Act, 2002	0	0
8.7	Section 9 — Relations with Governments	0	0
8.8	Section 10 — Third Party Information	0	1
8.9	Section 11 — Economic/Other Interests	0	0
8.10	Section 12 — Solicitor-Client Privilege	0	0
8.11	Section 13 — Danger to Safety or Health	0	0
8.12	Section 14 — Personal Privacy (Third Party)[2]	0	1
8.13	Section 14(5) — Refusal to Confirm or Deny	0	0
8.14	Section 15 — Information soon to be published	0	0

Section 8: Exemptions & Exclusions Applied

8.17	Section 52(2) — Act Does Not Apply[3]	0	0
8.18	Section 52(3) — Labour Relations & Employment Related Records	0	0
8.19	Section 53 — Other Acts	0	0
8.20	PHIPA Section 8(1) Applies	0	0
8.21	Total Exemptions & Exclusions Add Boxes 8.1 to 8.20 = 8.21	2	2

[1] not including Section 8(3)
[2] not including Section 14(5)
[3] not including Section 52(3)

Section 9: Fees

Did your institution collect fees related to request for access to records?

		Personal Information	General Records	Total
9.1	Number of REQUESTS where fees other than application fees were collected	0	0	0
9.2.1	Total dollar amount of application fees collected	$0.00	$0.00	$0.00
9.2.2	Total dollar amount of additional fees collected	$0.00	$0.00	$0.00
9.2.3	Total dollar amount of fees collected (Add Boxes 9.2.1 + 9.2.2 = 9.2.3)	$0.00	$0.00	$0.00
9.3	Total dollar amount of fees waived	$0.00	$0.00	$0.00

Section 10: Reasons for Additional Fee Collection

Enter the number of REQUESTS for which your institution collected fees other than application fees that apply to each category.

		Personal Information	General Records	Total
10.1	Search time	0	0	0
10.2	Reproduction	0	0	0
10.3	Preparation	0	0	0
10.4	Shipping	0	0	0
10.5	Computer costs	0	0	0
10.6	Invoice costs(and other as permitted by regulation)	0	0	0
10.7	Total (Add Boxes 10.1 to 10.6 = 10.7)	0	0	0

Section 11: Correction and Statements of Disagreement

Did your institution receive any requests to correct personal information?

		Personal Information
11.1	Number of correction requests received	0

Section 11: Correction and Statements of Disagreement

11.4	Total Corrections Completed [(11.1 + 11.2) - 11.3 = 11.4]	0

BOX 11.4 must equal BOX 11.9

What course of action did your institution take take regarding the requests that were received to correct personal information?

		Personal Information
11.5	Correction(s) made in whole	0
11.6	Correction(s) made in part	0
11.7	Correction refused	0
11.8	Correction requests withdrawn by requester	0
11.9	Total requests (Add Boxes 11.5 to 11.8 = 11.9)	0

BOX 11.9 must equal BOX 11.4

In cases where correction requests were denied, in part or in full, were any statements of disagreement attached to the affected personal information?

		Personal Information
11.10	Number of statements of disagreement attached:	0

If your institution received any requests to correct personal information, the Act requires that you send any person(s) or body who had access to the information in the previous year notification of either the correction or the statement of disagreement. Enter the number of notifications sent, if applicable.

		Personal Information
11.11	Number of notifications sent:	0

Note:

This report is for your records only and should not be faxed or mailed to the Information and Privacy Commissioner of Ontario in lieu of online submission. Faxed or mailed copies of this report will NOT be accepted. Please submit your report online at: https://statistics.ipc.on.ca.

Thank You for your cooperation!

Declaration:

I, Nicole Gauthier/Manager of Privacy, Risk & Governance, confirm that all the information provided in this report, furnished by me to the Information and Privacy Commissioner of Ontario, is true, accurate and complete in all respects.

Signature *Date*

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 009-19GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 June 20

JOINT OCCCUPATION HEALTH AND SAFETY ANNUAL REPORT – JUNE 2019

Recommendation

It is recommended that the Governance Committee receive Report No. 009-19 re: "Joint Occupational Health and Safety Annual Report – June 2019" for information.

Key Points

- The Joint Occupational Health and Safety Committee (JOHSC) annual report summarizes the Committee's health and safety accomplishments, challenges, incidents, and activities of the previous calendar year.
- The number of health-and-safety incidents reported by employees decreased by 30% from 2017.
- By the end of 2018, 38% of health and safety policies had been reviewed by the JOHSC and the Senior Leadership Team.

Occupational health and safety is an integral aspect of any successful organization. Ensuring that all workplace parties are aware of their roles and responsibilities under the *Occupational Health and Safety Act* (OSHA) is at the foundation of any health and safety program.

As part of the Occupational Health and Safety Program, the Human Resources Coordinator, Health and Safety, submits an annual report (**Appendix A**) summarizing the Joint Occupational Health and Safety Committee's (JOHSC) health and safety accomplishments, challenges, incidents, and activities of the previous calendar year. The annual report is shared with staff at all levels of the organization.

The attached report explains the functioning of the internal responsibility system, where each level of the organization has a role to play in enhancing occupational health and safety and ensuring MLHU is committed to fostering a safe work environment.

Over the course of 2018, there were 30 employee-reported incidents, a 30% decrease from 2017. The most common employee-reported incidents include: workplace violence (including domestic violence); musculoskeletal disorders (MSD Other), slips, trips and falls; and struck with/caught by/contact with incidents.

To address some of the commonly reported incidents, several training opportunities were offered to employees in 2018. The "Make It Our Business" training, which includes information on how to recognize warning signs and risk factors associated with domestic violence, how to respond to signs of domestic violence, and the community resources that are available for referral, was provided internally to 137 employees. Designated first aid responders are required under Regulation 1101, and 13 employees volunteered for this role, 8 of whom received first aid training in 2018. CPR certification and re-certification was also completed by 36 employees.

In addition, the JOHSC participated in North American Occupational Health and Safety (NAOSH) Week events and the Be Well Health Fair to build health-and-safety awareness and increase visibility of the JOHSC within the organization.

In the fourth quarter of 2018, the Health Unit began an intensive review of all its health-and-safety policies to ensure compliance with the OHSA. By the end of 2018, 8 of 21 health-and-safety policies had undergone review. The review of the remaining health-and-safety policies will be completed in 2019, and will be a major focus for the JOHSC. The Committee regularly discusses employee-reported incidents, non-employee incidents, worksite inspections, and program/policy updates at each scheduled meeting.

The Occupational Health and Safety program at MLHU and the work of the JOHSC continue to make improvements to the health and safety of all employees through awareness campaigns, ongoing training opportunities, and ensuring legislative compliance.

This report was prepared by the Healthy Organization Division.

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

https://hub.mlhu.on.ca/FOS/HRLR/OHS/SitePages/OHS.aspx

2018

Annual Report of the Joint Occupational Health and Safety Committee (JOHSC)

Management Commendation and Training Initiatives

Policy Review

In the fourth quarter of 2018, the Middlesex-London Health Unit (MLHU) began an intensive review of all MLHU health and safety policies to ensure compliance with the Occupational Health and Safety Act (OHSA). As per the OHSA, MLHU Occupational Health and Safety Policy, Workplace Violence Prevention and Harassment and Discrimination, policies are required to be reviewed on an annual basis. All other health and safety policies will be reviewed at least every two years in accordance with the approved MLHU policy review cycle.

By the end of 2018, 8 of 21 (38%) health and safety policies had been reviewed by the Senior Leadership Team. The review of the remaining health and safety policies will be completed in 2019.

Renewed Commitment of the "Make It Our Business Training"

In collaboration with the Corporate Trainer, MLHU began re-offering the 1-hour "Make It Our Business Training" to all employees. This training includes information on how to recognize warning signs and risk factors associated with domestic violence, how to respond to signs of domestic violence and the community resources that are available for referral. Over the course of 2018, nearly half (137) of employees completed this training.

In addition to the 1-hour session, employees were also invited to attend a 2-hour role playing session to practice responding to warning signs and/or risk factors and using the "See it, Check it, Name it" (SNC it) conversation tool. This session was developed in response to the results of the training evaluation where participants reported having low confidence levels in conducting the "SNC it" Conversation. Over the course of 2018, 5 employees (1.5%) completed this training.

Both training opportunities will continue to be available to all employees on a quarterly basis going forward.

First Aid and CPR Training

MLHU recognized the need to provide Standard First Aid and CPR training to employees who volunteered to take on the role of the designated first aid responder. As per Regulation 1101, "every employer employing 200 or more workers in any one shift at a place of employment shall provide and maintain a first aid room." Further, the regulation requires that the first aid station be, "in charge of a worker who (a) is the holder of a valid St. John Ambulance Standard First Aid Certificate or its equivalent; and (b) works in the immediate vicinity of the box (c) does not perform other work of a nature that is likely to affect adversely his or her ability to administer first aid. R.R.O. 1990, Reg. 1101, s. 11 (2). In 2018, 13 employees volunteered to take on this role and 8 required training. Training for designated first aid responders will continue into 2019.

The MLHU also offers annual CPR certification and re-certification to all permanent employees. In 2018, 36 employees were certified or re-certified in either CPR-C or CPR for health care providers (HCP).

Health and Safety at Team Meetings

Several teams have included health and safety as a standing item at team meetings. As a standing item, managers and employees are encouraged to identify and discuss health and safety challenges and/or concerns with their peers. This also illustrates the internal responsibility system at work, recognizing that health and safety is everyone's responsibility.

Hazard Identification

Workplace Inspections and Management Responses

The Joint Occupational Health and Safety Committee (JOHSC) conducts monthly inspections of all three office locations to identify hazards, make recommendations to management for corrective actions and to monitor progress of corrective actions and measures undertaken. See table 1 below for a summary of the results from the 2018 worksite inspections. The overarching goal of the worksite inspections is to monitor and evaluate the effectiveness of the Internal Responsibility System.

Management responses to identified hazards and risks associated with the facilities, equipment and furnishings were routinely and promptly provided in writing by the

Manager of Procurement and Operations. Most operational issues were resolved expeditiously or a plan to address them was put in place and communicated to the employees and the Committee within the required 21-day timeframe. At the end of 2018, 4 items were outstanding with action plans to resolve. These items included:

- Consistently open and damaged fire door in the basement of 201 Queens Avenue;
- Slip, trip and fall hazard in the Vector Borne Disease Team Cage in Strathroy;
- Entrance door at Strathroy Office was not being locked properly; and
- Consistently wet, damaged ceiling tiles along the second floor hallway by Room 2A at 50 King Street.

All items above were resolved in early 2019.

Employees are encouraged to review the posted worksite inspections on the HUB or on the dedicated JOHSC bulletin board in each office location's kitchen and to report any hazards to their reporting manager.

Table 1: Summary of 2018 Worksite Inspections

2018 Workplace Inspections	50 King Street	201 Queens Ave	Strathroy
Number of inspections	12	12	11
Total number of items (hazards (new and repeated), legislative compliance issues) identified	43	19	7
Types of hazards identified	0 - Physical 14 - Biological 2 - Chemical 0 - Musculoskeletal 0 - Psychosocial 25 - Safety 2 - Compliance	0 - Physical 2 - Biological 3 - Chemical 5 - Musculoskeletal 0 - Psychosocial 8 - Safety 1 - Compliance	0 - Physical 1 - Biological 0 - Chemical 0 - Musculoskeletal 0 - Psychosocial 3 - Safety 3 - Compliance

Physical – includes hazards that come from forms of energy that can result in bodily harm
Biological – includes hazards that come from living organisms
Chemical – includes hazards associated with chemicals / chemical use
Musculoskeletal – includes hazards that may result in Musculoskeletal Disorders
Psychosocial – includes hazards that affect the mental and physical well being of people
Safety – includes hazards associated with equipment, as well as slips, trips and falls
Compliance – includes practices or conditions that are not in compliance with relevant legislation/ regulations

Formal Recommendations

Under the OHSA, management is required to respond in writing within 21 days to a formal (written) recommendation from the JOHSC. There was one formal committee recommendation to management in 2018.

This recommendation addressed two employee reported incidents that occurred at the 201 Queens Office identifying the security risks associated with the office environment. After following up from the two employee-reported incident reports and concerns about office security, the JOHSC submitted a formal recommendation to Directors who upon receiving the recommendation took immediate action on these incidents.

The management team who works at the 201 Queens Office met and drafted a communication to employees outlining the corrective actions to address the JOHSC recommendations. An e-mail communication went out to all employees working in the 201 Queens office and was re-iterated at team meetings. One highlight stemming from the actions of management is that employees reported feeling supported and empowered that they can direct visitors to another location to use the washroom, rather than inviting them into the office space.

Injuries and Incidents

At the end of 2018 there were 30 employee-reported incidents, compared to 43 employee-reported incidents in 2017 (a 30% decrease). This decrease may be attributed to an enhanced focus on health and safety with the integration of Human Resources through the introduction of a dedicated full-time Human Resources Coordinator, Health and Safety.

The most commonly reported incidents were workplace violence (including domestic violence); musculoskeletal disorders (MSD other); slips, trips and falls; and struck with/ caught by/ contact with. All reported incidents are depicted in Figure 1 below.

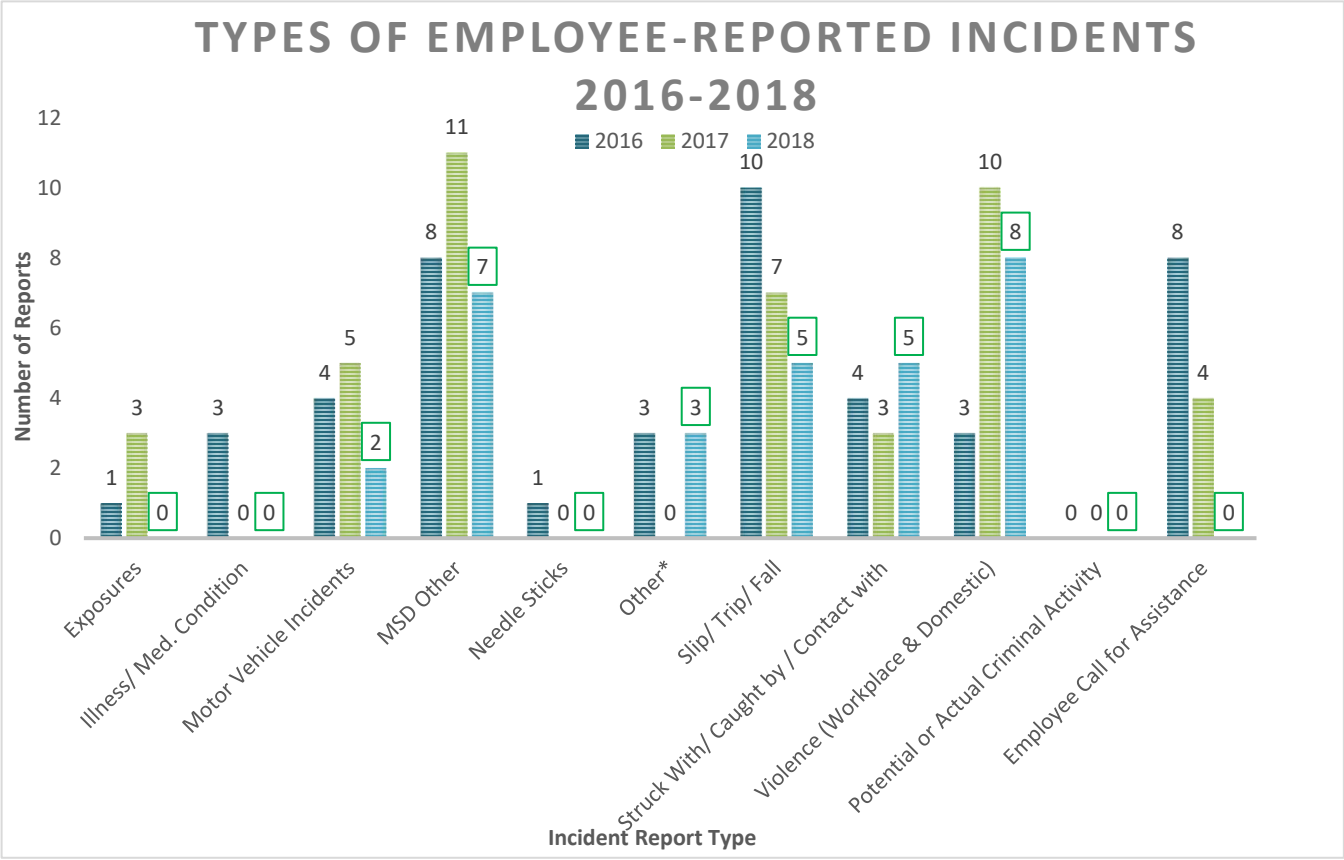


Figure 1: Employee- Reported Incidents 2016-2018

Examples of workplace violence incidents involves any situation that involves a worker in the workplace that may result in actual or potential harm/ injury, this may include reports of physical violence, verbal abuse, threat of physical violence etc.,

Examples of MSD other are employee requests for ergonomic reviews/ assessments as well as reports of discomfort in relation to work station set up/ material handling.

MLHU supports receiving incident reports from visitors, clients, contractors, unpaid students and volunteers, to identify and determine factors involved in non-employee incidents to ensure the appropriate corrective actions are completed if a hazard is identified. These reports also include the Security Guard's incident reports submitted to MLHU by Canadian Security Concepts.

Over the course of 2018, there were 14 non-employee incidents, all of which took place at 50 King Street. Most of the incidents were related to workplace violence, which involves the actual or the potential for harm/ injury. Of the 14 incidents, (including domestic violence), there were no reported injuries. The MLHU Security Guard responded to 10 of the 14 incidents involving visitors to the MLHU.

Injury Costs and Benchmarking

The following statistics (Table 2) are provided to MLHU by the Workplace Safety and Insurance Board (WSIB) on an annual basis (3rd Quarter) and provide a summary of the organization's injury counts, frequency rates, days lost and the severity rate as it compares to other organizations in our rate group (Treatment Clinics and Specialized Services). Similar information can also be found using the publicly accessible WSIB Compass Tool.

According to the WSIB Compass tool, 45% of the MLHU's lost time injuries between 2012-2017 were sprains and strains (MSD Other).

Table 2: WSIB Benchmarking and Injury Demographics Report

	2018	2017	2016
Employee Count[1]	323	339	364
Reported Incidents	30	43	45
Lost Time Injuries	1	1	1
No Lost Time Injuries	unavailable	4	7
Lost Time Injury Frequency	**.21**	**.21**	**.20**
WSIB Benchmark LTI Frequency	1.43	.30	.033
No Lost Time Injury Frequency	unavailable	**1.23**	**1.40**
WSIB Benchmark NLTI Frequency	unavailable	.70	.68
Year-to-date Days Lost	.20	99	272
Severity Rate	**0.04**	**20.32**	**54.44**
NEER Performance Index	0.030	1.83	0.20

[1] The employee count reflects full-time, part-time, and casual employees, including those on leave of absence at December 31, and does not account for employees who left MLHU during the year.

An LTI (lost-time injury) is a serious injury that results in time off work beyond the day of the incident, a loss of wages, or a permanent disability.

An NLTI (no-lost-time injury) is any injury in which no time is lost from work other than on the day of the incident, but medical attention/health care is sought (this does not include first aid that is received)

Injury Frequency and **Severity Rate** are calculated by the WSIB. **Injury Frequency** is an approximation of the number of LTI's per 100 workers. Severity Rate is an approximation of the number of days lost due to injuries occurring each year.

New Experimental Experience Rating (NEER) Performance Index is a comparison between MLHU's NEER cost record and the expected costs. If the costs are higher (lower) than expected, a surcharge (refund) is calculated.
0.0 – 0.99 – refund
1.00 – no surcharge or refund
1.01 to 4.00 – surcharge

Committee Involvement

Quarterly Meetings

The JOHSC conducted 5 meetings over the course of the 2018. The Committee regularly discusses employee-reported incidents, non-employee incidents, worksite inspections as well as program/ policy updates at each scheduled meeting. Minutes of the JOHSC meetings are made available on the JOHSC HUB page and are also posted on the JOHSC bulletin boards at each office location.

Generally, incidents, identified hazards and near misses are resolved satisfactorily by the employee's immediate manager, sometimes in consultation with Human Resources, Occupational Health and Safety, or by Operations.

Employees are always encouraged to raise concerns with their manager first. However, the JOHSC will follow up and discuss concerns raised by employees during worksite inspections. These types of concerns may engage the JOHSC in discussion, consultation, monitoring or the development of recommendations. The following themes, in addition to regular meeting agenda items, were discussed by the JOHSC in 2018:

- Activity based workstations
- Construction zones in the office
- Domestic violence training
- First aid and CPR training
- Footwear safety considerations
- Home visiting safety guidelines
- Mould in the lower level
- Near misses in the office related to entrance and exit doors
- Parking lot safety
- Personal safety guidelines
- The role of security
- Temporary overdose prevention site
- Vicarious trauma resources

- Visitor badges
- Winter conditions and the parking lot

NAOSH Week

The JOHSC celebrated the North American Occupational Safety and Health (NAOSH) Week (May 6th to 12th) by playing Plinko incorporating health and safety trivia with employees at all three office locations and offering a drop in automated external defibrillator (AED) demonstration. The Committee also provided fresh fruit in each of the kitchens at each office location. The 106 employees (33% of all employees) who participated in NAOSH week activities were entered into a draw for an emergency car kit or subway gift card.

Be Well Health Fair

The Committee participated in the Be Well Committee's second annual health fair where committee members engaged approximately 70 employees at their booth. Information about office ergonomics, workplace violence and the committee were provided to interested parties. All 33 employees (46% of health fair attendees) who engaged with the committee were entered into a draw for an emergency car kit.

JOHSC Membership

The JOHSC experienced a number of departures throughout 2018 and welcomed 5 new members. By the end of 2018, the committee was operating at full compliment. Three members of the committee also began their JHSC Certification training.

Every Joint Health and Safety Committee (JHSC) must have at least two certified members: one representing workers, and one from management. One worker and one management member must complete Part One and Part Two of the JHSC certification training to maintain active Certification status. A certified member is a JOHSC member who has completed both Part 1 (Basic Certification) and Part 2 (Workplace-specific Hazard Training) of the Joint Health and Safety Committee Certification program.

As a result of receiving special training in workplace health and safety, certified members are given additional powers under the Act. For example, certified employer and worker representatives can, under specified circumstances, collectively order the employer or constructor to stop work that is dangerous to a worker [subsection 45(4)].

MLHU's commitment to training allows for the JOHSC to act effectively when it comes to identifying workplace hazards.

Canadian Union of Public Employees	Ontario Nurses' Association	Management
Deborah Turner[1, 2] Worker Co-Chair Ext. 2437	Joanna Cuz [3] Ext. 2208	Lilka Young[2] Management Co-Chair Ext. 2349
Sharon Stein[2] Ext. 2306	Shelley Hlymbicky[3] Ext. 2268	Judy Green[3] Ext. 2371
Lisa Kelliher[3] Ext. 2508	Erica Zarins Ext. 2287	Tammy Beaudry[2] Ext. 2410

[1] Designated Certified Member
[2] JHSC Certified Member
[3] Certification Pending

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 010-19GC

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 June 20

Q2 2019 ACTIVITY REPORT – STRATEGIC PROJECTS

Recommendation

It is recommended that the Governance Committee receive Report No. 010-19GC re: "Q2 2019 Activity Report – Strategic Projects" for information.

Key Points

- The 2018–20 Balanced Scorecard identifies initiatives and tasks that the organization is pursuing to advance the strategic priorities identified in the 2015–20 Strategic Plan.
- The Q2 Balanced Scorecard Report (Appendix B) highlights the progress made to date on the strategic priorities, while detailed project status reports (Appendix C) summarize activities and tasks undertaken during Q2 2019.
- In summary, five projects in execution phase remained on track, while another five fell slightly behind schedule during Q2. Three projects were placed on hold following the provincial budget announcements and one project remains deferred from 2018.

Background

The Middlesex-London Health Unit's 2015–20 Strategic Plan details the vision, mission, and values of the organization and outlines its strategic priorities. The Board of Health approved the five-year plan at its September 17, 2015 meeting, and staff began working on many of the strategic priorities soon afterward. The 2018–20 Balanced Scorecard identifies strategic priorities to be carried out over the remaining 1.5-year horizon.

2018–20 Balanced Scorecard Reporting

The Project Management Office (PMO) is accountable for monitoring and reporting project status to the Board of Health. Regular reporting helps to identify recent accomplishments, key issues, lessons learned, and any variance from expected outcomes. The 2018–20 Balanced Scorecard and the Q2 2019 Balanced Scorecard Report are attached as Appendix A and Appendix B. Detailed project status reports are included in Appendix C and relate specifically to activities and tasks undertaken during Q2 2019.

Q2 2019 Activity

In Q2, five strategic projects that were in the execution phase continued to proceed as planned and remained on track according to project schedules:

- Relocation Project (PRJT#2018-001)
- Annual Service Plan Alignment and Implementation (PRJT#2018-002)
- Middlesex County Services Review (PRJT#2018-003)
- Electronic Client Record (PRJT#2018-005)

- Administrative Policy Manual – Policy Management Software Solution (PRJT#2018-015)

Strategic projects that were identified as being behind schedule due to issues requiring significant changes include:

- Enterprise Resource Planning (PRJT#2018-004)
- Community Engagement Strategy – Client Experience Tool (PRJT#2018-007)
- Community Health Status Reporting (PRJT#2018-008)
- Health Equity Indicator Assessment and Recommendations (PRJT#2018-010)
- Intake Lines (PRJT#2018-012)

Three strategic projects were placed on hold following the provincial budget announcement pending further direction from the Ministry regarding public health regionalization:

- Diversity and Inclusion (PRJT#2018-009)
- Implementation of Modernized Standards (PRJT#2018-011)
- MLHU Rebranding and Graphic Standards (PRJT#2018-013)

Currently there is one strategic initiative that has not yet started that was initiated prior to 2018: the Review of Learning Assessments project, to be deferred until Enterprise Resource Planning has been fully implemented.

For detailed information about each project listed above, refer to Appendix C.

Next Steps

The PMO will continue to provide support to staff to enable implementation of activities on the Balanced Scorecard to advance MLHU's strategic priorities. A comprehensive evaluation of the current Strategic Plan has been deferred. Consultation for the next strategic planning cycle will depend on further direction from the Ministry regarding public health regionalization.

This report was prepared by the Strategic Projects Team, Healthy Organization Division.

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

2018 -2020 MLHU Balanced Scorecard

Program Excellence

Deliver maximum value and impact with our resources

Objectives	Initiatives	Activities & Tasks	Measures
(A) Optimize evidence-informed planning and evaluation	1) Formalize a MLHU planning and evaluation framework that integrates: evidence-informed program planning, innovation, research advisory committee (when applicable), and regular evaluation of programs	• ***Ongoing implementation of the Planning and Evaluation Framework (PEF)*** *(Initiated prior to 2018)* ○ Develop policy to assist with implementation of PEF ○ Conduct PEF training workshops and topic-specific workshops for key staff • ***Implementation of the Modernized Standards*** *(PRJT#2018-011)* ○ Development of more detailed assessment of program standard compliance ○ Recommendations based on assessment ○ Implementation of recommendations	❖ Status of Planning and Evaluation Framework ❖ Status of Implementation of the Modernized Standards ❖ Status on the Establishment of PMO ❖ Status of Organizational Structure and Location Project ❖ Status of Intake Lines/PA Review ❖ Status of ECR project ❖ # of program reviews initiated ❖ Status of health equity indicators at MLHU ❖ MOHLTC performance indicators within 1% of target
	2) Utilize continuous quality improvement processes	• ***Establishment of the Project Management Office*** *(PRJT#2018-016)* ○ Assessment of current practices ○ Determine appropriate methodology, tools, processes ○ Develop and implement recommendations	
(B) Foster strategic integration and collaboration	1) Identify ideal organizational structure and complimentary processes to ensure our programs and services are focused on our core mission	• ***Continuation of the Organizational Structure and Location Project*** *(PRJT#2018-001)* ○ Establishment of OSL 2.0 and associated working groups ○ Space planning and clinic flow ○ Move Planning ○ Commissioning • ***Electronic Client Record*** *(PRJT#2018-005)* ○ Conduct needs assessment ○ Select the appropriate solution ○ Provide education and training ○ Implement new system	
(C) Address the social determinants of health	1) Knowledge exchange and skill building activities for social determinants of health (SDOH)	• ***Staff Capacity Building*** *(Initiated prior to 2018)* ○ From Bystander to Ally Training	
	2) Expand health equity impact assessment implementation and monitoring	• ***Health Equity Indicator Assessment and Recommendations*** *(PRJT#2018-010)*	

		○ Determination of how prioritized indicators can be adopted by MLHU, systematically collected and integrated into planning and evaluation • ***Community Health Status Report Updating*** *(PRJT#008-2018)* ○ Development of a plan to conduct data analysis and prepare reports	
	3) Establish a policy development and advocacy framework	• ***Policy Development: Advocacy Framework*** *(PRJT#2018-015)* ○ To ensure all advocacy initiatives and strategies align with the Health Unit's vision, mission and values, and are approved by Senior Leadership and/or the Board of Health. ○ To ensure all employees who are engaged in systemic advocacy initiatives consistently use effective and efficient planning and implementation processes.	
(D) Ensure programs achieve organizationally established Performance targets	1) To be determined through Divisional and Team Balanced Scorecard development	• ***Develop Divisional Balanced Scorecards*** *(PRJT#2018-016)* ○ Cascading from the Organizational Balanced Scorecard and incorporating the approved prioritized projects for the current strategic planning cycle ○ Collect and report on MOHLTC accountability agreement indicators	

Client and Community Confidence

Foster client satisfaction and community confidence

Objectives	Initiatives	Activities & Tasks	Measures
(A) Seek and respond to community input	1) Use community input and feedback to inform program planning and evaluation	• **Integrate community and client feedback mechanisms into strategic projects and program planning and evaluation** *(Initiated prior to 2018)* ○ Included within the Program Evaluation Framework and being rolled-out to the organization.	❖ # of client / community feedback interactions ❖ # of visits to healthunit.com website ❖ % of people familiar with the health unit ❖ Client / community partner experience ❖ Status of Middlesex County Services Review
(B) Ensure clients and the community know and value our work	1) Increase the awareness of public health and the role of the Middlesex-London Health Unit	• ***Complete the review and revisions to MLHU graphic standards and branding*** *(PRJT#2018-013)* ○ Adopt an ambassador strategy that will enable staff and teams to promote broader MLHU services	
(C) Deliver client-centred service	1) Use client input and feedback to inform service delivery and evaluation	• **Community Engagement Strategy – Client Experience Tool Development and Implementation** *(PRJT#2018-007)* ○ Utilize a tool that measures client experience and is implementation by teams and programs • ***Intake Lines/Program Assistant Review*** *(PRJT#2018-012)* ○ Consult with clients and staff re: proposed system ○ Conduct review of PA role ○ Procure systems and identify alternatives ○ Implementation and training	
	2) Deliver appropriate outreach services where people live, work, learn and play	• ***Middlesex County Services Review*** *(PRJT#2018-003)* ○ Assess the health needs of county residents, map current resources that are deployed and determine opportunities for enhancement ○ Identify effective strategies and provide recommendations for implementation	

Employee Engagement and Learning

Engage and empower all staff

Objectives	Initiatives	Activities & Tasks	Measures
(A) Promote transparent and inclusive decision-making processes	1) Increase opportunities (surveys, town halls, fire side chats) for staff to share input in MLHU decision-making (structure, location, budgets)	• ***Define annual opportunities to enhance engagement*** *(Initiated prior to 2018)* ○ Ensure a minimum of 3 Town Halls per year ○ Allow for consultation that will cultivate ideas at the front-line of the organization (PBMA, Location project, etc.)	❖ Employee engagement (overall engagement score) ❖ % of staff completing mandatory training ❖ % of policies reviewed within 2 years ❖ Annual EFAP Usage ❖ % of staff completing BeWell Survey ❖ # of active ABW stations ❖ Status of Performance Management Framework ❖ Status of ERP Project ❖ Status of the Establishment of PMO ❖ Status of Diversity and Inclusion Project
	2) Inclusive planning days and follow-up processes	• ***Increase transparency throughout the organization*** *(Initiated prior to 2018)* ○ Regular communication to all MLHU staff through various channels regarding status of strategic projects	
(B) Enhance staff development and continuing education	1) Establish and implement consistent performance management and measurement systems, tools and processes	• ***Determine areas of focus for performance management*** *(PRJT#2018-004)* ○ Incorporate functions of a human resources information system (HRIS), that includes performance management capabilities into an Enterprise Resource Planning system	
	2) Learning opportunities for staff are aligned with MLHU's strategic priorities and objectives	• ***Deliver the Learning at MLHU Program*** *(PRJT#2018-004)* ○ Incorporate functions of a human resources information system (HRIS), that includes learning and development into an Enterprise Resource Planning system	
(C) Strengthen positive organizational culture	1) Implement a comprehensive workplace wellness strategy	• ***Champion the BeWell Program*** *(Initiated prior to 2018)* ○ Review ROI and determine future investment opportunities • ***Develop and implement alternative-based work (ABW) arrangements*** *(PRJT#2018-006)* ○ Provide management training ○ Policy development ○ Continual change management strategies	
	2) Establish processes that acknowledge staff contributions to our mission, vision and values	• ***Staff engagement in strategic projects*** *(PRJT#2018-016)* ○ Provide information to staff at regular intervals (e.g. team presentations, town hall meetings, etc.) and establish a consultation model that is inclusive of all MLHU staff	
	3) Embed our values into all that we do	• ***Diversity Assessment and Recommendations*** *(PRJT#2018-009)* ○ Initiate organizational assessment of diversity and inclusiveness, and identify recommendations • ***Complete review of Administrative Policy Manual*** *(PRJT#2018-015)* ○ Develop policies that help us to live our values (i.e. work-life balance, diversity)	

Organizational Excellence

Enhance governance, accountability and financial stewardship

Objectives	Initiatives	Activities & Tasks	Measures
(A) Engage and inform the Board of Health	1) Provide appropriate recommendations and analysis to the Board of Health regarding developments affecting public health, the health unit and the community	• ***Annual Service Plan Alignment (ASP) and Implementation*** *(PRJT#2018-002)* ○ Ensure that programs align with the program standards and that tools used in the ASP are aligned to streamline reporting and roll-up of data. ○ Assessment and analysis of indicator needs across the organization in order to inform annual service plans.	❖ % of Divisions completing Balanced Scorecards ❖ % Budget Variance ❖ % of Budget Reallocated through PBMA ❖ Status of ERP project ❖ Status of Annual Service Plan ❖ % of mandatory training completed ❖ Status of Performance Management Framework ❖ Status of Risk Management Framework
	2) Deliver relevant and timely information and reports to the Board of Health	• ***Conduct training for staff who write board reports or present to the board*** *(Initiated prior to 2018)* ○ Focus on establishing clear expectations, development approach and timelines, integrating evidence to recommendations and presenting material in an impactful way	
(B) Demonstrate excellent organizational performance	1) Board of Health performance dashboard	• ***Enterprise Resource Planning System - Upgrade the financial reporting system*** *(PRJT#2018-004)* ○ Upgrade to include dashboard that provides easily accessible information • ***Alignment of budget and performance reporting*** *(PRJT#2018-002)* ○ Modify Program Budget Templates to align with Annual Service Plan requirements	
	2) Develop and implement an organizational performance management framework	• ***Performance Management Framework – Phase 1 (Planning)*** *(PRJT#2018-014)* ○ Provide the overall direction for MLHU performance management using the Balanced Scorecard method and articulate the strategy for roll-out. • ***Continued development of MLHU Risk Management Framework*** *(PRJT#2018-017)* ○ Develop an organizational risk register and embed risk management within existing MLHU processes (PBMA, Planning and Evaluation, Project Management)	
(C) Exercise responsible financial governance and controls	1) Financial policy compliance audits	• ***Review of Learning Assessments*** *(Initiated prior to 2018)* ○ Monitored annually through external audit and periodic financial review of employee activity	
	2) Ensure third parties are accountable to MLHU financial standards through agreements/reporting	• ***Enhance procurement operations by introducing a technological solution to manage contracts*** *(PRJT#2018-004)* Assess, implement, evaluate components of procurement functions within the Enterprise Resource Planning system.	
	3) Increase staff understanding of budgets, processes, and policies	• ***Support budget process education*** *(PRJT#2018-002)* ○ Develop and implement budget process training.	

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

Program Excellence

Activities & Tasks	*Overall Status*	*Comments*	*Q2 Status Report (Y/N)*
• ***Ongoing implementation of the Planning and Evaluation Framework (PEF)*** *(Initiated prior to 2018)* ○ Develop policy to assist with implementation of PEF. ○ Conduct PEF training workshops and topic-specific workshops for key staff.	☑	A PEF policy was developed to outline how to access the framework and describe the support available for program planning, implementation and evaluation activities. In addition, the policy highlights specific roles and responsibilities as well as program requirements. PEF implementation strategies include: HUB content and quick links, quick reference guides, streamlined support request process, engagement at division leadership and team meetings, staff assessments and development of learning opportunities (workshops, in-services at team meetings, one on one meetings, and project specific training).	**N**
• ***Implementation of the Modernized Standards*** *(PRJT#2018-011)* ○ Development of more detailed assessment of program standard compliance. ○ Recommendations based on assessment ○ Implementation of recommendations.	☒	MLHU will assess program standard compliance through enhanced program and budget reporting through requirements of the Annual Service Plan. This will be on hold until further direction provided by the Ministry with respect to public health regionalization.	**N**
• ***Establishment of the Project Management Office (PMO)*** *(PRJT#2018-016)* ○ Assessment of current practices. ○ Determine appropriate methodology, tools, processes. ○ Develop and implement recommendations.	👍	An assessment of current practices was completed and the PMO created the MLHU project management methodology to promote best practices, maintain project status and provide leadership with respect to managing projects. The PMO solidified a method for monitoring project status and enhancing reporting capabilities. PMO accountabilities will be further embedded into future strategic planning processes.	**N**

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

Activities & Tasks	*Status*	*Comments*	*Q2 Status Report (Y/N)*
• ***Continuation of the Organizational Structure and Location Project*** *(PRJT#2018-001)* ○ Establishment of OSL 2.0 and associated working groups. ○ Space planning and clinic flow. ○ Move Planning. ○ Commissioning.	👍	The project is currently on schedule with pre-qualification of the general contractor completed. Construction tender issued on May 13, 2019 and closing on June 24, 2019. Evaluation of bid documents and contract awarded to successful proponent by June 30, 2019. Kick-off for the construction phase will commence the week of July 2nd, 2019. The OSL 2.0 committee and working groups have been involved in modifying processes in response to the design and layout of the new location. The OSL 2.0 committee hosted a successful Spring Sale for employees featuring excess supplies and equipment identified during the purge activities. The sale generated over $2300 to allocate towards moving costs. Change management training has continued throughout Q2 and over 98% of full time employees who have completed the training as of June 2019.	**Y**
• ***Electronic Client Record*** *(PRJT#2018-015)* ○ Conduct needs assessment. ○ Select the appropriate solution. ○ Provide education and training. ○ Implement new system.	👍	Discovery period for workflows and business requirements completed and the build/configuration stage for phase 1 implementation has commenced. Production database released in early June 2019 and configuration will continue for 4-6 weeks. Testing is scheduled for early July 2019 and coincides with end user training throughout the month. Go-live for phase 1 implementation teams is targeted for end of July 2019. Phase 2 implementation will commence in Q3 2019.	**Y**
• ***Staff Capacity Building*** *(Initiated prior to 2018)* ○ From Bystander to Ally Training.	👍	Implementation of staff capacity building plan has progressed well. Indigenous Public Health Practice domain: Over 90 staff have completed or are registered to complete the Bystander to Ally education; ~80 staff have attended workshops with cultural educator and traditional healer; ~60 staff attended the See Me Exhibit and blanket exercise at At'lohsa; ~25 leaders participated in the Roots of Tolerance Workshop. Public Health Sciences domain: Health Equity Primer and Health Equity Concept Guides developed and available on the HUB; Learning Management System (LMS) module for employees almost ready to launch. Planning for next prioritized domains beginning.	**N**

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

Activities & Tasks	*Status*	*Comments*	*Q2 Status Report (Y/N)*
• ***Health Equity Indicator Assessment and Recommendations*** *(PRJT#2018-010)* ○ Determination of how prioritized indicators can be adopted by MLHU, systematically collected and integrated into planning and evaluation.	⚑	Board-approved prioritized indicators have been further refined to ensure they are 'SMART'. Assessment of MLHU's current state related to indicators, development of benchmarks and targets, and identification of recommended processes to monitor progress on indicators has been underway throughout the year. Progress on the project has been delayed since the provincial budget announcement resulting in a need to re-prioritize health equity indicators in response to public health restructuring.	**Y**
• ***Community Health Status Report Updating*** *(PRJT#2018-008)* ○ Development of a plan to conduct data analysis and prepare reports.	⚑	The project is designed to embed practices to support ongoing, routine updating of the Community Health Status Resource (CHSR) and ensure the information is up-to-date. The project is intended to align the indicator content with the modernized Standards including the assessment of inequities as feasible. Due to competing priorities, including public health restructuring, project timelines were reviewed and extended. Soft launch of Cycle 2 &3 were completed and Cycle 4 launch is scheduled for June 2019. Project management will be turned over to the project sponsor at the end of June 2019.	**Y**
• ***Policy Development: Advocacy Framework*** *(PRJT#2018-015)* ○ To ensure all advocacy initiatives and strategies align with the Health Unit's vision, mission and values, and are approved by Senior Leadership and/or the Board of Health. ○ To ensure all employees who are engaged in systemic advocacy initiatives consistently use effective and efficient planning and implementation processes.	☑	As part of the Health Equity Staff Capacity Building Plan the new MLHU Advocacy: A Process Planning Guide was introduced. This followed the launch of the Learning Management System (LMS) module regarding the new MLHU Advocacy Policy 2-090, which will be added to all staff development plans in the near future. A workshop was offered to staff with the objectives to provide staff with an understanding of the role systemic advocacy plays in supporting health and how to use advocacy process planning guide. A second workshop focused on engaging and influencing decision-makers will be offered. Additional steps will be taken to ensure familiarity with the process guide and the advocacy policy, and the Health Equity and Program Planning and Evaluation teams will provide ongoing consultative support to teams, as needed.	**N**
• ***Develop Divisional Balanced Scorecards*** *(PRJT#2018-016)* ○ Cascading from the Organizational Balanced Scorecard and incorporating the approved prioritized projects for the current strategic planning cycle.	👍	Division level balanced scorecards developed and monitored according to the 2018-2020 organizational balanced scorecard. MOHLTC accountability agreement indicators are collected and reported on by Program Planning and Evaluation team.	**N**

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

Activities & Tasks	Status	Comments	Q2 Status Report (Y/N)
Client and Community Confidence			
• ***Integrate community and client feedback mechanisms into strategic projects and program planning and evaluation*** *(Initiated prior to 2018)* ○ Included within the Program Evaluation Framework and being rolled-out to the organization.	👍	This activity is well underway with the implementation of PEF policy and resources in addition to the establishment of the PMO.	**N**
• ***Complete the review and revisions to MLHU graphic standards and branding*** *(PRJT#2018-013)* ○ Adopt an ambassador strategy that will enable staff and teams to promote broader MLHU services.	☒	This will be on hold until further direction provided by the Ministry with respect to public health regionalization.	**N**
• **Community Engagement Strategy – Client Experience Tool Development and Implementation** *(PRJT#2018-007)* ○ Utilize a tool that measures client experience and is implementation by teams and programs.	⚑	A client experience survey (CES) was selected and the development of an implementation plan for the health unit was targeted for the end of Q4 2018. Competing demands interfered with the proposed implementation date of the CES by the teams with service-seeking clients and the survey was launched in Q1 2019. Initiation of the project charter for phase 2 – mandated client experience survey has been delayed with the departure of the project managers assigned to this project during Q2 2019.	**N**
• ***Intake Lines*** *(PRJT#2018-012)* ○ Consult with clients and staff re: proposed system. Procure systems and identify alternatives. ○ Implementation and training.	⚑	A project charter has been initiated and a work plan and timelines for deliverables established. The proposed model for Intake Lines has been confirmed following extensive consultation. The project is currently behind schedule due to the delay in scoping the necessary requirements to go to tender for a new technology system. This work is in progress during June 2019 and it is anticipated that the project schedule will be back on track to meet the November 2019 implementation date.	**Y**
• ***Middlesex County Services Review*** *(PRJT#2018-003)* ○ Assess the health needs of county residents, map current resources that are deployed and determine opportunities for enhancement.	👍	The recommended action items contained within the report have been developed for each of the findings and will be going to the Board of Health, Middlesex County Council and lower tier municipalities for follow-up. The project has approached the close-out phase.	**Y**
Employee Engagement and Learning			

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

Activities & Tasks	*Status*	*Comments*	*Q2 Status Report (Y/N)*
• ***Define annual opportunities to enhance engagement*** *(Initiated prior to 2018)* ○ Ensure a minimum of 3 Town Halls per year ○ Allow for consultation that will cultivate ideas at the front-line of the organization (PBMA, Location project, etc.)	👍	Strategies that are currently underway include: 1) ongoing discussion and opportunities for information sharing available at Town Halls, 2) open sessions for PBMA investment/disinvestment proposals, 3) establishment of the OSL 2.0 Committee to cultivate ideas at the front-line in relation to the relocation project.	**N**
• ***Increase transparency throughout the organization*** *(Initiated prior to 2018)* ○ Regular communication to all MLHU staff through various channels regarding status of strategic projects	👍	The establishment of the PMO has increased transparency across the organization by: 1) creating a centralized repository for project documentation located on the shared drive, 2) maintaining resources on the HUB to allow staff to access information on project status, 3) communicating with staff through various channels (town halls, electronic newsletters, division/team meetings, etc.) to keep them informed about strategic projects.	**N**
• ***Determine areas of focus for performance management*** *(PRJT#2018-004)* ○ Incorporate functions of a human resources information system (HRIS), that includes performance management capabilities into an Enterprise Resource Planning system	⚑	Benefits, payroll and workforce management discovery sessions have been completed and the discovery workbook was submitted to Ceridian for review. Some discovery sessions had to be delayed due to availability of the Ceridian implementation team and may affect upcoming key milestones. The go-live date was pushed back from early September 2019 to the first week of October 2019.	**Y**
• ***Deliver the Learning at MLHU Program*** *(PRJT#2018-004)* ○ Incorporate functions of a human resources information system (HRIS), that includes learning and development into an Enterprise Resource Planning system	⚑	The project timeline for this work is dependent upon the implementation of Ceridian Dayforce scheduled for the first week of October 2019, which is a delay from the initial September 2019 go-live date.	**Y**
• ***Champion the BeWell Program*** *(Initiated prior to 2018)* ○ Review ROI and determine future investment opportunities	☑	In Q1 2019 a new partnership with Employee Wellness Solutions Network (EWSNetwork) was announced to enhance Be Well programming and provide a variety of wellness initiatives ranging from onsite exercise classes to awareness information based on nutrition, exercise, sleep, stress and more. Staff information sessions were offered to allow the Be Well Committee to share program changes.	**N**
Activities & Tasks	*Status*	*Comments*	*Q2 Status*

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

			Report (Y/N)
• ***Develop and implement Activity-Based Work (ABW) arrangements*** *(PRJT#2018-006)* ○ Provide management training ○ Policy development ○ Continual change management strategies	👍	A consultation process involving focus groups sessions was completed with those teams that had been part of the ABW pilot. Criteria was established to make ABW a permanent way of working at the Health Unit. The input and feedback gathered through the design consultations for the relocation project helped shape how ABW will be rolled out to the other teams that will be moving into ABW at the new office space in Citi Plaza. An ABW Policy and Guidelines have been drafted and will be rolled-out in alignment with the relocation project.	**N**
• ***Staff engagement in strategic projects*** *(PRJT#2018-016)* ○ Provide information to staff at regular intervals (e.g. team presentations, town hall meetings, etc.) and establish a consultation model that is inclusive of all MLHU staff	👍	The establishment of the PMO has increased staff engagement across the organization in strategic projects by: 1) creating a centralized repository for project documentation located on the shared drive, 2) maintaining resources on the HUB to allow staff to access information on project status, 3) communicating staff through various channels (town halls, electronic newsletters, division/team meetings, etc) to engage staff in strategic projects.	**N**
• ***Diversity Assessment and Recommendations*** *(PRJT#2018-009)* ○ Initiate organizational assessment of diversity and inclusiveness, and identify recommendations	☒	This will be on hold until further direction provided by the Ministry with respect to public health regionalization.	**N**
• ***Complete review of Administrative Policy Manual*** *(PRJT#2018-015)* ○ Develop policies that help us to live our values (i.e. work-life balance, diversity)	👍	MLHU signed a four-year contract with Policy Medical for the implementation of the policy management software solution. The migration of policies into Policy Manager (“the solution”) has progressed during Q2 2019 and the initial configuration of the solution is almost complete. Go-live for the administrative and governance level documents is on track for September 2019 with expansion to program level documents to follow in Q4 2019. Continued review of existing policies to identify documents for revision/consolidation/decommission is well underway.	**Y**

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

Organizational Excellence

Activities & Tasks	*Status*	*Comments*	*Q2 Status Report (Y/N)*
• ***Annual Service Plan Alignment (ASP) and Implementation*** *(PRJT#2018-002)* ○ Ensure that programs align with the program standards and that tools used in the ASP are aligned to streamline reporting and roll-up of data. ○ Assessment and analysis of indicator needs across the organization in order to inform annual service plans.	👍	Completed the process of revising enhanced reporting templates for the Annual Service Plan (ASP) and MLHU budget. The ASP was completed and filed on time with the Ministry by April 1, 2019. Approved budgets were uploaded to Management Reporter. The project will transition to operations and will approach the close-out phase will the presentation of lessons learned to SLT in June 2019 and the preparation to launch the 2020 PBMA process.	**Y**
• ***Conduct training for staff who write board reports or present to the board*** *(Initiated prior to 2018)* ○ Focus on establishing clear expectations, development approach and timelines, integrating evidence to recommendations and presenting material in an impactful way.	👍	Staff receive feedback from management and the senior leadership team in preparation for presentations to the Board. This occurs when staff are invited to attend Director/SLT meetings and present items for discussion before bringing that items forward to the Board.	**N**
• ***Enterprise Resource Planning System - Upgrade the financial reporting system*** *(PRJT#2018-004)* ○ Upgrade to include dashboard that provides easily accessible information	⚑	Successful upgrade to Great Plains (GP) 2018 and migration from FRX to Management Reporter. Q4 variance reporting was completed using Management Reporter. The next phase of the financial system upgrade will be the roll out of the procurement and fixed asset administration modules to be integrated with the GP Financial Accounting system. Although the upgrade to the financial system has been completed, changes to the chart of accounts is incomplete due to the holding the implementing the procurement module.	**Y**
• ***Alignment of budget and performance reporting*** *(PRJT#2018-002)* ○ Modify Program Budget Templates to align with Annual Service Plan requirements	👍	Staff completed the revised reporting template for the Annual Service Plan and MLHU budget. The ASP was completed and filed on time with the Ministry by April 1, 2019.	**Y**
Activities & Tasks	***Status***	***Comments***	***Q2 Status***

Complete ☑ On-Target / Ongoing 👍 Approaching Target / Behind Schedule ⚑ Not Started / Major Obstacles ☒

			Report (Y/N)
• ***Performance Management Framework – Phase 1 (Planning)*** *(PRJT#2018-014)* ○ Provide the overall direction for MLHU performance management using the Balanced Scorecard method and articulate the strategy for roll-out.	👍	Divisions are currently utilizing the Balanced Scorecard to monitor progress. Further developments will be underway with the implementation of HRIS that includes performance management capabilities within the Enterprise Resource Planning system.	**N**
• ***Continued development of MLHU Risk Management Framework*** *(PRJT#2018-017)* ○ Develop an organizational risk register and embed risk management within existing MLHU processes (PBMA, Planning and Evaluation, Project Management)	👍	A risk assessment was conducted that identified high, medium and low organizational risks resulting in an organizational risk register. Opportunities to enhance risk management practices within existing MLHU processes were assessed through the identification of risk mitigation strategies. MLHU met the requirement under the Public Health Accountability Framework and submitted the new Risk Management Report to the Ministry.	**N**
• ***Review of Learning Assessments*** *(Initiated prior to 2018)* ○ Monitored annually through external audit and periodic financial review of employee activity.	☒	This will be deferred until the HRIS implementation has been completed.	**N**
• ***Enhance procurement operations by introducing a technological solution to manage contracts*** *(PRJT#2018-004)* ○ Assess, implement, evaluate components of procurement functions within the Enterprise Resource Planning system.	⚑	The Enterprise Resource Planning project that addresses the upgrade of the financial reporting system includes the implementation of a purchasing module to be integrated with the GP Financial Accounting system. The introduction of the procurement module has been placed on hold following the provincial budget announcement in April 2019.	**Y**
• ***Support budget process education*** *(PRJT#2018-002)* ○ Develop and implement budget process training.	👍	Staff received training on the completion of the revised enhanced ASP reporting templates. Support was made available through the Finance Team and the Program Planning and Evaluation Team. Further training will be provided through the new ERP – Finance System implementation. Reports will be developed using Management Reporter to monitor spending by program throughout 2019.	**Y**

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Relocation Project	**Project Number:**	2018-001
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Procurement & Operations
Project Phase:	Execution	**Date:**	June 2019

Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Updated project plan received from Endri Poletti Architect Inc.
- Class "B" Estimate received, and budget approved by BOH.
- General contractor pre-qualification completed.
- Held a Spring Sale for employees featuring excess supplies and equipment for purchase generated over $2300 to be put towards relocation costs.
- Construction tender issued May 13th.
- Communications, audio visual and security consultants selected and hired.
- Private funding secured for fit-up costs.

Top Issues:

- Landlord's project plan received but there may be variability on completion date depending if any obstacles are identified.
- Design finalization was delayed in order to obtain budget estimates for fit-up.

Top Risks:

- Cost increases for construction labour and materials, impacting the overall project budget.
- Termination of lease at current locations may result in having to expedite the project schedule and increase cost.
- Concern of labour availability when the project is started.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Tender	May 13, 2019	✓	
2. Bidder Walk through	May 27, 2019	✓	
3. Tender Close	June 24, 2019	✓	
4. Tender Award	June 28, 2019	✓	
5. General Contractor Kick-off	July 2, 2019	✓	

Project Changes:

- Potential change to dental clinic due to Seniors Dental Program funding.

Key Activities for Next Period:

- Evaluate bid documents.
- Award tender for general contractor through BOH.
- Kick off construction phase with general contractor.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Annual Service Plan (ASP) / Planning and Budget Template / Planning and Evaluation Framework Alignment	**Project Number:**	2018-002
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Finance Manager Program Planning and Evaluation
Project Phase:	Transition to Operations	**Date:**	June 2019

Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- ASP was completed and filed on time with the Ministry on April 1, 2019.
- Uploaded approved budgets to Management Reporter (MR).
- Evergreen documents were created for each Program accessible in a shared file – intention is that modifications to program design and delivery are captured on a current basis to facilitate development of ASP in subsequent year(s).

Top Issues:

- Meeting with SLT planned for June 25 to outline lessons learned from initial ASP cycle.
- Aligning PBMA process with ASP (migrating from team basis to program basis).
- Integrating operating costs into program budgets (previously pro-rated based on distribution of team-based salaries & benefits costs).

Top Risks:

- Determine whether the ASP processes developed by MLHU are scalable for larger regional structure.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. Transition to Operations	Ongoing	✓	
2. Project Close-out: present lessons learned to SLT	June 25, 2019	✓	
3. Aligning 2020 PBMA Process with ASP	Sept, 2019	✓	

Project Changes:

- None to report.

Key Activities for Next Period:

- Prepare for launch of 2020 PBMA process.
- Develop templates to facilitate transition from Team Budgets to ASP-based Programs.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Review of Public Health Services in Middlesex County	**Project Number:**	2018-003
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Program Planning and Evaluation
Project Phase:	Close-out	**Date:**	June 2019

Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- The recommended action items have been developed for each of the findings from the report and has been reviewed by SLT.

Top Issues:

- Many of the recommended action items require the capacity of the program teams and other organizational supports and projects.

Top Risks:

- Regionalization of public health units impacting delivery of the recommended action items.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Board of Health Report	June 20, 2019	✓	
2. Presentation to Middlesex County	June 25, 2019	✓	
3. Project Close-out	July 31, 2019	✓	

Project Changes:

- None

Key Activities for Next Period:

- The recommendations and action items will now be going to the Board of Health, Middlesex County Council and lower tier municipalities for follow-up.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Enterprise Resource Planning – Implementation of Ceridian Dayforce	**Project Number:**	2018-004
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Human Resources Manager, Strategic Projects
Project Phase:	Execution	**Date:**	June 2019

Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Benefits, Payroll and Workforce Management (WFM) Discovery sessions have been completed and the Discovery Workbook has been submitted to Ceridian for review.

Top Issues:

- Great West Life (GWL) is unable to provide a resource for 4 – 6 months. MLHU to follow up with GWL to see what can be done to expedite resource assignment. If GWL cannot offer a resource earlier, MLHU will need to manage export requirements manually for Go-Live.

Top Risks:

- The delay of some of the discovery sessions may affect upcoming key milestones and shorten the allocated period for testing in order to achieve the target date for go-live.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. Discovery sign off for Pay, Benefits, and, Time and Attendance Modules	June 7th, 2019		X
2. Delivery of Test Cases	June 10th, 2019	✓	
3. Training Strategy & Plan Generation	June 15th, 2019	✓	
4. First Files Due	June 10th, 2019	✓	
5. Sandbox Available	June 10th, 2019	✓	

Project Changes:

- The anticipated Go-Live date of September 5th has been adjusted to October 1st to better align with full staff complement after summer vacations. This strategy will facilitate additional learning and development opportunities prior to implementing a significant platform change.

Key Activities for Next Period:

- Ceridian project implementation team to summarize requirements into Recap Document for MLHU review and sign off.
- Benefits requirements and module review meeting with Ceridian.
- Schedule General Ledger meetings once Earnings/Deductions updated in Dayforce.
- Dashboards/Doc Management discovery sessions to be scheduled.
- Test environment prepared with MLHU data – system testing commences.
- Online training continues for project leads.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Electronic Client Record (ECR)	**Project Number:**	2018-005
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Strategic Projects
Project Phase:	Execution	**Date:**	June 2019

Status Last Period:	Current Status:	Scope	Schedule:	Cost:

Recent Accomplishments:

- The MLHU Project Team completed Essentials Functional Training March 5 – 8, 2019.
- Completed workflow discovery sessions, current and future state workflow configuration sessions.
- Submitted Profile Implementation Workbook to Intrahealth for review.
- Project team participated in Form Builder Training offered through Intrahealth.
- Developed and refined existing forms to be built into Profile.
- Established a high-level training plan in preparation for go-live at the end of July 2019.

Top Issues:

- The personnel resources required to dedicate to this project will be extensive in order for it to be successful.

Top Risks:

- Project implementation for Phase 2 will overlap with the move according to the relocation project schedule resulting in competing priorities.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. Finalize Implementation Workbook	June 7, 2019	✓	
2. Workflow Presentations	May 30, 2019		**X**
3. Release Production Database & IT Set-Up	June 7, 2019	✓	
4. Build/Configuration of Profile	June 30, 2019	✓	
5. Testing & Data Migration	July 22, 2019	✓	
6. Super/End User Training	July 22, 2019	✓	

Project Changes:

- None to report.

Key Activities for Next Period:

- Assessment of privacy practices across MLHU.
- Complete build/configuration of Profile for Phase 1 teams – including forms & templates.
- Training plan finalization – schedule super/end user training and refine manuals and resources.
- Testing for phase 1 teams.
- Data migration from existing systems into Profile (e.g. Hampson and Sharepoint)
- Preparation for Phase 2 teams discovery workflows.
- Continue networking with all public health units currently using Profile across Ontario: Algoma, Brant, Durham, Niagara, and Porcupine.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Community Health Status Resource Update	**Project Number:**	2018-008
Project Sponsor:	Associate Medical Officer of Health	**Project Manager:**	Epidemiologist
Project Phase:	Execution	**Date:**	June 2019

Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Completed uploading of Cycle 2 & 3 content on the web March and May respectfully.
- Completed "soft launch" of Cycle 2 & 3 including internal knowledge translation activities by epidemiologists and all-staff email notification by AMOH.
- Provided update to board of health on May 16, 2019.
- Cycle 4 content analysis completed.
- Time to load content shortened due to the addition of Executive Assistant and streamlining of processes.

Top Issues:

- Due to competing priorities including public health system restructuring, review timelines for some topics needed to be extended and timelines for loading revised.
- Time to complete analysis took longer than originally anticipated. Due to staffing resources within the Population Health and Surveillance team, some topics originally planned to be part of the project will be deferred to be part of routine work in the fall.
- Involvement of multiple data analysts and epidemiologists on the project team required a standardized process that caused delays in the project schedule.

Top Risks:

- Epidemiologists staffing may further affect project completion timeline.
- Competing priorities including public health system restructuring may impact CHSR project work.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. Sustainability Report	March 22, 2019		**X**
2. Cycle 4 Web Launch	June 7, 2019	✓	
3. Cycle 5 (Child & Youth Topic) Review	July 12, 2019	✓	
4. General Launch	July 26, 2019		**X**

Project Changes:

- Revised timeline and scope.
- Extended timeline for completion of sustainability report.
- Currently considering if the launch should be delayed or move ahead as planned after Cycle 5 this summer.

Key Activities for Next Period:

- Complete interim sustainability report.
- Complete Cycle 4 web-loading (Topics include General Health, Infectious Disease, Behavioural Risk Factors).
- Complete Cycle 5 (Child & Youth).
- Project management to be turned over to project sponsor at the end of June.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Health Equity Indicators	**Project Number:**	2018-010
Project Sponsor:	Director, Healthy Start and Chief Nursing Officer	**Project Manager:**	Public Health Nurse, Health Equity and Social Determinants of Health
Project Phase:	Execution	**Date:**	June 2019

Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Consulted SLT and scaled down HEI assessment so ongoing efforts will address current program goals and/or goals likely to be relevant under new PH structure.
- Indicators for assessment in 2019 (phase 2) reviewed and adapted questions for relevance to MLHU and begun answering questions where information is known to working group.
- Made progress identifying specific tasks and responsibility necessary to operationalize processes re-approved by SLT for indicators for assessment in 2020 (phase 3).

Top Issues:

- Progress on project has been delayed since April 2019 due to need for guidance from SLT regarding re-prioritization of HEIs in response to proposed MOHLTC level system changes.
- Need to defer and/or scale back assessment of current state and identification of processes to move MLHU towards meeting indicators.

Top Risks:

- Delay in addressing Health inequities in our community and ability to meet Ontario Public Health Standards Health Equity mandate.
- Limited ability to report specific progress towards addressing health equity in our community on Annual Service Plan.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. Communicate processes as re-approved by SLT	July 31, 2019	✓	
2. Update project charter for Phase 2 and 3	June 30, 2019	✓	
3. Obtain approval for moving forward with re-prioritized indicators for 2019	December 31, 2019	✓	
4. Report to SLT on progress	December 31, 2019	✓	

Project Changes:

- In-depth assessment and/or approved processes for some HEIs deferred.

Key Activities for Next Period:

- Provide relevant program teams with information regarding re-approved processes and monitoring systems and respond to related requests for support to implement as capacity allows.
- Update project charter for phase 2 & 3.
- Continue to assess and develop processes to meet indicators in phase 3.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Intake Lines	**Project Number:**	2018-012
Project Sponsor:	Director, Healthy Living	**Project Manager:**	Manager, Child Health Manager, Oral Health
Project Phase:	Planning	**Date:**	June 2019

Status Last Period: N/A	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Initiated Project Charter for approval.
- Established work plan and timelines for deliverables.
- Confirm proposed model for Intake Lines.
- Developed position descriptions for defined roles.

Top Issues:

- Existing technology needs to be replaced as it hinders the implementation of other software applications.

Top Risks:

- Deployment of resources to support new model for intake lines resulting in reprioritization of work.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. Issue RFP	May 30, 2019		X
2. Select technology solution	June 30, 2019		X
3. Recruitment	August 30, 2019	✓	
4. Training & Resource Development	October 31, 2019	✓	
5. Implement new solution	November 1, 2019	✓	

Project Changes:

- Selecting a technological solution that is scalable to regionalization of health units following implementation.

Key Activities for Next Period:

- Scope Request for Proposal (RFP) requirements to go to tender for new phone system.
- Issue RFP and select successful proponent.
- Recruit for positions in relation to Intake Lines.
- Develop/Update resources to support new model for Intake Lines.

Status Legend	Proceeding as planned	Problems have surfaced, considered manageable	Major obstacles; requires intervention ☒

Project Name:	Administrative Policy Manual Review	**Project Number:**	2018-015
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Strategic Projects
Project Phase:	Execution	**Date:**	June 2019

Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Continuation of policy review.
- Migration of administrative and governance policies into PolicyManager.
- Completed initial configuration of solution.

Top Issues:

- Challenges connecting to PolicyMedical's environment based on age of MLHU's head router; delayed LDAP and VPN setup which pushed out time lines for system configuration and Power User training – IT believes it has identified a solution in test environment and does not anticipate problems moving forward.
- Allocating time with management teams to review outdated policies can be challenging based on the number of complex strategic projects that are in the execution phase.

Top Risks:

- Introducing a new policy management system amid other competing priorities during Q1 and Q2.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. Solution configuration	June 30, 2019		X
2. Go-live with administrative and governance level documents	September 1, 2019	✓	
3. Expansion to program level documents	September 30, 2019	✓	

Project Changes:

- None to report.

Key Activities for Next Period:

- Continued review of existing policies to identify documents for revision/consolidation/decommission.
- Complete solution configuration following LDAP and VPN setup.
- Document preparation.
- Develop and provide Power User training.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 011-19GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / Chief Executive Officer

DATE: 2019 June 20

GOVERNANCE POLICY REVIEW AND DEVELOPMENT

Recommendation

It is recommended that the Governance Committee:

1) ***Receive Report No. 011-19GC re: "Governance Policy Review and Development" for information; and***
2) ***Recommend that the Board of Health approve the governance by-laws and policies appended to this report.***

Key Points

- It is the responsibility of the Governance Committee to make recommendations to the Board of Health regarding review and development of governance by-laws and policies.
- The approved policy model requires that governance by-laws and policies be reviewed at least every two years; review and revision of governance by-laws and policies can be initiated at any time, as needed.
- The by-laws and policies brought forward to the Governance Committee have been reviewed by Health Unit staff and by the Finance & Facilities Committee (where these relate to the financial operations), and updated to enhance clarity and ensure continued compliance with applicable standards, legislation, and agreements.

Background

In 2016, the Board of Health approved a plan for review and development of by-laws and policies based on a model that incorporates best practices from the Ontario Public Health Organizational Standards and advice obtained through legal counsel. Refer to Report No. 018-16GC.

Policy Review

The set of by-laws and policies brought forward for review by the Governance Committee is delineated in a comprehensive listing in Appendix A.

The following by-laws and policies (Appendix B) were prepared for review by the Governance Committee:

- G-B20 By-law No. 2 – Banking and Finance
- G-B40 By-law No. 4 – Duties of the Auditor
- G-120 Risk Management
- G-410 Board Member Remuneration and Expenses (formerly Board Remuneration)

Note: The by-laws and Board remuneration and expense policies were reviewed by the Finance & Facilities Committee at its June 6, 2019 meeting.

Next Steps

The Governance Committee has the opportunity to review the appended by-laws and policies. Once the Governance Committee is satisfied with its review, the by-laws and policies will be forwarded to the Board of Health for approval.

This report was prepared by the Privacy, Risk and Governance Team, Healthy Organization Division.

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

FOR REVIEW

Governance Manual By-laws and Policies

June 20, 2019

Policy #	Section	Title	Date Implemented	Last Review	Status	Notes
G-000	Board of Health	By-laws, Policy and Procedures	1992-11-19	2018-11-15	Current	
G-B10	By-laws	By-law No. 1 Management of Property	2016-12-08	2019-04-02	Current	
G-B20	By-laws	By-law No. 2 Banking and Finance	2016-12-08		**Revised – For Approval**	• Updated to reflect changes to cash management processes, including use of cheque imaging, electronic signatures, and updates to the Summary of Banking Resolution for changes to authorized signors
G-B30	By-laws	By-law No. 3 Proceedings of the Board of Health	2016-12-08	2018-09-20	Current	
G-B40	By-laws	By-law No. 4 Duties of the Auditor	2016-12-08		**Revised – For Approval**	• Updated to align with auditor requirements set out in the *Municipal Act*, s. 296: "Where the board represents more than one municipality, only the auditor of the municipality that is responsible for the largest share of the expenses of the board in the year is required to audit the board in that year." Current policy states that "the Auditor shall be the same Auditor as the City of London may from time to time appoint"
G-010	Strategic Direction	Strategic Planning	1992-09-09	2018-11-15	Current	
G-020	Leadership and Board Management	MOH/CEO Direction	2016-12-08	2018-11-15	Current	
G-030	Leadership and Board Management	MOH/CEO Position Description	2016-12-08	2018-11-15	Current	

Policy #	Section	Title	Date Implemented	Last Review	Status	Notes
G-040	Leadership and Board Management	MOH/CEO Selection and Succession Planning	2017-10-19		Current	
G-050	Leadership and Board Management	MOH/CEO Performance Appraisal	2016-12-08	2018-11-15	Current	
G-080	Program Quality and Effectiveness	Occupational Health and Safety	2018-11-15		Current	
G-100	Program Quality and Effectiveness	Information Privacy and Confidentiality	2017-06-15	2019-04-02	Current	
G-120	Program Quality and Effectiveness	Risk Management	2017-04-21		**Revised – For Approval**	• Staff responsibilities removed to align with scope and application of governance policy • Risk Management Framework included as an appendix
G-150	Program Quality and Effectiveness	Complaints	2018-07-01		Current	
G-160	Program Quality and Effectiveness	Jordan's Principle	2016-12-08	2018-11-15	Current	
G-180	Financial and Organizational Accountability	Financial Planning and Performance	2017-06-15		Review Pending	• To be brought forward to GC in September 2019
G-190	Financial and Organizational Accountability	Asset Protection	2017-06-15		Review Pending	• To be brought forward to GC in September 2019
G-200	Financial and Organizational Accountability	Approval and Signing Authority	2000-07-20	2016-12-08	Review Pending	• To be brought forward to GC in September 2019

Policy #	Section	Title	Date Implemented	Last Review	Status	Notes
G-205	Financial and Organizational Accountability	Borrowing	2018-09-20		Current	
G-210	Financial and Organizational Accountability	Investing	2017-06-15		Current	• To be brought forward to GC in September 2019
G-220	Financial and Organizational Accountability	Contractual Services	2000-08-30	2016-12-08	Review Pending	• To be brought forward to GC in September 2019
G-230	Financial and Organizational Accountability	Procurement	2008-02-21	2019-04-02	Current	
G-240	Financial and Organizational Accountability	Tangible Capital Assets	2017-06-15		Review Pending	• To be brought forward to GC in September 2019
G-250	Financial and Organizational Accountability	Reserve and Reserve Funds	2017-06-15		Review Pending	• To be brought forward to GC in September 2019
G-310	Financial and Organizational Accountability	Corporate Sponsorship	1997-09-25	2017-06-15	Review Pending	• To be brought forward to GC in September 2019
G-320	Financial and Organizational Accountability	Donations	2014-03-31	2017-06-15	Review Pending	• To be brought forward to GC in September 2019
G-330	Financial and Organizational Accountability	Gifts and Honorariums	1992-09-30	2017-06-15	Review Pending	• To be brought forward to GC in September 2019
G-410	Financial and Organizational Accountability	Board Member Remuneration	2017-06-15		**Revised – For Approval**	• G-410 and G-420 consolidated into one policy that addresses both remuneration and reimbursement of expenses

Policy #	Section	Title	Date Implemented	Last Review	Status	Notes
G-420	Financial and Organizational Accountability	Travel Reimbursement	2013-10-17	2017-06-15	**Revised – For Approval**	• G-410 and G-420 consolidated into one policy that addresses both remuneration and reimbursement of expenses
G-430	Financial and Organizational Accountability	Informing of Financial Obligations	2018-07-01		Current	
G-260	Board Effectiveness	Governance Principles and Board Accountability	2018-07-01		Current	
G-270	Board Effectiveness	Roles and Responsibilities of Individual Board Members	2017-03-16	2018-06-21	Current	
G-280	Board Effectiveness	Board Size and Composition	2017-03-16	2019-04-02	Current	
G-290	Board Effectiveness	Standing and Ad Hoc Committees	2017-03-16	2018-09-20	Current	
G-300	Board Effectiveness	Board of Health Self-Assessment	2017-03-16	2019-04-02	Current	
G-340	Board Effectiveness	Whistleblowing	2018-09-20		Current	
G-350	Board Effectiveness	Nominations and Appointments to the Board of Health	2017-03-16	2019-04-02	Current	
G-360	Board Effectiveness	Resignation and Removal of Board Members	2018-07-01		Current	
G-370	Board Effectiveness	Board of Health Orientation and Development	2017-03-16	2019-04-02	Current	
G-380	Board Effectiveness	Conflicts of Interest and Declaration	2017-10-19	2018-06-21	Current	
G-395	Board Effectiveness	Local Health Integration Network Relationships	2018-09-20		Current	
G-400	Board Effectiveness	Political Activities	2018-07-01		Current	

Policy #	Section	Title	Date Implemented	Last Review	Status	Notes
G-470	Communications and External Relations	Annual Report	1992-09-23	2019-04-02	Current	
G-480	Communications and External Relations	Media Relations	1992-09-23	2019-04-02	Current	
G-490	Communications and External Relations	Board of Health Reports	1994-06-15	2019-04-02	Current	
G-500	Communications and External Relations	Advocacy			To Be Developed	• To be brought forward to GC in September 2019

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **By-law No. 2**

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

1. In this by-law:

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

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

   (c) “Bank” means a financial institution including registered chartered bank, trust company or credit union.

2. The Board through the Medical Officer of Health / Chief Executive Officer will enter into an agreement with a bank which will provide the following services:

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

   (b) provision for scanned images of cancelled cheques on demand on a monthly basis, together with a statement showing all debits and credits to facilitate timely account reconciliation;

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

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

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

4. Formal procedures are in place to ensure that each issued cheque contains two electronic signatures, comprising one Board Member and the Medical Officer of Health / Chief Executive Officer. These signatures shall be kept and held in custody with the Manager, Finance.

5. Notwithstanding item 4 of this by-law, cheque signing shall be restricted to the Chair of the Board of Health, Medical Officer of Health / Chief Executive Officer, Associate Medical Officer of Health, and Manager, Finance, any two of whom may sign cheques in the absence of the Chair and/or Medical Officer of Health / Chief Executive Officer. Additional details pertaining to approval and signing authority are outlined in the current Summary of Banking Resolution maintained by the bank.

6. The Medical Officer of Health / Chief Executive Officer is hereby authorized on behalf of the Board to:

   (a) deposit to the bank (but only for the credit of the Board) all or any cheques, Electronic Fund Transfers (EFT) or wire payments;

   (b) sign the Banking Resolution maintained with the bank and ensure that it is kept current;

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

7. The Secretary-Treasurer of the Board, shall prepare and control the Annual Budget under the jurisdiction of the Board for submission to the Board, and perform additional responsibilities pertaining to the Annual Budget as outlined in Policy G-030 MOH / CEO Position Description, as amended, from time to time.

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

First Reading – June 20, 2019
Second Reading – June 20, 2019
Third Reading – June 20, 2019

This By-law is to be in force and effect and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this June 20, 2019.

Reviewed by:	Finance and Facilities Committee	
Approved by:	Board of Health	
Date:	June 20 8, 2019	
Signature:	Ms. Trish Fulton Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **By-law No. 4**

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

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

   (b) In accordance with the Municipal Act, s. 296, where the board represents more than one municipality, only the auditor of the municipality that is responsible for the largest share of the expenses of the board in the year is required to audit the board in that year.

2. The Auditor shall:

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

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

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

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

First Reading – June 20, 2019
Second Reading – June 20, 2019
Third Reading – June 20, 2019

This By-law is to be in force and effect and to remain in force and effect until otherwise amended by enactment by the Board.

Executed in London, in the Province of Ontario, on this June 20, 2019.

Reviewed by:	Finance and Facilities Committee
Approved by:	Board of Health

Date:	June 20, 2019	
Signature:	Ms. Trish Fulton Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

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

IMPLEMENTATION:	2017-04-20	**APPROVAL:**	Board of Health
SPONSOR:	MOH/CEO	**SIGNATURE**:	
REVIEWED BY:	Governance Committee	**DATE**:	2019-06-20

PURPOSE

To ensure that an appropriate and effective risk management process is in place to monitor and respond to emerging issues and potential threats to the Middlesex-London Health Unit (MLHU), from both internal and external sources.

POLICY

MLHU engages in a wide range of activities, in its facilities and in the community, all of which are subject to some level of risk. It is the policy of MLHU to:

- Embed risk management into the culture and operations of MLHU;
- Integrate risk management into strategic planning, program planning, performance management and resource allocation decisions;
- Manage threats and leverage opportunities as appropriate and in accordance with best practices;
- Re-assess regularly and to report on MLHU's risks and the effectiveness of existing risk mitigation strategies;
- Anticipate and respond to changing social, environmental and legislative requirements;
- Support the development of risk management competencies across the organization; and
- Encourage all staff to report risks and to ensure that no person who in good faith reports a risk is subjected to any form of retribution, retaliation or reprisal.

In accordance with the requirements set out in the Ontario Public Health Standards, the Board of Health shall be responsible for providing risk oversight and ensuring a formal risk management framework is in place that identifies, assesses and addresses risks. The Board shall obtain an understanding of the risks inherent in the organization's strategies and shall monitor and provide advice to management regarding critical risk issues. The Board shall also provide direction on the extent and categories of risk that it regards as acceptable and define the scope and frequency of risk management reporting.

MLHU has adopted the Ontario Public Service Risk Management Framework (Appendix A), which includes the following steps:

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

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

The Medical Officer of Health/Chief Executive Officer shall have overall responsibility for risk management, ensuring the effective execution of the organization's risk management framework and processes, and that all significant risks are addressed. The Director, Corporate Services shall be responsible for the development, implementation, and review of a systematic risk management process.

APPENDICES

Appendix A – MLHU Risk Management Framework

APPLICABLE LEGISLATION AND STANDARDS

Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, 2018

REVISION DATES (* = major revision)

Risk Management Strategy & Process Toolkit

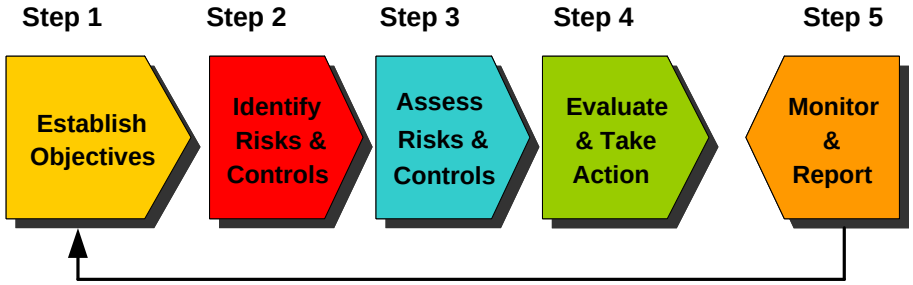
Step 1: Establish objectives

- Risks must be assessed and prioritized in relation to an objective
- Objectives can be at any level; operational, program, initiative, unit, branch, health system
- Each objective can be general or can include specific goals, key milestones, deliverables and commitments

Risk
The future event that may impact the achievement of established objectives. Risks can be positive or negative.

Control / Mitigation Strategy
Controls / mitigation strategies reduce negative risks or increase opportunities.

The risk management process



Consequences
- Identify the specific consequences of each risk
- Consider financial, non-financial, performance, etc.

Vulnerability
- Identify exposure to risk
- Vulnerability may vary with each situation and change over time

Cause/Source of Risk
- Understand the cause/source of each risk
- Use a fish-bone diagram

Step 2: Identify risks & controls

Identify risks - What could go wrong?
- Consider each category of risk
- Obtain available evidence
- Brainstorm with colleagues and/or stakeholders
- Examine trends and consider past risk events
- Obtain information from similar organizations or projects
- Increase awareness of new initiatives/ agendas and regulations

Identify existing controls – What do you already have in place?
- Preventive controls
- Detective controls
- Recovery / Corrective controls

14 categories of risk

RISK	Description
Financial	Uncertainty around obtaining, committing, using, losing economic resources; or not meeting overall financial budgets/commitments.
Operational or Service Delivery	Uncertainty regarding the activities performed in carrying out the entity's strategies or how the entity delivers services.
People / Human Resources	Uncertainty as to the capacity of the entity to attract, develop and retain the talent needed to meet the objectives.
Environmental	Uncertainty usually due to external risks facing an organization including air, water, earth, forests. . An example of an environmental, ecological risk would be the possible occurrence of a natural disaster and its impact on an organization's operations.
Information / Knowledge	Uncertainty regarding access to, or use of, inaccurate, incomplete, obsolete, irrelevant or untimely information; unreliable information systems; inaccurate or misleading reporting.
Strategic / Policy	Uncertainty around strategies and policies achieving required results; or that old and/or new policies, directives, guidelines, legislation, processes, systems, and procedures fail to recognize and adapt to changes.
Legal / Compliance	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, contracts, MOUs and the risk of litigation.
Technology	Uncertainty regarding alignment of IT infrastructure with technology and business requirements; availability of technological resources.
Governance / Organizational	Uncertainty about maintenance or development of appropriate accountability and control mechanisms such as organizational structures and systems processes; systemic issues, culture and values, organizational capacity, commitment, and learning and management systems, etc.
Privacy	Uncertainty with regards to exposure of personal information or data; fraud or identity theft; unauthorized data.
Stakeholder / Public Perception	Uncertainty around managing the expectations of the public, other governments, Ministries, or other stakeholders and the media to prevent disruption or criticism of the service and a negative public image.
Security	Uncertainty relating to breaches in physical or logical access to data and locations (offices, warehouses, labs, etc).
Equity	Uncertainty that policies, programs, or services will have a disproportionate impact on the population.
Political	Uncertainty that events may arise from or impact the Minister's Office/Ministry, e.g. a change in government, political priorities or policy direction.

RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

Step 3: Assess Risks & Controls

Assess inherent risks

- *Inherent likelihood* – Without any mitigation, how likely is this risk?
- *Inherent impact* – Without any mitigation, how big will be the impact of the risk on your objective?

Assess controls

- Evaluate possible preventive, detective, or corrective mitigation strategies.

Reassess residual risks

- Re-assess the impact, likelihood and proximity of the risk with mitigation strategies in place.
- *Residual likelihood* – With mitigation strategies in place, how likely is this risk?
- *Residual impact* – With mitigation strategies in place, how big an impact will this risk have on your objective?

Key Risk Indicators (KRI)

- Leading Indicators - Early or leading indicators that measure sources or causes to help prevent risk occurrences
- Lagging Indicators - Detection and performance indicators that help monitor risks as they occur.

Risk Tolerance

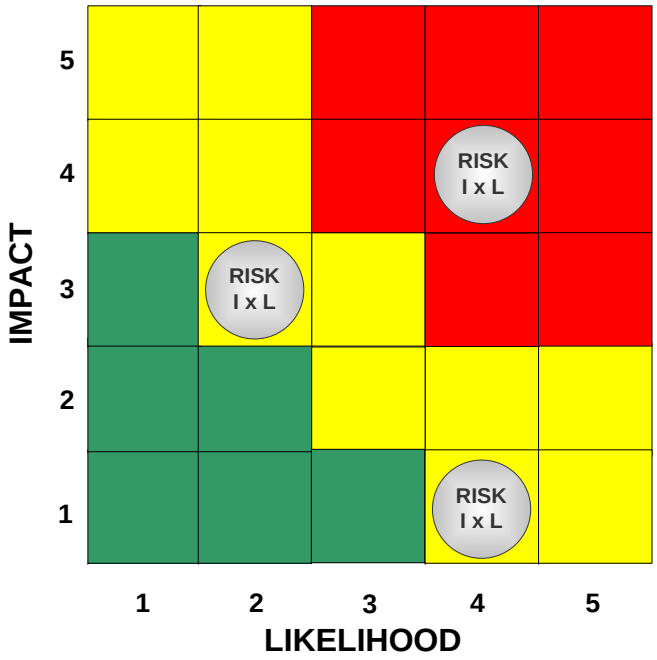
- The amount of risk that the area being assessed can manage

Risk Appetite

- The amount of risk that the area being assessed is willing to manage

The tolerance and risk appetite values may differ e.g. Staff can afford to lose email capabilities for five hours (risk tolerance) but only be willing to lose email capabilities for one hour (risk appetite).

RISK PRIORITIZATION MATRIX



Step 4: Evaluate & Take Action

- Identify risk owners.
- Identify control owners.
- Have mitigation strategies reduced the risk rating (Impact x Likelihood) enough that the risk is below approved risk tolerance levels?
- Do you need to implement further mitigation strategies?
- Develop SMART (Specific, Measurable, Achievable, Realistic, Time-specific) actions that will either reduce the likelihood of the risks or minimise the impact.
- Develop detailed action plans with timelines, responsibilities and outline deliveries.

Step 5: Monitor & Report

- Have processes in place to review risk levels and risk mitigation strategies as appropriate.
- Monitor and update by asking:
  - Have risks changed? How?
  - Are there new risks? Assess them
  - Do you need to report or escalate risks? To whom? When? How?
- Develop and monitor risk indicators

Definitions

VALUE	LIKELIHOOD	IMPACT	PROXIMITY	*SCALE*
1	Unlikely to occur	Negligible Impact	More than 36 months	*Very Low*
2	May occur occasionally	Minor impact on time, cost or quality	12 to 24 months	*Low*
3	Is as likely as not to occur	Notable impact on time, cost or quality	6 to 12 months	*Medium*
4	Is likely to occur	Substantial impact on time, cost or quality	Less than 6 months	*High*
5	Is almost certain to occur	Threatens the success of the project	Now	*Very High*

SUBJECT:	Board of Health Remuneration and Expenses	**POLICY NUMBER:**	**G-410**
SECTION:	Financial and Organizational Accountability	**PAGE:**	1 of 2

IMPLEMENTATION:	June 15, 2017	**APPROVAL:**	Board of Health
SPONSOR:	MOH / CEO	**SIGNATURE**:	
REVIEWED BY:	Finance and Facilities Committee	**DATE**:	June 15, 2017

PURPOSE

To ensure that Board of Health members receive appropriate remuneration for their activities and reimbursement of incurred expenses on behalf of the Board of Health.

POLICY

In accordance with the Health Protection and Promotion Act, s. 49, Board Members shall receive remuneration for each day on which they conduct business on behalf of the Board of Health. For the purposes of this policy, such business includes official meetings at which the member represents the Board and attendance at conferences but does not include ceremonial functions or special events. Board Members shall also be reimbursed for all reasonable expenses incurred.

PROCEDURE

1. Remuneration

1.1. Remuneration for Board of Health business is to be paid for each day on which any eligible Board Member attends a Board meeting, Board committee meeting, a meeting which the member attends on behalf of the Board of Health, or an approved convention or conference.

1.2. Rate of remuneration for Board of Health members who are eligible to receive remuneration are based on comparable rates passed by local municipalities and shall not exceed the limits established by s. 49(6) of the Health Protection and Promotion Act. The half-day per diem rate is reported and approved by the Board of Health on an annual basis.

1.3. Board Members shall receive only one fee per day, regardless of whether the member attends more than one official function in a day.

1.4. All community appointees shall receive this remuneration. Municipal appointees, other than the chair, who receive annual remuneration from their municipality shall not be eligible for additional remuneration from the Middlesex-London Health Unit (MLHU).

1.5. In circumstances in which the municipality does not provide annual remuneration to its councilors, MLHU shall provide remuneration for the municipal appointees, based on the days on which they are engaged in Board business.

1.6. Board Members eligible to receive remuneration shall complete and submit the Reimbursement for Monthly Activities form (Appendix A).

2. Expenses

2.1. Board of Health members shall complete and submit the Reimbursement for Monthly Activities form (Appendix A), with original receipts, for reimbursement of eligible expenses (see Appendix B for mileage rates and out-of-town travel).

APPENDICES

Appendix A – Reimbursement for Monthly Activities Form
Appendix B – Mileage and Out-of-Town Expenses

APPLICABLE LEGISLATION AND STANDARDS

Health Protection and Promotion Act, R.S.O. 1990, c. H.7

RELATED POLICIES

G-420 Board of Health Reimbursement and Travel

Appendix A
Policy G-410

Middlesex-London Board of Health

Reimbursement for Monthly Activities

Name of Board Member: _____

Please use a separate form for each month and include all activities for that month.
Only expenses claimed below are eligible for reimbursement.

1. REGULARLY SCHEDULED BOH MEETING

Date	Mileage (in kilometers)
	kms

Rate
0 - 5000 kms @ 51 cents
5000 kms and over @ 45 cents

2. BOARD CHAIR PREPARATION MEETING WITH MOH (*25% of regular meeting rate)

Date	Mileage (in kilometers)
	kms

3. OTHER ACTIVITIES (i.e. special meetings, summer meetings, teleconferences etc.)

Date	Name/Purpose of Meeting	Mileage (kms)	Parking	Phone	Accom'n	Other

4. FOR alPHa CONFERENCE ONLY *

	Attended		
	AM	**PM**	**Evening**
DAY 1			
DAY 2			
DAY 3			

Check if Applicable		
Additional day required for travel		
Hotel/transportation receipts attached		**$**
Mileage		kms

* Board members are remunerated for 3 rate payments per day of attendance: morning/afternoon/evening session

Financial Services Use Only

Vendor # ___ ___ ___ -- ___ ___ ___

Voucher #	Account	Amount
	70098-800-000	**$** .
	70098-800-000	**$** .
	70098-800-000	**$** .
	75098-800-000	**$** .
	78098-800-000	**$** .
	13600-800-000	**$** .
	78098-800-000	**$** .
	13600-800-000	**$** .
	Total:	**$** .

Board Member's Signature

Secretary-Treasurer's Signature

Financial Services Signature

Reimbursable Expenses

A. Mode of Transportation

The mode of transportation chosen – air, train, or car – should be that which enables the board member to attend to MLHU business with the least cost to MLHU, consistent with a minimal amount of interruption to regular business and personal schedules. Consideration should be made as to unproductive time away from the workplace.

For travel by air or train, basic economy/coach fares will be paid by MLHU. Any upgrades are the responsibility of the board member, except where upgraded travel is authorized in accordance with this policy.

Travel by Air

Board members may travel by air for trips that are beyond reasonable driving distance.

Every effort should be made to book travel well in advance to take advantage of discounted fares and to obtain the lowest fares compatible with necessary travel requirements. The cost of an additional night of accommodation may be incurred, and will be reimbursed, if it is required, in order to take advantage of a discount fare, provided that the cost of the extra accommodation is not greater than the savings realized from benefitting from the discounted fare.

Original boarding passes and ticket/e-ticket must be attached to the Reimbursement for Monthly Activities form (Appendix A) for each segment of travel.

Travel by Rail

When booking train travel, the VIA Rail promotion code (700603) shall be used in order to receive the corporate discount.

Board members will choose the most economical and direct form of transportation by train. Wherever possible, travel arrangements should be made in advance to ensure availability of economy class seats and at the best price. Business class may be authorized in exceptional circumstances if less expensive seats are not available.

Travel by Car

When a car is the most practical and economical way to travel, a personal vehicle can be used but mileage reimbursement will be the actual distance travelled or 250 km (round-trip), whichever is less, at the allowable rates. For travel distances greater than 250 km, a rental vehicle should be used. Consideration will be given to board members who require an accommodation.

Rental Vehicle

- The car rental company approved by MLHU is Enterprise and it should be used wherever possible to ensure the most favourable rates.
- Rental of compact or mid-sized vehicles is normally to be used. Consideration may be given for a car rental upgrade based on the number of passengers, weather conditions and other safety reasons. All luxury and sports car rentals are expressly prohibited.

- Rental cars must be refueled before returning to avoid extra charges, and the receipt for the gasoline purchase must be attached to the Reimbursement for Monthly Activities form (Appendix A), together with a copy of the rental agreement.

Personal Vehicle

- The owner of the vehicle must ensure that the vehicle is in safe working condition and is adequately insured.
- MLHU assumes no financial responsibility for personal vehicles being used for MLHU business other than paying the mileage rate. The mileage rate covers the cost of fuel, depreciation, maintenance, and insurance. When calculating the total kilometres of a trip that originates from the employee's home, the normal distance driven to MLHU should be excluded. A maximum of 250 km per out-of-town trip is allowed for reimbursement unless an accommodation prevents use of a rental vehicle.

B. Parking and Other Fees

Cost of parking a vehicle at a transportation terminal while on out-of-town business will be reimbursed, provided that the cost of the parking does not exceed the cost of ground transportation from departure point (home or place of business) to the transportation terminal.

Cost of parking in another city while on out-of-town business will also be reimbursed.

Highway and bridge tolls and ferry charges will be reimbursed with receipts attached.

Traffic and parking violations incurred while driving on MLHU business will not be reimbursed.

C. Hotel Accommodation

Government rates should be requested at the time of making the hotel reservation. Individuals may be reimbursed for the total cost (including taxes) of either a single or double room depending on individual circumstances. An overnight stay in association with a one-day meeting or business event out-of-town is justified only when the employee is required to leave home early to be on time for the event starting before 9:00 a.m.

While travelling on business related to MLHU, in situations where board members choose to stay overnight with friends or relatives instead of at a hotel, accommodation expenses will not be reimbursed, but appropriate meal allowances will still apply.

Hotel charges incurred because of failure to cancel a reservation on a timely basis will not be reimbursed.

D. Meals

A meal expense will be reimbursed when board members are re out-of-town over a normal meal period or have prior approval for the meal expense.

The maximum allowable amount that will be reimbursed for meals (inclusive of taxes and gratuities) is $10 for breakfast, $20 for lunch and $30 for dinner. Original receipts must be provided for all meal expenses. Expenses must be incurred during normal working hours, or on route to home. The approver is responsible for ensuring that submissions for meal allowances fall within the maximum allowable amounts.

It is understood that gratuities may be provided during meals to acknowledge good service received. The maximum allowable gratuity that MLHU will reimburse is 15% of the total after tax amount of the meal.

E. Alcohol

The cost of alcoholic beverages will not be reimbursed. In the event that alcohol is consumed during a meal or otherwise, board members are to ask the restaurant for a separate invoice/receipt for the alcohol so that there is clarity for the reimbursable food portion.

F. Combining Personal Travel

Board members are responsible for all additional and incremental expenses incurred as a result of a spouse, partner, companion, or any other person, travelling with them. Expenses should be tracked very carefully to be able to clearly distinguish between the board member portion, and that which applies to the other person.

When personal travel is combined with business travel, only the business portion of the trip will be reimbursed. Expenses should be tracked very carefully to be able to clearly distinguish between the personal portion and the business portion.

G. Other Travel-Related Expenses

Business expenses, such as computer access charges, photocopying, word processing services, facsimile transmissions, internet connections, rental and transportation of necessary office equipment will be reimbursed provided the charges incurred are reasonable and related to MLHU business.

Additionally, board members will be reimbursed for taxicab fares, airport limousines and buses (or equivalents, e.g. subway) for transportation between the individual's home/workplace and the designated transportation terminal. While out-of-town, transportation to/from the transportation terminal and the hotel, and transportation within the destination city, will also be reimbursed. Staff should use public transit when available.

Recreational items (e.g. video rentals, mini-bars, special facilities charges, entertainment not directly related to MLHU business, etc.) will not be reimbursed.

H. Non-Reimbursable Expenses

In addition to other items mentioned above, which are not reimbursable, expenses of a personal nature will not be reimbursed. Such expenses include, but are not limited to:

- Expenses resulting from unlawful conduct,
- Damage to personal vehicle as a result of a collision,
- Personal items not required to conduct MLHU business,
- Memberships to reward programs or clubs (e.g., airline clubs),
- Personal credit card fees and/or late payment charges.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 012-19GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / Chief Executive Officer

DATE: 2019 June 20

2019 BOARD OF HEALTH SELF-ASSESSMENT RESULTS

Recommendation

It is recommended that the Governance Committee receive Report No. 012-19GC re: "2019 Board of Health Self-Assessment Results" for information.

Key Points

- There was an overall 90% response rate to the survey; however, Board composition includes a number of newly appointed members, and accordingly response rates for individual items were lower.
- Valuable comments were provided, which showed that Board members are receiving the necessary information to support their governance mandate.
- Several respondents affirmed the critical need for governance to support and maintain the important work of the Health Unit throughout the provincial restructuring process.

Background

The Board of Health Self-Assessment Survey provides an opportunity for members of the Board of Health to assess their effectiveness in meeting the requirements set out in the Ontario Public Health Standards. On March 21, 2019, the Board approved the Board of Health Self-Assessment Tool and initiated the Board's self-assessment process for 2019 (refer to Report No. 006-19GC). The survey was distributed to Board of Health members on April 9, 2019, for completion by April 19, 2019. Some additional responses were provided after the completion date and were included in the results. Participation in the survey was voluntary and all individual responses are kept confidential.

Self-Assessment Results

Nine out of ten Board of Health members (90%) completed the survey. However, given the Board onboarded several newly appointed City and County members in January, many Board members were understandably challenged in completing a number of the survey questions. Due to the low response rate to questions, and in order to maintain confidentiality, a summary of these responses is not included with this report.

Several respondents commented on the need to maintain strong governance to support the Health Unit in this time of unprecedented change. When asked, "What is the most important thing that you could recommend for discussion or action in order to improve the Board of Health's performance?", comments included:

- "Ensure that the MLHU mission and successes are maintained throughout the transformation and restructuring it will be undergoing in the next year."
- "Receiving as much information as possible regarding the significant changes proposed for Public Health."

Many respondents also affirmed the quality and usefulness of information provided to support the Board in achieving its governance mandate:

- "Board and committee packages are extensive, and staff are present and able to provide additional information if required."
- "The primary source of this information comes from the excellent delegation reports from managers and other senior staff. Their interactions and presentations to the Board are top-notch."
- "I have always found the presentations to be complete and informative, with attending staff able to engage in further dialogue if necessary."

One respondent noted the challenge implicit in not being able to read in advance the agenda items for the in-camera sessions.

Next Steps

The Governance Committee may propose recommendations to support its effectiveness in the months ahead as we navigate system transformation. Any recommendations proposed by the Governance Committee would be recommended to the Board for approval.

This report was prepared by the Privacy, Risk and Governance Team, Healthy Organization Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 013-19GC

TO: Chair and Members of the Governance Committee

FROM: Laura Di Cesare, Director Healthy Organization

DATE: 2019 June 20

2018 MEDICAL OFFICER OF HEALTH AND CHIEF EXECUTIVE OFFICER PERFORMANCE APPRAISAL

Recommendations

It is recommended that:

1) ***The Governance Committee receive Report 013-19GC; and***
2) ***The Governance Committee form a sub-committee to initiate the performance appraisal process for the Medical Officer of Health and Chief Executive Officer.***

Key Points

- The 2016/17 performance appraisal was initiated in April 2017 with the appraisal being completed in April 2018.
- The Governance Committee Terms of Reference and the 2018 reporting calendar highlights that the MOH & CEO performance appraisal will be initiated in the second quarter of the calendar year.
- A sub-committee is necessary for the administration of the 2018 performance appraisal.

Background

The Governance Committee is responsible for initiating the annual performance appraisal process for the Medical Officer of Health and Chief Executive Officer (MOH & CEO). The most recent performance appraisal of the MOH & CEO was initiated in the first quarter of 2017 to cover the 2016 calendar year. However, given a leave of the MOH/CEO this process was not completed until April 2018 and resulted in a combined 2016/2017 performance review.

The Performance Appraisal Tool for the Middlesex-London Health Unit's MOH & CEO was developed in 2015 following a review of the Ontario Public Health Organizational Standards, templates provided by the Association of Local Public Health Agencies, best practices for performance appraisals and input from the Governance Committee. In 2016, the process of collecting feedback to inform the appraisal was simplified utilizing available technology in the form of an on-line 360-degree feedback tool. The Board of Health recently renewed its approval of this appraisal process when it approved Policy G-050 Medical Officer of Health and Chief Executive Officer Performance Appraisal at the November 15, 2018 board meeting.

2018 Performance Appraisal Process

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

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

This report was prepared by the Healthy Organization Division.

Laura Di Cesare, CHRE
Director, Healthy Organization

MLHU MOH/CEO PERFORMANCE APPRAISAL

Name:	Dr. Christopher Mackie
Title:	**Medical Officer of Health and Chief Executive Officer**

This performance appraisal is due on:	

It reviews the performance for the period:			
From:	January 1, 2018	**To:**	December 31, 2018

And sets objectives for the period:			
From:	January 1, 2019	**To:**	December 31, 2019

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

Append additional sheets / documentation where required/appropriate.

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

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

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

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

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

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

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

SUMMARY OF OVERALL PERFORMANCE

AREA OF FOCUS	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required
Program Excellence				
Community and Client Impact				
Employee Engagement and Learning				
Governance				
Comments – (Including comments with respect to the major strengths of the MOH/CEO and areas for future development.)				

GOALS FOR THE NEXT PERIOD – BY AREA OF FOCUS

Program Excellence	Key Performance Indicator

Client and Community Impact	Key Performance Indicator

Employee Engagement and Learning	Key Performance Indicator

Governance	Key Performance Indicator

Personal Development	Key Performance Indicator

Other	Key Performance Indicator

SIGNATURES

Medical Officer of Health

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

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

Comments

_____

_____

_____

_____ _____

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

For the Board of Health

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

_____ _____

Chair, Board of Health **Date**

_____ _____

Board of Health **Date**

Appendix B to Report No. 013-19GC

Middlesex-London Health Unit
Medical Officer of Health and Chief Executive Officer
Performance Appraisal Process Timeline 2019

Date	Activities
June 20 2019	• Governance Report initiates the appraisal process • Governance Committee strikes a performance appraisal sub-committee • Sub-committee reviews performance appraisal tool • Update to the Board of Health on the process
After June 20, 2019 meeting	• Request the Medical Officer of Health and Chief Executive Officer complete the appraisal tool and return to sub-committee upon his return • Collect supporting documentation required for performance appraisal • Invite stakeholder feedback
TBD	• Review and consolidate all feedback into one document • Once MOH & CEO self-appraisal is received the sub-committee and Medical Officer of Health and Chief Executive Officer may meet if there are any questions regarding the self-appraisal • Sub-committee prepares recommendations for the Board of Health regarding the performance appraisal and goals for next performance appraisal period
Tentatively: September 19, 2019	• Governance Committee convenes an in-camera session of the Board of Health to discuss and reach agreement on final appraisal results and goals identified for the next performance appraisal period.
TBD	• The Board of Health Chair and a representative of the sub-committee meet with the Medical Officer of Health and Chief Executive Officer to discuss the final appraisal results and the goals identified for the next performance appraisal period