AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

Thursday, February 27, 2020 6:00 p.m.
399 Ridout Street North, London
Side entrance (recessed door)
MLHU Boardroom

1. ELECTION OF CHAIR, GOVERNANCE COMMITTEE

2. DISCLOSURE OF CONFLICTS OF INTEREST

3. APPROVAL OF AGENDA

4. APPROVAL OF MINUTES – November 21, 2019

5. NEW BUSINESS

5.1 Q4 2019 Activity Report – Strategic Plan Update (Report No. 001-20GC)
5.2 Terms of Reference and Reporting Calendar (Report No. 002-20GC)
5.3 Governance By-Law and Policy Review (Report No. 003-20GC)
5.4 Board of Health Self-Assessment (Report No. 004-20GC)
5.5 Annual Privacy Program Update (Report No. 005-20GC)

6. OTHER BUSINESS

Next meeting will be Thursday, June 18, 2020 @ 6:00 p.m.

7. ADJOURNMENT

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

Thursday, November 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. Trish Fulton
Mr. Ian Peer
Ms. Maureen Cassidy

OTHERS PRESENT: Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications Coordinator (Recorder)
Dr. Alex Summers, Associate Medical Officer of Health
Mr. Joe Belancic, Manager, Procurement and Operations
Ms. Laura Di Cesare, Director, Healthy Organization
Mr. Brian Glasspoole, Manager, Finance
Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance
Ms. Kendra Ramer, Manager, Strategic Projects
Ms. Cynthia Bos, Manager, Human Resources

Chair DeViet called the meeting to order at 6:01 p.m.

DISCLOSURE OF CONFLICTS OF INTEREST

Chair DeViet inquired if there were any disclosures of conflicts of interest to be declared. None were declared.

APPROVAL OF AGENDA

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

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Ms. Fulton, *that the **MINUTES** of the September 19, 2019 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Q3 Activity Report – Strategic Projects (Report No. 015-19GC)

Ms. Kendra Ramer introduced this report and outlined the activities and projects that have taken place in the third quarter, the projects that remain on track, those that remain slightly behind schedule and those that have closed out in Q3. Ms. Ramer also noted projects that have been placed on hold due to the recent amalgamation announcement and discussions.

Discussion ensued about the Diversity Assessment and staff recommendations to put this project on hold pending results of the amalgamation discussions.

It was moved by Ms. Fulton, seconded by Ms. Cassidy, *that the that the Governance Committee receive Report No. 015-19GC re: "Q3 2019 Activity Report – Strategic Projects" for information.*

Carried

Governance Policy Review and Development (Report No. 016-19GC)

Ms. Gauthier introduced this report and highlighted the six Governance policies for review this evening (Appendix B):

- G-050 MOH/CEO Performance Appraisal
- G-080 Occupational Health and Safety
- G-200 Approval and Signing Authority
- G-220 Contractual Services
- G-230 Procurement
- G-250 Reserve and Reserve Funds
- G-395 Local Health Integration Network Relationships

Ms. Gauthier drew the committee's attention to the policy that is recommended to be decommissioned (G-395, Local Health Integration Network Relationships) and advised the Board on the new Policy Manager software launching for the Board to access in the coming weeks.

It was moved by Mr. Peer, seconded by Ms. Cassidy, *that the Governance Committee:*
1) *Receive Report No. 016-19GC re: "Governance Policy Review and Development" for information; and*
2) *Approve the governance policies as appended to this report.*

Carried

OTHER BUSINESS

The next Governance Committee meeting will be at 6:00 p.m. on Thursday, February 20, 2020.

CONFIDENTIAL

At 6:11 p.m., it was moved by Ms. Cassidy, seconded by Mr. Peer *that the Governance Committee move in-camera to consider matters regarding identifiable individuals and the security of the property of the Board of Health.*

Carried

At 6:20 p.m., it was moved by Ms Cassidy, seconded by Mr. Peer, *that the Board of Health rise and return to public session.*

Carried

At 6:20 p.m., the Governance Committee returned to public session.

ADJOURNMENT

At 6:20 p.m., it was moved by Ms. Fulton, seconded by Ms. Cassidy, *that the meeting be adjourned.*

Carried

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AINA DEVIET **TRISH FULTON**
Committee Chair **Board Chair**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 001-20GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

Q4 2019 ACTIVITY REPORT – STRATEGIC PLAN UPDATE

Recommendation

It is recommended that the Governance Committee receive Report No. 001-20GC re: "Q4 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 Q4 Balanced Scorecard Report (Appendix B) highlights the progress that has been made to date on the strategic priorities, while detailed project status reports have been prepared in relation to activities and tasks undertaken during Q4 2019. The status reports are included as Appendix C.
- In summary, nine projects in planning or execution phase remained on track, three fell behind schedule, and four reached project close-out during Q4. Three projects remain on hold in anticipation of regional amalgamation and one project remains deferred from 2018.

Background

The Health Unit's 2015–20 Strategic Plan details the vision, mission, and values of the organization and outlines the strategic priorities. The Board of Health approved the five-year plan at its September 17, 2015 meeting, and staff began working on many of its strategic priorities soon afterward. The 2018–20 Balanced Scorecard identifies the strategic priorities that are to be carried out over the remaining 2.5-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, top issues, lessons learned, and variances from expected outcomes. The 2018–20 Balanced Scorecard and the Q4 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 Q4 2019.

Q4 2019 Activity

In Q4, nine strategic projects in planning or execution phase continued to proceed as planned and remained on track, according to project schedules. These include:

- Relocation Project (PRJT#2018-001)
- Middlesex County Services Review (PRJT#2018-003)
- Enterprise Resource Planning (PRJT#2018-004)
- Develop and Implement Activity-Based Work (ABW) arrangements (PRJT#2018-006)
- Intake lines (PRJT#2018-012)

- Performance Management Framework – Phase 1 (PRJT #2018-014)
- Administrative Policy Manual – Policy Management Software Solution (PRJT#2018-015)
- Risk Management Framework (PRJT#2018-017)
- Conduct training for staff who write Board reports or present to the Board (initiated prior to 2018)

Three strategic projects were identified as behind schedule due to issues that arose which required significant changes:

- Electronic Client Record (PRJT#2018-005)
- Community Engagement Strategy – Client Experience Tool (PRJT#2018-007)
- Health Equity Indicator Assessment and Recommendations (PRJT#2018-010)

Four strategic projects have transitioned into operational work during project close-out in Q4:

- Administrative Policy Manual – Policy Management Software Solution (PRJT#2018-015)
- Establishment of the Project Management Office (PRJT#2018-016)
- Define annual opportunities to enhance engagement (initiated prior to 2018)
- Increase transparency across the organization (initiated prior to 2018)

Three strategic projects were placed on hold following the provincial budget announcement and await further direction from the Ministry regarding public health regionalization before moving forward:

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

Currently, only one strategic initiative initiated prior to 2018 has not yet begun: the Review of Learning Assessments project, deferred until the Human Resources Information System (Ceridian) – which is part of the Enterprise Resource Planning project – has been fully implemented. It is anticipated that implementation of the remaining talent management modules will be complete by the end of Q1 2020. It is also anticipated that the review of learning assessment will commence in Q2 2020.

For detailed information regarding project activities and tasks undertaken during Q4, refer to Appendix C.

Next Steps

The PMO will continue to provide support to staff to help implement activities on the Balanced Scorecard and advance MLHU's strategic priorities. A comprehensive evaluation of the current strategic plan and close-out report will be prepared in Q2 2020. Consultation for the next strategic planning cycle will depend on further direction from the Ministry regarding public health regionalization. It is anticipated that this work will commence in Q2 2020.

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*	*Q4 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.	☑	Resources were developed to outline how to access the PEF framework and describe the support available for program planning, implementation and evaluation activities. 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 Gap Analysis*** *(PRJT#2018-011)* ○ Development of more detailed assessment of program standard compliance. ○ Recommendations based on assessment ○ Implementation of recommendations.	☒	MLHU assesses program standard compliance through enhanced program and budget reporting based on the requirements of the Annual Service Plan. Implementation of the modernized standards gap analysis will be on hold until further direction provided by the Ministry with respect to public health modernization.	**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. Close-out of the project is now complete and transitioned to operational work for the Strategic Projects team.	**Y**

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

Activities & Tasks	*Status*	*Comments*	*Q4 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 move for 201 Queens staff was completed on December 28, 2019. New workstations, Audio Visual, and IT equipment was installed to allow for the 2nd floor of Citi Plaza to be open to staff on January 2, 2020. The schedule for the first-floor construction is on-time with a completion date of March 12, 2020. The clinic space will be open to the public on March 30, 2020. The OSL 2.0 committee partnered with the Be Well Committee to welcome staff to Citi Plaza and help them settle into their new space.	**Y**
• ***Electronic Client Record*** *(PRJT#2018-015)* ○ Conduct needs assessment. ○ Select the appropriate solution. ○ Provide education and training. ○ Implement new system.	⚑	The Healthy Growth and Development Line successfully launched Profile on December 19, 2020. The launch of Profile for other teams in Healthy Start was delayed from December 2019 to Q1 2020 due to the implementation of other systems occurring simultaneously (e.g. new phone system/Intake Lines) that put a strain on the availability of resources. Testing and training for Healthy Start teams will proceed in Q1 2020. The workflow discovery process for teams targeted for Phase 2 has commenced and will continue into Q1 2020. Configuration and build for phase 2 teams will be underway in Q1. Redefining roles within the core project team to address the gap in resource availability will allow for more timely onboarding of teams into Profile throughout 2020.	**Y**
• ***Staff Capacity Building*** *(Initiated prior to 2018)* ○ From Bystander to Ally Training. ○ Workshops & LMS modules (Public Health Sciences - health equity, advocacy). ○ Additional Indigenous Public Health Practice learning opportunities. ○ Diversity and Inclusion education and skill-building.	👍	Early in 2020, SLT provided direction to modify the volume of capacity building interventions planned for 2019. An ongoing staff vacancy in the team's staff capacity building lead also impacted capacity. In 2019, 39 consultations regarding incorporating health equity into public health programs were provided. The domains of focus for 2019 were: ***Public Health Sciences****:* LMS Health Equity staff orientation module was revised; will be uploaded on the HUB in 2020. ***Indigenous Public Health Practice*****:** In 2019, 25 people completed the Indigenous Cultural Safety Core Training, keeping the MLHU at full staff compliance. The Bystander to Ally Training was completed by 26 people, and 40 staff in total attended Indigenous staff wellness events that focused on self-care and Indigenous Cultural Teachings. Fifteen different people/teams consulted with the Manager, HE&IR regarding Indigenous Public Health Practice. ***Diversity and Inclusion:*** In February 2019, MLHU hosted a workshop conducted by the National Collaborating Centre for Determinants of Health, "Shifting Towards a Culture of Racial Equity in Public Health"; 25 staff as well as students, community partners, and staff from other health units attended. An Eid lunch and learn was held, with over 100 staff attending. Work began an educational and awareness-raising Diversity and Inclusion calendar that will be launched early in 2020 and pushed out to employee Outlook calendars, with over 350 MLHU staff having access to it. In 2020, there will be a renewed focus on staff capacity building, with significant focus remaining on Indigenous Public Health Practice, and an increased focus on the Diversity and Inclusion domain, including gender equity and inclusion.	**N**

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

Activities & Tasks	*Status*	*Comments*	*Q4 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.		Work continues with the various teams responsible for indicator-specific tasks, as the recommendations previously approved by SLT are being operationalized. Progress with some of the original 7 and the remaining 8 indicators has been delayed and/or put on hold due to the modernization of public health and competing priorities.	**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. Cycles 1 through 4 are complete, reflecting 80% updating of the CHSR. The full CHSR update was launched on November 21, 2019. The project has now moved into close-out with updating of the CHSR now becoming routine work for the Population Health Assessment and Surveillance (PHAS) team, utilizing the 'cycle' approached developed during the project.	**N**
• ***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.		The public health modernization announcement and the move of the MLHU to a new location both resulted in direction from SLT to significantly reduce the activities related to this initiative. In 2019, the Advocacy LMS module for MLHU employees was updated to keep current.	**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 are developed and monitored according to the 2018-2020 organizational balanced scorecard. Many MOHLTC accountability agreement indicators are being reported upon, however, based on prioritization of strategic projects further work in this area has been placed on hold. The overall status of the project remains on track based on other deliverables achieved through the PMO. Close-out of the project is now complete and transitioned to operational work for the Strategic Projects team. There will be consideration for how this will be leveraged in preparation for the next strategic planning cycle.	**Y**

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

Client and Community Confidence

Activities & Tasks	*Status*	*Comments*	*Q4 Status Report (Y/N)*
• ***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.	☑	Close-out of the project is now complete and transitioned to operational work for the Program Planning and Evaluation team and the Strategic Projects team.	**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.	⚑	To assess client experience, a validated client-centred care tool was selected for use and additional social determinants of health (SDOH) questions were added to the survey. Implementation plans for teams working with service-seeking clients were developed. The survey was launched in Q1 2019, with data collection completed in Q4 2019. Difficulties with gathering data in one program resulted in delays to data analysis and it could not be completed by the end of 2019 as anticipated. Analysis of results will be finalized by the middle of February 2020. Survey findings will be shared with the relevant teams in March and April 2020 and action plans will be developed by the teams with support from the Community Health Nursing Specialist as needed. The project charter for Phase Two (mandated clients) will be developed by the end of March 2020. Phase One of this project will be closed out by April 2020.	**Y**
• ***Intake Lines*** *(PRJT#2018-012)* ○ Consult with clients and staff re: proposed system. Procure system. ○ Resource development, training and implementation.	👍	The new phone system (3CX) launched on December 16, 2019 following a delay that was related to call porting caused by the current phone provider. Although 3CX was launched in the absence of full call porting being completed, the project team from MLHU and Telecom Metric have submitted all required documents for the process to move forward. The Client Service Representative (CSR) role was fully activated with the launch of 3CX, introducing a two-tier client service model. Ongoing technical issues have been reported while making calls in 3CX applications and the IT team and Telecom Metric technicians have been collaborating to prioritize items for resolution.	**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 are in various stages of implementation. A written update to the Board of Health of the actions taken to date went to the Board in December. Meetings with Middlesex County and lower tier municipalities will occur throughout 2020 and continue on an ongoing basis.	**Y**

Employee Engagement and Learning

Activities & Tasks	*Status*	*Comments*	*Q4 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 ongoing include: 1) regular 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 the status of changes and strategic projects	☑	Multiple channels (town halls, electronic newsletters, division/team meetings, etc), transparent communication from all levels and areas within MLHU, with increased opportunities for staff feedback, have been used to inform and engage staff. Close-out of the project is now complete and transitioned to operational work for the Strategic Projects team.	**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	👍	The Enterprise Resource Planning (ERP) project included upgrading the financial reporting system in addition to implementing a new human resources information system (HRIS). Dayforce by Ceridian, our new HRIS, was launched on September 9, 2019. The time and attendance module in Dayforce replaced MyTime and the implementation of the talent management modules in Dayforce will take place throughout Q1 and Q2 2020. The subsequent modules will automate existing manual human resources processes such as onboarding, recruitment, performance management and dashboard reporting.	**Y**
• ***Deliver the Learning at MLHU Program*** *(PRJT#2018-004)* ○ Incorporate functions of a human resources information system (HRIS), that includes learning and development	👍	The Learning Management System in Dayforce is now live in production and continues to be updated with training modules and the learning catalogue. New online training initiatives are scheduled to be launched in the new system which has greater functionality and an improved End User experience.	**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***	***Q4 Status Report (Y/N)***
• ***Develop and implement Activity-Based Work (ABW) arrangements*** *(PRJT#2018-006)* ○ Provide management training ○ Policy development ○ Continual change management strategies	👍	New ABW spaces was prepared to align with the move into the 2nd floor of Citi Plaza at the beginning of January 2020. The ABW space on the1st floor of Citi Plaza will be completed in early March 2020. An ABW Advisory Committee has been established with representation from each ABW team across MLHU. This committee maintains ongoing communication for ABW practices and provides recommendations for continuous improvement. The ABW Policy and Guidelines were prepared for SLT approval and will be rolled out to staff in Q1 2020.	**Y**
• ***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	☑	Using multiple channels (town halls, electronic newsletters, division/team meetings, etc), transparent communication from all levels and areas within MLH, with increased opportunities for staff feedback, have been used to engage staff in strategic projects and activities at MLHU. The establishment of the PMO has also increased staff engagement across the organization in strategic projects by: 1) creating a centralized repository for project documentation located on the shared drive, and 2) maintaining resources on the HUB to allow staff to access information on project status. The strategic project team members are composed of staff across the organization and consultations are held with relevant teams as related to the nature of the project. Close-out of the project is now complete and transitioned to operational work for the Strategic Projects team.	**Y**
• ***Diversity Assessment and Recommendations*** *(PRJT#2018-009)* ○ Initiate organizational assessment of diversity and inclusiveness, and identify recommendations	☒	The Diversity and Inclusion Assessment was put on hold until further notice due to the public health modernization process. It is expected that this Assessment will be reinitiated in Q3 or Q4 2020.	**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)	☑	Launching of the new policy management software solution “Policy Manager” for administrative policies occurred on October 28, 2019. Go-live for governance policies occurred on December 12, 2019. Expansion to program level documents began in Q4 2019 with a number of Environmental Health and Infectious Disease programs and will continue as the project transitions to operational work having reached project close-out.	**Y**

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

Organizational Excellence

Activities & Tasks	*Status*	*Comments*	*Q4 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 project transitioned to operations and reached the close-out phase when lessons learned from the project life cycle were incorporated into the modified ASP process.	**N**
• ***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. Options will be confirmed in Q1 2020 for the delivery of online and in person courses related to technical writing skills. Once these professional development course have been made available, this strategic project will be completed.	**N**
• ***Enterprise Resource Planning System - Upgrade the financial reporting system*** *(PRJT#2018-004)* ○ Upgrade to include dashboard that provides easily accessible information	👍	Roll out of the procurement and fixed asset administration modules that were to be integrated with the GP Financial Accounting system was put on hold pending further direction from the Ministry regarding regional amalgamation. It is anticipated that the roll-out of these modules will be introduced to a limited extent by the end of Q2 2020.	**Y**
• ***Alignment of budget and performance reporting*** *(PRJT#2018-002)* ○ Modify Program Budget Templates to align with Annual Service Plan requirements	☑	The 2018 ASP was completed and filed on time with the Ministry by April 1, 2019 and no feedback has been received to date. Work is underway for completion of the 2019 submission. Potential changes to the 2020 template from the Ministry remain unknown. The project has proceeded to close-out and has now transitioned to operational work.	**N**

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

Activities & Tasks	*Status*	*Comments*	*Q4 Status 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.	👍	Further developments are underway with the implementation of the Performance Management module within Ceridian Dayforce that encompasses the Enterprise Resource Planning system. The project charter was approved, and a performance management framework will be developed in Q1 for approval by SLT. A performance management tool is being created in Dayforce to be submitted for approval. Consultations with key partners are ongoing. Investigating possible support of a consultant to support with this project and potential collaboration with other health units.	**Y**
• ***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)	☑	An organizational risk register was developed in Q3 2018 that includes high, medium and low organizational risks and associated risk mitigations. The organizational risk register is maintained and updated on an annual basis to reflect changes in status of previously identified risks and to include any new risks. MLHU is compliant with risk management reporting to the Board and the Ministry under the Public Health Accountability Framework as part of the Standards Activity Reports. Opportunities to enhance risk management practices within existing MLHU processes have been assessed and implemented, including, the embedding of risk assessment considerations in Project Management Office tools to ensure formal risk identification and mitigation is part of all strategic projects.	**Y**
• ***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 procurement module to be integrated with the GP Financial Accounting system. This phase of the project was put on hold pending further direction from the Ministry regarding regional amalgamation. It is anticipated that the roll-out of these modules will be introduced to a limited extent by the end of Q2 2020.	**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. The project has proceeded to close-out and has now transitioned to operational work.	**N**

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

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

Project Name:	Relocation Project	**Project Number:**	2018-001
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Procurement & Operations
Project Phase:	Execution	**Date:**	January 31, 2020

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

Recent Accomplishments:

- Moving contract awarded to Sheffield Moving.
- IT Equipment and Infrastructure Quotes awarded to Stronghold Services.
- Supply and Install of AV Equipment Awarded to Best Buy for Business
- New workstations installed on second floor of Citi Plaza.
- 201 Queens Ave Move Completed.
- IT Equipment and computers installed prior to staff move in.
- AV Installed in Meeting Rooms.
- Flexibility provided by landlord to leave existing furniture at 50 King which will result in $120k in savings and a 2-week buffer in the project schedule.

Top Issues:

- Additional changes to furniture configurations could impact 1st floor installations.
- Additional change orders for electrical modifications will add a 1 week to the project schedule.
- Insufficient space is available in the basement to satisfy all program areas and additional purging is required.

Top Risks:

- Unexpected costs during construction are consuming the contingency expenditure budget very quickly.
- Seniors Dental Program fit-up may delay opening of the dental clinic.
- Continued changes requested by management and staff will impact occupancy dates.

Upcoming Key Milestones	Targeted Completion Date	On Track (✓)	Delayed (X)
1. 3rd and 2nd Floor King Street Move	January 17, 2020	✓	
2. Completion of 1st Floor Construction	March 12, 2020	✓	
3. Basement Install and Move	March 12, 2020	✓	
4. 1st Floor Move	March 27, 2020	✓	
5. Clinics Open to the Public	March 30, 2020	✓	

Project Changes:

- None

Key Activities for Next Period:

- Complete deficiencies identified on the 2nd floor of Citi Plaza.
- Prepare for move in of the first floor.
- Encourage additional purging activities in storage areas

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

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:**	January 31, 2020

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:

- None.

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	✓	
4. Follow-up Report and Presentation to County Council	December 2019 and February 2020	✓	

Project Changes:

- None

Key Activities for Next Period:

- Next steps will be going to County Council for follow-up

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

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:**	January 31, 2020

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

Recent Accomplishments:

- Learning Management System is available in production for employee use.
- Transition of carry-over and vacation entitlements to automatic calculation process in Dayforce replaced the previous manual flushing, calculating and uploading vacation balance process at the beginning of each year.

Top Issues:

- Data migration of employee learning history from the existing Learning Management System (Lanteria) to Dayforce requires manual entry.
- Continuous improvement and learning of the Time and Attendance system requires time and support of MLHU staff who are also working on implementing the additional talent management modules. The HR team has limited resources dedicated to implementation and several competing priorities.
- The Performance Management module requires the development of a performance management framework and may not be ready for implementation before the March 31, 2020 Ceridian deadline.

Top Risks:

- The contract with Ceridian requires full implementation of all modules by March 31, 2020. All talent modules will need to be moved to production by this date and MLHU will not have the dedicated support from the Ceridian Implementation team. Requests for assistance will move to Customer Support, which has longer response times.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Implementation of Talent Management Modules	March 31, 2020	✓	
2. Continued refinement of Learning module	March 31, 2020	✓	
3. Implementation of HR Dashboard	June 30, 2020		X

Project Changes:

- Talent Management modules to be launched to all staff in Q1 2020, excluding Performance Management. Learning module was launched but training modules and learning history still needs to be uploaded.

Key Activities for Next Period:

- HR strategic planning session for coordination of communication, training, and implementation of talent modules.
- Loading of learning courses onto Learning module of Dayforce.
- Development of forms and workflows to support Onboarding module.
- Performance management meetings to confirm direction and use of module.
- Reviewing and finalizing workflows, development of templates, and design of external facing applicant website to align with branding for recruitment module.
- Training of additional HR team members on Workforce Management and Document Management modules for tracking “HR Incidents” in Dayforce and moving to electronic personnel records.
- Continued review of changes to previous processes, roles and responsibilities within the HR and Finance teams.

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

Project Name:	Electronic Client Record (ECR)	**Project Number:**	2018-005
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Strategic Projects
Project Phase:	Execution	**Date:**	January 31, 2020

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

Recent Accomplishments:

- Launched Profile for the Healthy Growth and Development Line on December 19, 2020.
- Form Building for Healthy Start Teams is complete, and teams are testing the use of forms Profile.
- Approximately 80% configuration of the database was completed for the Healthy Start teams in Q4.

Top Issues:

- The launch of other new systems occurring simultaneously (e.g. new phone system/Intake Lines) put a strain on the availability of resources, in particular, IT personnel.
- Preparation for Phase 1 of the move to Citi Plaza required a shift in priorities and availability of resources.
- Redefine roles to address the current gap in resource availability in order to configure the database for new teams being onboarded to Profile in Phase 2.

Top Risks:

- Too many changing processes occurring all at once will increase staff stress and performance levels.
- Staff losing confidence in the system and become disengaged if lack of support is available

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Launch Healthy Start for Healthy Growth and Development Line	December 19, 2020	✓	
2. Launch Healthy Start Teams	May 31, 2020	✓	
3. Configuration/Build for Phase 2 teams	March 31, 2020		**X**
4. Phase 3 Workflow Discovery	June 30, 2020	✓	

Project Changes:

- Soft launch of Profile for Healthy Start teams to balance competing priorities such as the introduction of the new phone system and the need to focus on the relocation to Citi Plaza.

Key Activities for Next Period:

- Fully launch Profile for the Healthy Start Teams in Q1 2020.
- Complete testing and training of Profile for Nurse Family Partnership, Healthy Babies/Healthy Children, Early Years and Reproductive Health Teams.
- Configuration//Build of Phase 2 teams: Oral Health, Quit Clinic, and Vaccine Preventable Diseases teams anticipated to commence in Q1 and continue throughout Q2.
- Deliver advanced Power User training for program leads in Q1 2020.
- Deliver advanced System Administrator training for core project team members to expedite onboarding of new teams (Phase 2 & 3).
- Consolidate program reporting requirements with Profile functionality and deliver training for subject matter experts within various teams.
- Development of web-based scheduling tool to interface with Profile.

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

Project Name:	Activity-Based Workstations (ABW)	**Project Number:**	2018-006
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Procurement & Operations
Project Phase:	Execution	**Date:**	January 31, 2020

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

Recent Accomplishments:

- Established an ABW Advisory Committee to maintain ongoing communication for ABW practices and provide recommendations for continuous improvement.
- Opened new ABW spaces with the move into 2nd floor of Citi Plaza.
- Submitted the ABW policy to SLT for approval.

Top Issues:

- 1st floor of Citi Plaza will not be completed until early March requiring all ABW teams to use the ABW space on the 2nd floor since early January.

Top Risks:

- Staff not adhering to the ABW policy and guidelines.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Roll-out of ABW Policy to Staff	February 28, 2020	✓	
2. Identification of training needs for ABW Staff	March 31, 2020	✓	
3. Move into 1st Floor ABW Space at Citi Plaza	March 31, 2020	✓	
4. Project Close-out	March 31, 2020	✓	

Project Changes:

- None

Key Activities for Next Period:

- Implementation of ABW policy to staff.
- Continue to hold meetings (at least quarterly) for the ABW Advisory Committee.
- Prepare for project close-out.

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

Project:	Client and Community Partner Experience Project		**Project #:** 2018-007	
Project Sponsor:	Chief Nursing Officer		**Project Manager:** Community Health Nursing Specialist	
Project Phase	Client Experience Survey: Phase One - Execution		**Date:** January 31, 2020	
Status Last Period:	Current Status:	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Participating teams completed data collection (November 2019).
- TOPHC abstract submitted and accepted (November 2019).
- Abstract submitted to Canadian Community Health Nursing conference (November 2019).
- Analysis of data started (December 2019).
- Development of outline for action planning process initiated (December 2019).
- Additional 'lessons learned' identified that will strengthen future phases of this initiative, as well as future rounds of this assessment (service-seeking clients' experience).
- Vacancy since June in CHNS role (project lead) filled (November 2019).

Top Issues:

- Data gathering in one program took longer than expected, and this delayed the data analysis such that it could not be completed by the end of 2019 as originally planned. This has also delayed the finalization of the Phase One project close-out.
- Statistical software needed is not available to do more in-depth analysis; support from the PHAST team is required.
- Phase Two (assessment of experience of mandated clients) still postponed.

Top Risks:

- Delays in completion of Phase One (service-seeking clients) and postponement of Phase Two (mandated clients) will likely extend timeline for later phases (clients that don't speak English or French; community partners).

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Completion of data analysis	February, 2020	✓	
2. Sharing of findings	March/April 2020	✓	
3. Phase One project close out	April 2020	✓	

Project Changes:

- Changes in staffing on the project in both the Community Health Nursing Specialist and Program Evaluator roles.
- Timelines shifted due to difficulties in gathering data in one program.

Key Activities for Next Period (Jan-June 2020):

- After findings are shared with teams, recommendations and action plans will be developed by directors/managers/staff, with support from the CHNS as needed or desired.
- Directors and managers will be accountable for implementation of action plans. The CHNS will support implementation, as appropriate and as requested.
- Once analysis is complete and findings are shared, Phase One will be closed out.
- The Project Charter for **Phase Two**: **Mandated Client Experience Survey** will be completed by March 31st, 2020.

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

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:**	January 31, 2019

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

Recent Accomplishments:

- Continued work with teams responsible for indicator-specific tasks, to operationalize recommendations previously approved by SLT.

Top Issues:

- Some approved processes continue to be delayed due to direction from SLT to re-prioritize HE indicator assessment in response to proposed MOHLTC system level changes, and capacity limitations (including staff changes and leaves of absence) of involved staff.
- Continued need to defer and/or scale back assessment of additional indicators in order to successfully move towards implementation of previous recommendations from assessment of initial set of indicators.

Top Risks:

- Delay in assessing and reporting on current status related to health equity indicators for public health, and in establishing and/or refining monitoring of health equity indicators.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. First report to Division Management teams and SLT on progress made towards implementing recommendations and meeting indicators.	March 31, 2020	✓	

Project Changes:

- In-depth assessment of remaining indicators on hold.
- Implementation of approved recommendations for some HEIs deferred.

Key Activities for Next Period:

- Continue to provide relevant program teams with information regarding processes and monitoring systems and respond to related requests for support to implement as capacity allows.
- Continue to collect tracking data and measure progress towards meeting indicators.
- Prepare report for divisional management teams and SLT.

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

Project Name:	Intake Lines	**Project Number:**	2018-012
Project Sponsor:	Director, Healthy Living	**Project Manager:**	Manager, IT Manager, Community Outreach and Clinical Support Services
Project Phase:	Execution	**Date:**	January 31, 2020

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

Recent Accomplishments:

- Power and End User training completed in November 2019.
- New phone system (3CX) launched on December 16, 2019.
- Client Service Representatives (CSR) role fully activated with the launch of 3CX introducing the two-tier client service model.
- Development of issues log to identify and prioritize the list of action items for MLHU and Telecom Metric technical teams.

Top Issues:

- Ongoing delays with number porting from previous provider.
- Feedback received daily from staff related to technical issues while making calls in 3CX applications, including choppy sound quality, dropped calls, and no incoming call display. IT Team is exploring issues in with Telecom Metric support technicians.

Top Risks:

- Deployment of resources to support new model for intake lines resulting in reprioritization of work and resulted in the project running slightly behind schedule (1 – 2 weeks).
- Issues identified with incoming and outbound calls due to "anonymous" call display. This should be resolved once numbers porting is complete (10 business days)

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Porting	December 16, 2019		**X**
2. Traffic Shaping	February 29, 2020	✓	
3. Call Logging/Tracking	March 31, 2020	✓	
4. Develop Metrics	June 30, 2020	✓	

Project Changes:

- A second launch delay led to intake lines going live on December 16, 2019.

Key Activities for Next Period:

- Continue to develop/update resources to support new model for Intake Lines.
- Prepare comprehensive list of metrics for evaluation of Intake Lines.
- Explore compatible programs for call logging to provide comprehensive metrics for Tiers 1 and 2. Current admin reports are limited to quantitative data.
- Evaluate new model for Intake Lines in Q2 2020.

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

Project Name:	Performance Management	**Project Number:**	2018-014
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Human Resources
Project Phase:	Planning	**Date:**	January 2020

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

Recent Accomplishments:

- Project Charter was approved by SLT.

Top Issues:

- Consultation with external stakeholders (e.g. other health units) can delay the project schedule and expand the scope.

Top Risks:

- Ceridian implementation consultant is only available until the end of March 2020 when all talent modules will need to be moved to production by this date. If the availability of resources delays the project schedule, a dedicated support from Ceridian may not be obtained and requests for assistance will move to Customer Support, which has longer response times.
- Public health modernization could impact the scope of the project if public health units merge.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Develop performance management framework	February 28, 2020		✓
2. Update the performance management policy	March 20, 2020	✓	
3. Approval of performance management framework, tools	March 20, 2020	✓	
4. Create the performance appraisal tool in Dayforce	March 31, 2020	✓	

Project Changes:

- None

Key Activities for Next Period:

- Create a performance management framework that can be used by all employees.
- Consult with key partners and collaborate with other health units.
- Create a draft performance management tool in Dayforce.
- Update the performance management policy.

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

Project Name:	Administrative Policy Manual Review			**Project Number:**	2018-015
Project Sponsor:	Director, Healthy Organization			**Project Manager:**	Manager, Strategic Projects
Project Phase:	Close-out			**Date:**	January 31, 2020
Status Last Period:	Current Status: ☑	Scope:		Schedule:	Cost:

Recent Accomplishments:

- Completion of policy review, with several policies updated and consolidated/decommissioned, as appropriate.
- Policies prioritized for updating have been identified.
- Launched Policy Manager for administrative policies on October 28, 2019.
- Launched Policy Manager for governance policies on December 12, 2019.
- Initiated expansion to program level documents in Q4 2019, beginning with several Environmental Health and Infectious Disease programs.

Top Issues:

- 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:

- None identified.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Go-live with Governance Level documents	December 1, 2019	✓	
2. Initiate expansion to program level documents.	December 31, 2019	✓	
3. Project Close-out	December 31, 2019	✓	

Project Changes:

- None to report.

Key Activities for Next Period:

- Maintenance of administrative and governance policy manuals and expansion of system to program level documents as project transitions to operational work.

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

Project:	Project Management Office (PMO)		**Project #:** 2018-016	
Project Sponsor:	Director, Healthy Organization		**Project Manager:** Kendra Ramer	
Project Phase	Close-out		**Date:** January 31, 2020	
Status Last Period:	Current Status: ☑	Scope:	Schedule:	Cost:

Recent Accomplishments:

- Assessment of current practices was completed and MLHU project management methodology rolled out to programs and teams across MLHU.
- Established a plan for embedding PMO accountabilities in preparation for future strategic planning processes.
- Transitioned to operational work for Strategic Projects team.

Top Issues:

- None to report.

Top Risks:

- None to report.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Project Close-out	December 31, 2019	✓	
2. Strategic Plan Evaluation	April 30, 2020	✓	
3. Determine Strategic Planning Process for 2021-2025	April 30, 2020	✓	

Project Changes:

- None to report.

Key Activities for Next Period:

- Evaluation of the current strategic plan and defining the role of PMO.
- Planning for the new strategic planning cycle utilizing project management methodology established by PMO.

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

Project Name:	Risk Management Framework	**Project Number:**	2018-017
Project Sponsor:	Director, Healthy Organization	**Project Manager:**	Manager, Procurement & Operations
Project Phase:	Execution	**Date:**	January 31, 2020

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

Recent Accomplishments:

- The organizational risk register was reviewed and updated in Q3 2019 to reflect changes in status of previously identified risks and to include any new risks.
- MLHU is compliant with risk management reporting to the Board and the Ministry under the Public Health Accountability Framework as part of the Standards Activity Reports.
- Risk assessment considerations have been embedded in Project Management Office tools to ensure formal risk identification and mitigation as part of all strategic projects.

Top Issues:

- Staff capacity to enhance risk management practices at the program level.

Top Risks:

- None identified.

Upcoming Key Milestones	**Targeted Completion Date**	**On Track (✓)**	**Delayed (X)**
1. Complete annual Ministry risk management report	November 1, 2020	✓	
2. Project Close-out	March 31, 2020	✓	

Project Changes:

- None

Key Activities for Next Period:

- The organizational risk register will be maintained and updated on an annual basis, with risk management reporting to the Board and the Ministry in accordance with the Ontario Public Health Standards and the Public Health Accountability Framework.
- Continue to assess and implement opportunities to enhance risk management practices within existing MLHU processes as project transitions to operational work.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 002-20GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

TERMS OF REFERENCE AND REPORTING CALENDAR

Recommendation

It is recommended that the Governance Committee:

1) ***Receive Report No. 002-20GC re: "Governance Committee Terms of Reference and Reporting Calendar";***
2) ***Recommend that the Board of Health approve the Governance Committee Terms of Reference (Appendix A); and***
3) ***Recommend that the Board of Health approve the 2020 Governance Committee Reporting Calendar (Appendix B).***

Key Points

- The Governance Committee Terms of Reference outline the role of the Committee and its responsibilities to the Board of Health.
- The 2020 Governance Committee Reporting Calendar provides a framework for activities to be undertaken in the current year.
- The 2020 Committee meeting schedule was approved by the Board of Health at its December 12, 2019 meeting.

Background

In accordance with Policy G-290 Standing and Ad Hoc Committees, the Governance Committee is authorized by the Board of Health to serve a specific purpose set out in the Terms of Reference.

The Reporting Calendar delineates the regular activities required of the Committee each calendar year, in compliance with applicable statutes. Further, it serves as an account of the Committee's proactive approach to Board of Health governance, performance, and accountability.

The Terms of Reference is reviewed and approved every two years, and the Reporting Calendar is reviewed and approved annually.

Amendments to Terms of Reference and Reporting Calendar

The Committee Terms of Reference (Appendix A) and Reporting Calendar (Appendix B) have been amended to align with the approved meeting dates for 2020. The 2020 Governance Committee meeting schedule, approved by the Board of Health at its December 12, 2019 meeting, includes three meetings rather than one per quarter. Additional meetings may occur as needed at the behest of the chair of the Committee.

Next Steps

The Governance Committee has the opportunity to review the appended Terms of Reference and Reporting Calendar for 2020.

Once the Governance Committee is satisfied with its review, the Terms of Reference and Reporting Calendar 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

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GOVERNANCE COMMITTEE
TERMS OF REFERENCE

PURPOSE

The Governance Committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health/Chief Executive Officer (MOH/CEO), and the Director, Healthy Organization in the administration and risk management of matters related to Board membership and recruitment, Board self-evaluation, and governance policy.

REPORTING RELATIONSHIP

The Governance Committee reports to the Board of Health of the Middlesex-London Health Unit. The Chair of the Governance Committee, with the assistance of the Director, Healthy Organization and the MOH/CEO, will make reports to the Board of Health following each of the meetings of the Governance Committee.

MEMBERSHIP

The membership of the Governance Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board member, one City of London Board member and two provincial Board members.

The Secretary-Treasurer will be an ex-officio non-voting member.

Staff support includes:

- Director, Healthy Organization;
- Manager, Privacy, Risk and Governance; and
- Executive Assistant (EA) to the Board of Health and/or EA to the MOH/CEO.

Other Board of Health members may to attend the Governance Committee but are not able to vote.

CHAIR

The Governance Committee will elect a Chair at the first meeting of the year to serve for a one or two-year term. The Chair may be appointed for additional terms following the completion of an appointment to enhance continuity of the Committee.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the Governance Committee membership. At that time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the Committee as long as they remain a Board of Health member.

DUTIES

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The Governance Committee will seek the assistance of and consult with the MOH/CEO and the Director, Healthy Organization for the purposes of making recommendations to the Board of Health on the following matters:

1. Board member succession planning and recruitment;
2. Orientation and continuing education of Board members;
3. Assessment and enhancement of Board and Board committee performance;
4. Performance indicators that are reported to the Board;
5. Compliance with the Board of Health Code of Conduct;
6. Performance evaluation of the MOH/CEO;
7. Governance policy and by-law development and review;
8. Compliance with the Ontario Public Health Standards;
9. Strategic planning;
10. Privacy program;
11. Risk management;
12. Human resources strategy and workforce planning; and
13. Occupational health and safety.

FREQUENCY OF MEETINGS

The Governance Committee will meet three times per year or at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director, Healthy Organization and the MOH/CEO, will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the EA to the Board of Health or the EA to the MOH/CEO.
4. Agenda and minutes will be made available at least five (5) days prior to meetings.
5. Agenda and meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable. This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every two (2) years.

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2020 Governance Committee Reporting Calendar

Q1 (Jan 1 to Mar 31) – Feb 27th Meeting

- Approve Reporting Calendar
- Initiate Terms of Reference Review (every two years)
- Annual Declarations – Confidentiality and Conflict of Interest
- Initiate Board of Health Self-Assessment
- Initiate Board of Health Orientation and Development
- Report on Strategic Plan and Balanced Scorecard Performance Indicators
- Report on Privacy Program
- Review Governance By-laws and Policies

Q2 (Apr 1 to Jun 30) – Jun 18th Meeting

- Initiate Medical Officer of Health Performance Appraisal
- Report on Board of Health Self-Assessment
- Complete Board of Health Orientation and Development
- Report on Public Health Funding and Accountability Agreement Indicators
- Report on Strategic Plan and Balanced Scorecard Performance Indicators
- Report on Occupational Health and Safety Program
- Review Governance By-laws and Policies

Q3 (Jul 1 to Sep 30) – *No Meeting*

Q4 (Oct 1 to Dec 31) – Oct 15th Meeting

- Report on Board of Health Risk Assessment
- Report on Strategic Plan and Balanced Scorecard Performance Indicators
- Review Governance By-laws and Policies

Annual Declarations

In accordance with Ontario privacy laws and the Ontario Public Health Standards, Board of Health members are accountable for maintaining the confidentiality and security of personal information, personal health information, and other confidential information that they gain access to for the purpose of discharging their duties and responsibilities as a member of the Board. As such, Board members will sign an annual confidentiality attestation. (Refer to Policy G-100 Privacy and Freedom of Information and Policy.)

Board of Health members also have a duty to avoid conflicts of interest – situations where financial, professional or other personal considerations may compromise, or have the appearance of compromising, a Board member's judgment in carrying out his/her fiduciary duties as a Board of Health member. As such, Board members will sign an annual conflicts of interest declaration. (Refer to Policy G-380 Conflicts of Interest and Declaration.)

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Board of Health Orientation and Development

In accordance with the Ontario Public Health Standards, the Board of Health must ensure that members are aware of their roles and responsibilities by ensuring the development and implementation of a comprehensive orientation plan for new board members and a continuing education program for all board members. (Refer to Policy G-370 Board of Health Orientation and Development.)

Board of Health Self-Assessment

In accordance with the Ontario Public Health Standards, the Board of Health must complete a self-assessment at least every other year and provide recommendations for improvements in Board effectiveness and engagement. (Refer to Policy G-300 Board of Health Self-Assessment.)

Governance By-laws and Policies

By-laws and policies establish the governing principles, practices and accountability frameworks for the Board of Health. The Ontario Public Health Standards set out by-laws and policies that must be in place for Board operation and require that these are reviewed at least every two years. (Refer to Policy G-000 By-laws, Policy and Procedures.)

Medical Officer of Health and Chief Executive Officer Performance Appraisal

The Medical Officer of Health and Chief Executive Officer (MOH/CEO) performance appraisal will be conducted annually with a report coming to the Governance Committee on the results. (Refer to Policy G-050 MOH/CEO Performance Appraisal.)

Occupational Health and Safety Program

The Board of Health has statutory duties in accordance with the Occupational Health and Safety Act to maintain a safe and healthy workplace. The Board shall be informed of all significant health and safety activities including employee incidents and investigations through an annual report summarizing the health and safety program. (Refer to Policy G-080 Occupational Health and Safety.)

Privacy Program

The Board of Health must ensure there is a privacy program in place to monitor compliance with governance accountabilities and legislative requirements with respect to privacy and the confidentiality and security of personal information and personal health information. (Refer to Policy G-100 Information Privacy and Confidentiality.)

Public Health Funding and Accountability Agreement Indicators

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The Public Health Funding and Accountability Agreements provide a framework for setting specific performance expectations and establishing data requirements to support monitoring of these performance expectations.

Reporting Calendar

The reporting calendar ensures the Committee's requirements to assist and advise the Board of Health on matters outlined in the Committee terms of reference. (Refer to Appendix A.)

Risk Management

The Ontario Public Health Standards require the Board of Health to have a formal risk management framework in place that identifies, assesses, and addresses risks. (Refer to Policy G-120 Risk Management.) In accordance with the Ontario Public Health Standards and the Public Health Funding and Accountability Agreement, the Board of Health will report to the ministry the high risks that are being managed by the Board.

Strategic Planning

The organization's strategic plan is developed in consultation with the Board of Health, staff, other key stakeholders as appropriate, and is subject to final approval by the Board of Health. The strategic plan is reviewed annually by management and the Board of Health. (Refer to Policy G-010 Strategic Planning.)

Terms of Reference

The Governance Committee terms of reference set out the parameters for how authority is delegated to the Committee and how the Committee is accountable to the Board of Health. It is incumbent upon the Governance Committee to review the terms of reference every two years to ensure that components (purpose, reporting relationship, membership, chair, term of office, duties, frequency of meetings, agenda and minutes, by-laws and review) are still relevant to the needs of the committee. (Refer to Policy G-290 Standing and Ad Hoc Committees.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-20GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

GOVERNANCE BY-LAW AND POLICY REVIEW

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to:
1) Receive Report No. 003-20GC re: "Governance By-law and Policy Review" for information; and
2) Approve the governance by-laws and policies as 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 Standards and advice obtained through legal counsel. Refer to Report No. 018-16GC.

Policy Review

The following by-laws/policies (see Appendix B) have been prepared for review by the Governance Committee:

- G-030 MOH/CEO Position Description
- G-290 Standing and Ad Hoc Committees
- G-380 Conflicts of Interest and Declaration
- G-B30 By-law No. 3 - Proceedings of the Board of Health

Appendix A details the recommendations for each of these by-laws/policies.

Policy G-290 Appendices C (FFC Terms of Reference) and D (FFC Reporting Calendar) were reviewed and approved by the Finance & Facilities Committee at its February 6, 2020 meeting.

Next Steps

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

This report was prepared by the Healthy Organization Division.

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

Governance By-law and Policy Review Status and Recommendations

February 27, 2020

Document Name	Last Review	Status	Recommended Changes
G-000 Bylaws, Policy and Procedures	11/15/2018	Current	
G-010 Strategic Planning	11/15/2018	Current	
G-020 MOH/CEO Direction	11/15/2018	Current	
G-030 MOH/CEO Position Description	11/15/2018	Revised - For Approval	Appendix A updated to reflect that MOH/CEO compensation is in accordance with the Ministry of Health and Long-Term Care Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation (September 2018).
G-040 MOH/CEO Selection and Succession Planning	10/19/2017	Review Pending	
G-050 MOH/CEO Performance Appraisal	11/21/2019	Current	
G-080 Occupational Health and Safety	11/21/2019	Current	
G-100 Information Privacy and Confidentiality	03/21/2019	Current	
G-120 Risk Management	06/20/2019	Current	
G-150 Complaints	06/21/2018	Current	
G-160 Jordan's Principle	11/15/2018	Current	
G-180 Financial Planning and Performance	09/19/2019	Current	
G-190 Asset Protection	09/19/2019	Current	
G-200 Approval and Signing Authority	11/21/2019	Current	
G-205 Borrowing	09/20/2018	Current	
G-210 Investing	09/19/2019	Current	
G-220 Contractual Services	11/21/2019	Current	

Document Name	Last Review	Status	Recommended Changes
G-230 Procurement	11/21/2019	Current	
G-240 Tangible Capital Assets	09/19/2019	Current	
G-250 Reserve and Reserve Funds	11/21/2019	Current	
G-260 Governance Principles and Board Accountability	06/21/2018	Current	
G-270 Roles and Responsibilities of Individual Board Members	06/21/2018	Current	
G-280 Board Size and Composition	03/21/2019	Current	
G-290 Standing and Ad Hoc Committees	09/20/2018	Revised - For Approval	Governance Committee and Finance & Facilities Committee Reporting Calendars (Appendix B and Appendix D respectively) updated to align with reporting requirements and meeting schedules for 2020. Governance Committee Terms of Reference updated to reflect meeting frequency of three meetings per year rather than one per quarter, based on 2020 meeting schedule approved by the Board of Health at its December 12, 2019 meeting. Note: FFC terms of reference and reporting calendar reviewed and approved at Feb 6, 2020 FFC meeting (Report No. 001-20FFC).
G-300 Board of Health Self-Assessment	03/21/2019	Current	
G-310 Corporate Sponsorship	09/19/2019	Current	
G-320 Donations	09/19/2019	Current	
G-330 Gifts and Honoraria	09/19/2019	Current	
G-340 Whistleblowing	09/20/2018	Current	

Document Name	Last Review	Status	Recommended Changes
G-350 Nominations and Appointments to the Board of Health	03/21/2019	Current	
G-360 Resignation and Removal of Board Members	06/21/2018	Current	
G-370 Board of Health Orientation and Development	03/21/2019	Current	
G-380 Conflicts of Interest and Declaration	06/21/2018	Revised - For Approval	Editorial revisions only – conflicts of interest procedure moved to an appendix.
G-400 Political Activities	06/21/2018	Current	
G-410 Board Member Remuneration and Expenses	06/20/2019	Current	
G-430 Informing of Financial Obligations	06/21/2018	Current	
G-470 Annual Report	03/21/2019	Current	
G-480 Media Relations	03/21/2019	Current	
G-490 Board of Health Reports	03/21/2019	Current	
G-B10 By-law No. 1 Management of Property	03/21/2019	Current	
G-B20 By-law No. 2 Banking and Finance	06/20/2019	Current	
G-B30 By-law No. 3 Proceedings of the Board of Health	09/20/2018	Revised - For Approval	By-law (item 9.1) updated to define quorum – consistent with current practice (i.e. more than half of the voting members).
G-B40 By-law No. 4 Duties of the Auditor	06/20/2019	Current	

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MOH/CEO POSITION DESCRIPTION

PURPOSE

To outline the role and duties of the Medical Officer of Health and Chief Executive Officer (MOH/CEO). The position description provides the foundation for effective performance management of incumbents and for selection and succession planning.

POLICY

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

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

Refer to Appendix A for a detailed position description for the MOH/CEO.

APPENDICES

Appendix A – MOH/CEO Position Description

APPLICABLE LEGISLATION AND STANDARDS

Health Protection and Promotion Act
Ontario Public Health Standards

RELATED POLICIES

By-law No. 1 – Management of Property
By-law No. 2 – Banking and Finance
By-law No. 3 – Proceedings of the Board of Health
G-010 Strategic Planning
G-020 MOH/CEO Direction
G-050 MOH/CEO Performance Appraisal

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APPENDIX A
To Policy G-030

Title: **MEDICAL OFFICER OF HEALTH & CHIEF EXECUTIVE OFFICER**	HR Code: NU18 Page: 1 of 5
Salary Range: Compensation will be in accordance with the Ministry of Health and Long-Term Care Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation (September 2018)	Status: Non-union
Reports to: Board of Health	Salary Band: N/A
Original Date Approved: September 1997	Revision Date: April 2000 January 1, 2001 March 16, 2006 October 19, 2006 August 2010 October 2014 December 2016 February 27, 2020
Signature: _____ Chair, Board of Health _____ Director, Healthy Organization	

SUMMARY

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

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

STAFF

Associate Medical Officer of Health & Director, Foundational Standards; Director, Healthy Organization; Director, Environmental Health & Infectious Disease; Director, Healthy Living; Director, Healthy Start; Manager, Communications; Executive Assistant to the MOH/CEO.

EXPECTATIONS

Knowledge of the Organization

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

Decision Making and Responsibility

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

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

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

Communication

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

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

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

Technical Knowledge and Skills

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

Leadership skills are considered essential to this position to facilitate engagement with Board members, management, staff, and stakeholders to achieve an alignment of goals, action and

resources with the identified public health needs and to communication effectively to achieve these changes.

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

Sensory, Physical Demands, and Health and Safety Requirements

This position is carried out in a standard office setting and potentially may work in a clinical exam setting.

Physical:

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

Mental:

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

Professionalism and Standards of Performance

The MOH/CEO is expected to meet all professional standards and follow all applicable legislation requirements under HPPA, Ontario Public Health Standards, and other relevant legislation and protocols.

Medical Officer of Health Duties

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

- Work in collaboration and provide leadership to the Board of Health, health unit management and staff, partner agencies, the community and broader public health community. The MOH/CEO has the ability to create opportunities to speak out on an ongoing basis regarding public health matters.
- Ensure optimally functioning systems are in place for population health surveillance and assessment, operational planning, program monitoring, evaluation and implementation of improvements based on evaluation findings and program delivery.
- Work effectively with colleagues (other health units, Ministry of Health and Long-Term Care and municipal governments) to safeguard and enhance the public health system.
- Participate in the education and mentoring of public health professionals, and students/trainees through a range of education forums.
- Maintain effective relations and communication with the CMOH and other personnel within the Ministry of Health and Long-Term Care and other provincial agencies. As part of these relationships the MOH/CEO seeks consultation and provides input and information into matters of mutual interest. The MOH/CEO defers authority to the CMOH as required by HPPA.

Chief Executive Officer Duties

- Accountable to the Board of Health for the management of public health programs. Staff report to the MOH/CEO and the MOH/CEO in turn reports to the Board on program delivery as well as population health needs and issues, program delivery and financial and human resources matters.
- Responsible for all aspects of resource management. This includes the management of financial resources as well as human resources. The MOH/CEO shall appoint an individual(s) to carry out responsibilities assigned to them by the Board of Health.
- Responsible for the care and maintenance of all properties as required by the Board and the keeping of an inventory of all properties possessed by the Board and shall update this inventory list annually. Additionally, pursuant to HPPA and the terms of any leasing or rental agreements, the MOH/CEO responsibilities include, but are not limited to, the replacement of, or major repairs to, capital items such as the heating, cooling, and ventilation systems; roof and structural work; plumbing; lighting and wiring; the maintenance and repair of the parking areas and the exterior of the building; the care and upkeep of the grounds of the property; the cleaning, maintaining, decorating and repairing of the interior of the building; and the maintenance of up-to-date insurance including both property and personal liability coverage, fire, theft, malpractice, errors and omissions and automobile insurance.
- In collaboration with management and staff, the MOH/CEO develops the annual budget for consideration, input and approval of the Board of Health.
- Prepare financial and operating statements for the Board in accordance with established ministry policies indicating the financial position of the Board with respect to the current operations; act as custodian of the books of account and accounting records of the Board required to be kept by the laws of the province; in conjunction with the auditor, arrange for an annual audit of all accounting books and records; report to the Board on all financial and banking matters; and perform other duties as the Board may direct.
- Ensure the development, implementation and regular review of Board of Health by-laws, policies and administrative policies and procedures.
- Responsible for ensuring that systems are in place to fulfill PHFAA as signed by the Board of Health and the Ministry of Health and Long-Term Care.

- Maintain compliance with HPPA, OPHS and PHFAA.
- Maintain a positive public image for the health unit and positive and effective working relations with partner organizations by ensuring that there are optimal systems for the management of media communications and for effective partnership collaboration.
- Act of the primary spokesperson for the agency on all matters of public health significance.

QUALIFICATIONS

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

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

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

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

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STANDING AND AD HOC COMMITTEES

PURPOSE

To outline the requirements for the establishment of and appointment to committees, committee roles and responsibilities, and the rules for committee proceedings.

POLICY

Standing and ad hoc committees are organized to assist the Board of Health in doing its work effectively and efficiently. These committees operate as a component of the collective body and are authorized by and report to the larger Board of Health in accordance with this policy.

Establishment and Appointment to Committees

The Board may establish committees to consider particular matters as specified by the Board (e.g. human resources, planning, etc.). At the first meeting of each calendar year, the Board shall appoint Board members to the standing and ad hoc committees of the Board of Health along with chairs for each committee.

All members of the Board of Health are expected to serve on at least one Board committee with each standing committee including at least 5 members. In addition, the Board Chair will be ex-officio voting member of every Board committee.

The role of each Board committee is to oversee specific activities of the organization as well as activities of the Board. Each Board committee has a set of responsibilities that ensures that the Board can stay focused on matters of strategic importance.

Standing Committees

Standing committees are constituted every year or when the need arises to work on a continuous basis. Standing Committees of the Board of Health include:

- Governance Committee (Refer to Appendix A for terms of reference and Appendix B for reporting calendar); and
- Finance and Facilities Committee (Refer to Appendix C for terms of reference and Appendix D for reporting calendar).

Ad Hoc Committees

Ad hoc committees are created at the approval of the Board. Membership must include municipal, county and provincial representation and be determined based on the specific purpose of the committee, notwithstanding any other standing committee that Board members may be a part of.

Ad hoc committees are temporary and created for a specific task. Once that task is completed, the ad hoc committees cease to exist. Examples of an ad hoc committee include the Medical Officer of Health/Chief Executive Officer Performance Appraisal Committee.

Conduct of Business in Committees

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

It shall be the duty of the Committee:

a) To report to the Board on all matters referred to them and to recommend such action as they deem necessary;
b) To forward to the Board the minutes of meetings; and
c) To forward to the incoming Committee for the following year any matter indisposed of.

APPENDICES

Appendix A – Governance Committee Terms of Reference
Appendix B – Governance Committee Reporting Calendar
Appendix C – Finance and Facilities Committee Terms of Reference
Appendix D – Finance and Facilities Committee Reporting Calendar

APPLICABLE LEGISLATION AND STANDARDS

Health Protection and Promotion Act
Municipal Act

RELATED POLICIES

G-B30 By-law No. 3 Proceedings of the Board of Health
G-270 Roles and Responsibilities of Individual Board Members

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APPENDIX A
To Policy G-290

GOVERNANCE COMMITTEE
TERMS OF REFERENCE

PURPOSE

The Governance Committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health/Chief Executive Officer (MOH/CEO), and the Director, Healthy Organization in the administration and risk management of matters related to Board membership and recruitment, Board self-evaluation, and governance policy.

REPORTING RELATIONSHIP

The Governance Committee reports to the Board of Health of the Middlesex-London Health Unit. The Chair of the Governance Committee, with the assistance of the Director, Healthy Organization and the MOH/CEO, will make reports to the Board of Health following each of the meetings of the Governance Committee.

MEMBERSHIP

The membership of the Governance Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board member, one City of London Board member and two provincial Board members.

The Secretary-Treasurer will be an ex-officio non-voting member.

Staff support includes:

- Director, Healthy Organization;
- Manager, Privacy, Risk and Governance; and
- Executive Assistant (EA) to the Board of Health and/or EA to the MOH/CEO.

Other Board of Health members may to attend the Governance Committee but are not able to vote.

CHAIR

The Governance Committee will elect a Chair at the first meeting of the year to serve for a one or two-year term. The Chair may be appointed for additional terms following the completion of an appointment to enhance continuity of the Committee.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the Governance Committee membership. At that time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the Committee as long as they remain a Board of Health member.

DUTIES

The Governance Committee will seek the assistance of and consult with the MOH/CEO and the Director, Healthy Organization for the purposes of making recommendations to the Board of Health on the following matters:

1. Board member succession planning and recruitment;
2. Orientation and continuing education of Board members;
3. Assessment and enhancement of Board and Board committee performance;
4. Performance indicators that are reported to the Board;
5. Compliance with the Board of Health Code of Conduct;
6. Performance evaluation of the MOH/CEO;
7. Governance policy and by-law development and review;
8. Compliance with the Ontario Public Health Standards;
9. Strategic planning;
10. Privacy program;
11. Risk management;
12. Human resources strategy and workforce planning; and
13. Occupational health and safety.

FREQUENCY OF MEETINGS

The Governance Committee will meet three times per year or at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the committee, with input from the Director, Healthy Organization and the MOH/CEO, will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the EA to the Board of Health or the EA to the MOH/CEO.
4. Agenda and minutes will be made available at least five (5) days prior to meetings.
5. Agenda and meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable. This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every two (2) years.

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APPENDIX B
To Policy G-290

Governance Committee Reporting Calendar

Q1 (Jan 1 to Mar 31) – February Meeting

- Approve Reporting Calendar
- Initiate Terms of Reference Review (every two years)
- Annual Declarations – Confidentiality and Conflict of Interest
- Initiate Board of Health Self-Assessment
- Initiate Board of Health Orientation and Development
- Report on Strategic Plan and Balanced Scorecard Performance Indicators
- Report on Privacy Program
- Review Governance By-laws and Policies

Q2 (Apr 1 to Jun 30) – June Meeting

- Initiate Medical Officer of Health Performance Appraisal
- Report on Board of Health Self-Assessment
- Complete Board of Health Orientation and Development
- Report on Public Health Funding and Accountability Agreement Indicators
- Report on Strategic Plan and Balanced Scorecard Performance Indicators
- Report on Occupational Health and Safety Program
- Review Governance By-laws and Policies

Q3 (Jul 1 to Sep 30) – *No Meeting*

Q4 (Oct 1 to Dec 31) – October Meeting

- Report on Board of Health Risk Assessment
- Report on Strategic Plan and Balanced Scorecard Performance Indicators
- Review Governance By-laws and Policies

Annual Declarations

In accordance with Ontario privacy laws and the Ontario Public Health Standards, Board of Health members are accountable for maintaining the confidentiality and security of personal information, personal health information, and other confidential information that they gain access to for the purpose of discharging their duties and responsibilities as a member of the Board. As such, Board members will sign an annual confidentiality attestation. (Refer to Policy G-100 Privacy and Freedom of Information and Policy.)

Board of Health members also have a duty to avoid conflicts of interest – situations where financial, professional or other personal considerations may compromise, or have the appearance of compromising, a Board member's judgment in carrying out his/her fiduciary duties as a Board of Health member. As such, Board members will sign an annual conflicts of interest declaration. (Refer to Policy G-380 Conflicts of Interest and Declaration.)

Board of Health Orientation and Development

In accordance with the Ontario Public Health Standards, the Board of Health must ensure that members are aware of their roles and responsibilities by ensuring the development and implementation of a comprehensive orientation plan for new board members and a continuing education program for all board members. (Refer to Policy G-370 Board of Health Orientation and Development.)

Board of Health Self-Assessment

In accordance with the Ontario Public Health Standards, the Board of Health must complete a self-assessment at least every other year and provide recommendations for improvements in Board effectiveness and engagement. (Refer to Policy G-300 Board of Health Self-Assessment.)

Governance By-laws and Policies

By-laws and policies establish the governing principles, practices and accountability frameworks for the Board of Health. The Ontario Public Health Standards set out by-laws and policies that must be in place for Board operation and require that these are reviewed at least every two years. (Refer to Policy G-000 By-laws, Policy and Procedures.)

Medical Officer of Health and Chief Executive Officer Performance Appraisal

The Medical Officer of Health and Chief Executive Officer (MOH/CEO) performance appraisal will be conducted annually with a report coming to the Governance Committee on the results. (Refer to Policy G-050 MOH/CEO Performance Appraisal.)

Occupational Health and Safety Program

The Board of Health has statutory duties in accordance with the Occupational Health and Safety Act to maintain a safe and healthy workplace. The Board shall be informed of all significant health and safety activities including employee incidents and investigations through an annual report summarizing the health and safety program. (Refer to Policy G-080 Occupational Health and Safety.)

Privacy Program

The Board of Health must ensure there is a privacy program in place to monitor compliance with governance accountabilities and legislative requirements with respect to privacy and the confidentiality and security of personal information and personal health information. (Refer to Policy G-100 Information Privacy and Confidentiality.)

Public Health Funding and Accountability Agreement Indicators

The Public Health Funding and Accountability Agreements provide a framework for setting specific performance expectations and establishing data requirements to support monitoring of these performance expectations.

Reporting Calendar

The reporting calendar ensures the Committee's requirements to assist and advise the Board of Health on matters outlined in the Committee terms of reference. (Refer to Appendix A.)

Risk Management

The Ontario Public Health Standards require the Board of Health to have a formal risk management framework in place that identifies, assesses, and addresses risks. (Refer to Policy G-120 Risk Management.) In accordance with the Ontario Public Health Standards and the Public Health Funding and Accountability Agreement, the Board of Health will report to the ministry the high risks that are being managed by the Board.

Strategic Planning

The organization's strategic plan is developed in consultation with the Board of Health, staff, other key stakeholders as appropriate, and is subject to final approval by the Board of Health. The strategic plan is reviewed annually by management and the Board of Health. (Refer to Policy G-010 Strategic Planning.)

Terms of Reference

The Governance Committee terms of reference set out the parameters for how authority is delegated to the Committee and how the Committee is accountable to the Board of Health. It is incumbent upon the Governance Committee to review the terms of reference every two years to ensure that components (purpose, reporting relationship, membership, chair, term of office, duties, frequency of meetings, agenda and minutes, by-laws and review) are still relevant to the needs of the committee. (Refer to Policy G-290 Standing and Ad Hoc Committees.

FINANCE & FACILITIES COMMITTEE
TERMS OF REFERENCE

PURPOSE

The Finance & Facilities Committee serves to provide an advisory and monitoring role. The committee's role is to assist and advise the Board of Health, the Medical Officer of Health/Chief Executive Officer (MOH/CEO), and the Manager, Finance in the administration and risk management of matters related to the finances and facilities of the organization.

REPORTING RELATIONSHIP

The Finance & Facilities Committee is a committee reporting to the Board of Health of the Middlesex-London Health Unit (MLHU). The Chair of the Finance & Facilities Committee, with the assistance of the Manager, Finance and the MOH/CEO, will make reports to the Board of Health as a whole following each of the meetings of the Finance & Facilities Committee.

MEMBERSHIP

The membership of the Finance & Facilities Committee will consist of a total of five (5) voting members. The members will include the Chair and Vice-Chair of the Board of Health and in total, the membership will contain at least one Middlesex County Board member, one City of London Board member and two provincial Board members.

The Secretary-Treasurer will be an ex-officio non-voting member.

Staff support includes:

- Director, Healthy Organization;
- Manager, Finance; and
- Executive Assistant (EA) to the Board of Health and/or the EA to the MOH/CEO.

Other Board of Health members are able to attend the Finance & Facilities Committee but are not able to vote.

CHAIR

The Finance & Facilities Committee will elect a Chair at the first meeting of the year to serve for a one or two-year term. The Chair of the Committee may be appointed for additional terms following the completion of an appointment to enhance continuity of the Committee.

TERM OF OFFICE

At the first Board of Health meeting of the year the Board will review the committee membership. At this time, if any new appointments are required, the position(s) will be filled by majority vote. The appointment will be for at least one year, and where possible, staggered terms will be maintained to ensure a balance of new and continuing members. A member may serve on the committee as long as they remain a Board of Health member.

DUTIES

The Finance & Facilities Committee will seek the assistance of and consult with the MOH/CEO, the Director, Healthy Organization and the Manager, Finance for the purposes of making recommendations to the Board of Health on the following matters:

1. Financial statements and analyses;
2. Annual cost-shared and 100% funded program budgets;
3. Annual financial statements and auditor's report;
4. Insurance carried by MLHU;
5. Physical assets and facilities;
6. Service level agreements;
7. Funding agreements;
8. Governance-related financial policies; and
9. Financial risks faced by the organization and the appropriateness of related controls to minimize their potential impact.

FREQUENCY OF MEETINGS

The Finance & Facilities Committee will meet monthly between Board of Health meetings, if a meeting is deemed to be not required it shall be cancelled at the call of the Chair of the Committee.

AGENDA & MINUTES

1. The Chair of the Committee, with input from the Director, Healthy Organization and the MOH/CEO, will prepare agendas for regular meetings of the committee.
2. Additional items may be added at the meeting if necessary.
3. The recorder is the EA to the Board of Health or the EA to the MOH/CEO.
4. Agenda and minutes will be made available at least five (5) days prior to meetings.
5. Agenda and meeting minutes are provided to all Board of Health members.

BYLAWS:

As per Section 19.1 of Board of Health By-Law No. 3, the rules governing the proceedings of the Board shall be observed in the Committees insofar as applicable. This will include rules related to conducting of meetings; decision making; quorum and self-evaluation.

REVIEW

The terms of reference will be reviewed every two (2) years.

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APPENDIX D
To Policy G-290

Finance & Facilities Committee Reporting Calendar

Q1 (Jan 1 to Mar 31)

- 2019 Q4 Financial Update and Factual Certificate Update
- Review Insurance Coverage
- Review Benefits Provider
- Review Terms of Reference
- Visa and Accounts Payable Update
- Approve Reporting Calendar
- Review and Recommend 2020 Board of Health Budget
- Public Sector Salary Disclosure
- Review and Recommend Board of Health Remuneration
- Financial Borrowing Update

Q2 (Apr 1 to Jun 30)

- Q1 Financial Update and Factual Certificate Update
- Review and Recommend - Audited Financial Statements for MLHU
- Recommend Budget Parameters and Planning Assumptions
- Recommend Guidelines for Municipal Budget Targets
- Review Funding and Service Level Agreements
- Financial Borrowing Update

Q3 (Jul 1 to Sep 30)

- Q2 Financial Update and Factual Certificate Update
- Review and Recommend Audited Financial Statements for April 1 to March 31 Programs
- Review and Recommend Program Budgeting Marginal Analysis (PBMA) Process, Criteria and Weighting
- Financial Borrowing Update

Q4 – (Oct 1 to Dec 31)

- Q3 Financial Update and Factual Certificate Update
- Review and Recommend PBMA Proposed Resource Reallocation
- Financial Borrowing Update

Audited Financial Statements

The preparation of the financial statements is the responsibility of the Middlesex-London Health Unit's (MLHU) staff and is prepared in compliance with legislation and in accordance with Canadian public sector accounting standards. The Finance & Facilities Committee meets with staff and the external auditors to review the financial statements and discuss any significant financial reporting or internal control matters prior to their approval of the financial statements.

It is a requirement of the Board of Health is to provide audited financial reports to various funding agencies for programs that are funded from April 1st – March 31st each year. The

purpose of this audited report is to provide the agencies with assurance that the funds were expended for the intended purpose. The agencies use this information for confirmation and as a part of their settlement process.

These programs are also reported in the main audited financial statements of MLHU which are approved by the Board of Health in June, however this report includes program revenues and expenditures of these programs during the period of January 1st to December 31st, which does not coincide with the reporting requirements of the funding agencies. Therefore, a separate audited statement is required.

Benefits Provider

Group insurance for MLHU is reviewed at the completion of a service agreement. Staff are responsible for preparing a review of the needs of MLHU following appropriate market analysis and providing recommendation to the Finance & Facilities Committee.

Board of Health Budget

The Board of Health Budget is presented to the Finance & Facilities Committee through the use of the Annual Service Plan which integrates a summary of planned expenditure by team and allocation of team-based expenditures to specific programs. Description of each program integrates (A) Program Summary, (B) Program Mandate & Relevant Legislation, (C) Program Management, (D) Key Partners & Stakeholders, (E) Community needs and Priorities, (F) Target and Priority Populations, (G) Intended Program Outcomes (long-term, intermediate and short-term, (H) Program Interventions, (I) Performance / Service Level Indicators , (J) Highlights / Initiatives Planned for Next Fiscal Operating Cycle, (K) Program Challenges and Risks, (L) Staffing Complement, (M) and Expenditures & Funding Sources.

Board of Health Remuneration

Section 49 of the Health Protection and Promotion Act (HPPA) sets out the composition, term, and remuneration of Board of Health members. Subsections (4), (5), (6), and (11) relate specifically to remuneration and expenses. This is to be reviewed by the Finance & Facilities Committee who makes recommendations to the Board of Health each year. (Refer to Policy G-410 Board of Health Remuneration and Expenses.)

Budget Parameters and Planning Assumptions

Developing high level planning parameters is an integral part of any budget process. They help guide and inform planning and resource allocation decisions. Ideally the parameters should be linked to the organization’s strategic direction, key budget planning assumptions and take into consideration municipal and provincial outlooks.

Strategic and financial targets can also be considered during the Budget Parameters and Planning Assumptions deliberations at the Finance & Facilities Committee.

Factual Certificate

MLHU staff completes a factual certificate to increase oversight in key areas of financial and risk management. The certificate process ensures that the Committee has done its due diligence. The certificate is reviewed on a quarterly basis alongside financial updates.

Financial Borrowing

The Finance & Facilities Committee is responsible for quarterly review of financial obligations of MLHU.

Financial By-laws and Policies

By-laws and policies represent the general principles that set the direction, limitations and accountability frameworks for MLHU. The Finance & Facilities Committee is responsible for reviewing the governance policies relating to the financial management of the organization, including but not limited to, procurement, investments, and signing authority. (Refer to Policy G-000 By-laws, Policy and Procedures.)

Financial Update

MLHU staff provide financial analysis for each quarter and report the actual and projected budget variance as well as any budget adjustments, or noteworthy items that that have arisen since the previous financial update that could impact the MLHU budget.

Funding and Service Level Agreements

MLHU receives grant funding, both one-time and ongoing from a variety of different sources. It is incumbent upon the Finance & Facilities Committee to annually, or as deemed necessary, review all service level and funding agreements.

Guidelines for Municipal Budgets

While the municipal funders can set targets for the Board, the final decision regarding budget requirements rests with the Board of Health. It is therefore essential that the Board of Health determine its approach to the development of the budget and provide the municipalities of intended changes to the budget.

Insurance Coverage

The Finance & Facilities Committee is responsible for an annual review of the types and amounts of insurance carried by MLHU. Staff are responsible for preparing a review of the insurance needs of MLHU and providing recommendations to the Finance & Facilities Committee in regard to the level and types of insurance MLHU should purchase.

Program Budgeting Marginal Analysis

Program Budgeting Marginal Analysis (PBMA) is a criteria-based budgeting process that facilitates reallocation of resources based on maximizing service. This is done through the

transparent application of pre-defined criteria and decision-making processes to prioritize where proposed funding investments and disinvestments are made.

Public Sector Salary Disclosure

The Public Sector Salary Disclosure Act, 1996 makes Ontario's public sector more open and accountable to taxpayers. The act requires organizations that receive public funding from the Province of Ontario to disclose annually the names, positions, salaries and total taxable benefits of employees paid $100,000 or more in a calendar year.

The main requirement for organizations covered by the act is to make their disclosure or if applicable to make their statement of no employee salaries to disclose available to the public by March 31st each year. Organizations covered by the act are also required to send their disclosure or statement to their funding ministry or ministries by the fifth business day of March.

Reporting Calendar

The reporting calendar ensures the Committee’s requirements to assist and advise the Board of Health on matters outlined in the Committee terms of reference. (Refer to Appendix A.)

Terms of Reference

The Finance & Facilities Committee terms of reference sets out the parameters of how authority is delegated to the Committee and how the Committee is accountable to the Board of Health.

It is incumbent upon the Finance & Facilities Committee to review the terms of reference at least every two years to ensure that components (purpose, reporting relationship, membership, chair, term of office, duties, frequency of meetings, agenda and minutes, by-laws and review) are still relevant to the needs of the committee.

Visa and Accounts Payable

In accordance with Section 5.17 of the Procurement Protocols (Refer to Policy G-230), the Manager of Finance is to report annually the suppliers who have invoiced a cumulative total value of $100,000 or more in a calendar year.

The Finance & Facilities Committee also requested to report annually a summary of purchases made with corporate purchase cards.

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CONFLICTS OF INTEREST AND DECLARATION

PURPOSE

To ensure the highest business and ethical standards and the protection of the integrity of the Board of Health, subject to the requirements of the Health Protection and Promotion Act and the Municipal Conflict of Interest Act.

To guide Board of Health members with a real, potential or perceived conflict of interest on how to declare their conflict and the process for dealing with conflict situations.

POLICY

Board members owe a fiduciary duty to the Board of Health. Included in that duty is the requirement to avoid conflicts of interest. Where a conflict of interest exists, the Municipal Conflict of Interest Act S. 5(1) and S. 5(2) imposes disclosure requirements on all Board of Health members. (Refer to Appendix A for conflicts of interest procedure.)

The term “conflict of interest” refers to situations where financial, professional or other personal considerations may compromise, or have the appearance of compromising, a Board member’s judgment in carrying out their fiduciary duties as a Board of Health member.

Board members have the responsibility to determine whether a conflict of interest exists. Board members should refer to Ontario’s Municipal Conflict of Interest Act – A Handbook 2017 and consult independent legal counsel if necessary.

Situations where a conflict of interest might arise cannot be set out exhaustively, but generally arise in the following circumstances:

(a) When a Board member is directly or indirectly interested in a contract or proposed contract with the Board of Health. For example: Board members are bidding on or doing contract work for the Board of Health.

(b) When a Board member acts in self-interest or for a collateral purpose. When a Board member diverts to their own personal benefit an opportunity in which the Board of Health has an interest.

(c) When a Board member has a conflict of “duty and duty”. This might arise when:
    i. The Board member serves as a board member or officer of another corporation that is related to; has a contractual relationship with; has the ability to influence the Board of Health policy; or has any dealings whatsoever with the Board of Health; or
    ii. The Board member is also a Board member or officer of another corporation related or otherwise, and possesses confidential information received in one

boardroom that is of importance to a decision being made in the other boardroom. The Board member cannot discharge the duty to maintain such information in confidence as a Board member of one corporation while at the same time discharging the duty to make disclosure as a Board member of the other.

(d) When a Board member uses for personal gain information received in confidence only for the Board of Health's purposes, for example information related to human resources, financial aspects of the Board of Health, or related to services provided.

(e) When a Board member or a member of the Board member's immediate family accepts gifts, payments, services or anything else of more than token or nominal value from a party that hopes to transact business with the Board of Health (including a supplier of goods and services) for the purposes or perceived purpose of influencing an act or decision of the Board. Board members shall not accept any financial or other endorsements for fulfilling their duties and obligations as members of the Board of Health other than provided for by legislation and Board of Health policy.

(f) When a Board member and their family will gain or be affected by the decision of the Board. For example, a Board member or member of the Board member's family may benefit from a specific health care service or program that the Board of Health is considering.

All Board members must understand their duties when a conflict of interest arises.

In addition to complying with the ongoing responsibilities set out in this policy, Board members are required to complete an Annual Conflicts of Interest Declaration form (Appendix B).

The principles set out in this policy are to be regarded as illustrative. Board members are required to meet both the letter and spirit of this policy.

Special Considerations for the Board of Health

The Board of Health's unique governance structure creates automatic potential conflicts. These structural conflicts need not be a bar to participation in most aspects of the Board's deliberations. In these circumstances, the Board members are aware of the potential for conflicts of interest and as a practical matter it should not be necessary to make note of the potential conflict in regular Board proceedings. Where the potential for conflicts might not be obvious, the potential conflict of interest should be declared and recorded in the minutes so that all Board members are aware of the situation. This places an extra burden on Board members to be acutely aware of when their actions and/or other responsibilities might create a conflict and follow the procedures in this policy to protect themselves and the best interests of the Board of Health.

APPENDICES

Appendix A – Conflicts of Interest Procedure
Appendix B – Annual Conflicts of Interest Declaration Form

APPLICABLE LEGISLATION AND STANDARDS

Municipal Conflict of Interest Act
Health Protection and Promotion Act

RELATED POLICIES

G-270 Roles and Responsibilities of Individual Board Members
G-410 Board Member Remuneration and Expenses
G-310 Corporate Sponsorship
G-330 Gifts and Honoraria

APPENDIX A
To Policy G-380

Conflicts of Interest Procedure

1. Declaration of Conflict of Interest

1.1. At the beginning of each Board of Health or Committee meeting, the Chairperson asks Board members if they have any conflicts of interest to declare.

1.2. Board members must declare any conflicts of interest as soon as they have been identified. The declaration should be made to the Board Chair. The declaration shall disclose the nature and extent of the Board member's interest. Disclosure shall be made at the earliest possible time and prior to any discussion, vote or decision-making on the matter (unless such discussion, vote or decision making has occurred before the conflict was discovered). The Board member shall not attempt in any way to influence and such vote or decision.

2. Public Meeting

2.1. Once a conflict of interest has been identified, the Board member(s) with the conflict of interest cannot participate in the discussion or vote. The Board member(s) is not to attempt, in any way, to influence the voting on the issue under consideration.

3. In Camera Meeting

3.1. Where the meeting is not open to the public, the Board member shall forthwith leave the meeting or the part of the meeting during which the matter is under consideration.

4. Disclosure to Be Recorded in Minutes

4.1. Where the meeting is open to the public, the declaration of interest and the general nature is to be recorded in the minutes of the meeting.

4.2. Where the meeting is not open to the public, every declaration, but not the general nature of that interest, is to be recorded in the minutes of the next meeting that is open to the public.

5. When Absent from Meeting at Which Matter Considered

5.1. Where the interest of a Board member has not been disclosed by reason of the Board member's absence from the meeting, the member shall disclose the interest at the first meeting of the Board/Committee, as the case may be, attended by the Board member after the meeting where the matter was considered.

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APPENDIX A
To Policy G-380

ANNUAL CONFLICTS OF INTEREST DECLARATION
BOARD OF HEALTH MEMBERS

Introduction:

Members of the Board of Health are required to complete, sign and deliver this annual declaration form to the Chair of the Board. Any questions concerning this form or the Conflicts of Interest Policy (G-380) should be directed to the Board Chair or the Medical Officer of Health/Chief Executive Officer.

Declaration:

I declare that:

a) I have read Policy G-380 Conflicts of Interest.

b) I acknowledge that I am bound by Policy G-380 Conflicts of Interest, including the disclosure requirements that apply to me.

c) I understand and acknowledge that my failure to comply with Policy G-380 Conflicts of Interest will be considered a breach of my obligations to the Health Unit and may result in my removal from the Board.

_____	_____	_____
Name	Signature	Date (YYYY/MM/DD)

MIDDLESEX-LONDON HEALTH UNIT

Board of Health: **By-law No. 3**

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

1. In this by-law:

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) "Secretary-Treasurer" means the Secretary-Treasurer as defined in Policy G-270 as may be amended, from time to time.

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

1.0 General

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

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

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

2.0 Convening Meeting

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

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

3.0 Special Meetings

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

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

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

4.0 Notifying Board Members of Meetings

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

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

4.3 The notice shall be delivered by electronic mail to each member so as to be received no later than five days prior to the scheduled Board meeting.

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

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

5.0 Notifying the Public of Board Meetings

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

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

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

6.0 Meetings Open to the Public

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

6. 2 In accordance with Section 238 (3.1) of the *Municipal Act*, R.S.O., the Board shall ensure that members can participate electronically in a meeting which is open to the public. Any such member shall not be counted in determining whether or not a quorum of members is present at any point in time. Board members shall not be permitted to participate electronically in a meeting which is closed to the public. See Item 7.0 re Convening In-Camera (Closed) Meeting(s).

6. 3 A member who is participating electronically in a meeting shall be able to vote on any matter that is before the Board, subject to restrictions contained elsewhere in this policy, and otherwise at law.

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

7.1 Pre-requirements for in-camera sessions

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

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

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

7.2 Criteria for in-camera meetings

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

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

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

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

(d) labour relations or employee negotiations;

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

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

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

(h) Information explicitly supplied in confidence to the Middlesex-London Health Unit by Canada, a province or territory or a Crown agency of any of them;

(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the Middlesex-London Health Unit, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;

(j) a trade secret or scientific, technical, commercial, or financial information that belongs to the Middlesex-London Health Unit and has monetary value or potential monetary value; or

(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on or by or on behalf of the Middlesex-London Health Unit.

7.3 Criteria for in-camera voting

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

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

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

7.4 In-camera record keeping requirements

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

8.0 Preparation of the "Agenda"

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

(a) Call to Order and Declarations of Interest;

(b) Minutes of Previous Meeting;

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

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

(e) Other Business from the Floor;

(f) Date of Next Meeting;

(g) Adjournment

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

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

9.0 Commencement of Meetings

9.1 As soon as there is a quorum after the hour fixed for the meeting, the Chair or Vice-Chair, or person appointed to act in their place and stead, shall take the chair and call the members to order. A majority of the Board is required for quorum (i.e. more than half of the voting members).

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

9.3 If there is no quorum within thirty minutes after the time appointed for the meeting, the meeting shall then adjourn until the next day of meeting unless the Board otherwise decides.

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

10.0 Rules of Debate and Conduct of Members of the Board

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.0 Motions and Order of Putting Questions

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

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

(a) to accept;

(b) to recommend for approval;

(c) to approve in principle;

(d) to approve;

(e) to ratify;

(f) to adopt;

(g) to amend;

(h) * to table;

(i) to refer;

(j) to receive;

(k) * to adjourn the meeting; or

(l) * that the vote be now taken.

* these items are to be voted on without debate.

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

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

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

12.0 Voting

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

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

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

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

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

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

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

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

13.0 Minutes

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

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

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

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

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

14.0 Adjournment

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

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

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

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

15.0 Communications

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

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

16.0 Proceedings on By-laws

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

16.2 Every by-law shall receive three readings at the Board of Health before being passed. The Board may by a majority vote provide for two or more readings at one meeting.

16.3 The procedure for approving a by-law or amendments to the by-laws is as follows:

(a) The motion “this by-law be now read for a first time" shall be decided without amendment or debate;
(b) The motion “this by-law be now read for a second time” with debate and decision that the adoption of the by-law follow thereafter;
(d) The motion “the by-law be now read for a third time” with resolution that the adoption of the by-law follow thereafter.

16.4 All amendments made at the Board of Health shall be reported by the Chair thereof to the Board which shall receive the same forthwith without debate.

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

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

16.7 All by-laws adopted by the Board shall be kept in a separate volume.

17.0 Secretary-Treasurer

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

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

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

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

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

18.0 Elections and Appointment of Committees

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

18.2 The Chair of the Board shall be selected for one year with a possible renewal of an additional year. The Chair shall rotate among the City, County and Provincial appointees.

18.3 The Vice-Chair and Secretary-Treasurer shall be elected for a one-year term.

18.4 The Secretary-Treasurer function is customarily performed by the Medical Officer of Health / Chief Executive Officer.

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

18.6 The Board may appoint committees from time to time to consider such matters as specified by the Board (e.g., Finance and Facilities, Governance, etc.).

19.0 Conduct of Business in Committees

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

19.2 It shall be the duty of the Committee:

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

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

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

20.0 Corporate Seal

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

21.0 Execution of Documents

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

22.0 Duties of Officers

22.1 The Chair of the Board shall:

(a) preside at all meetings of the Board;

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

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

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

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

23.0 Remuneration

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

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

24.0 Board of Health Performance Assessment

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

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

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

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

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

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

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

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

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

25.0 Amendments

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

First Reading – February 27, 2020
Second Reading – February 27, 2020
Third Reading – February 27, 2020

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 December 8, 2016.

Reviewed by:	Governance Committee	
Approved by:	Board of Health	
Date:	February 27, 2020	
Signature:	Ms. Maureen Cassidy Chair, Board of Health	Dr. Christopher Mackie Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 004-20GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

BOARD OF HEALTH SELF-ASSESSMENT

Recommendation

It is recommended that the Governance Committee:

1) Receive Report No. 004-20GC re: "Board of Health Self-Assessment";

2) Recommend that the Board of Health approve the Board of Health Self-Assessment Tool appended to this report and approve initiation of the Board of Health self-assessment process for 2020.

Key Points

- Board of Health self-assessment is required under the Ontario Public Health Standards.
- The self-assessment results are essential for understanding Board effectiveness and engagement, and for developing recommendations for improvement.
- The Governance Committee is responsible for initiating the annual Board self-assessment process and for assisting and advising staff in its administration.

Background

The Ontario Public Health Standards require that boards of health complete a self-assessment of their governance practices and outcomes at least every other year. It has been the Governance Committee's practice to complete the self-assessment annually.

Self-Assessment Process

1. The Governance Committee reviews and recommends for Board approval the Board of Health Self-Assessment Tool (attached as Appendix A).
2. Following Board approval, the Board of Health Self-Assessment Tool is distributed via email to Board members for completion.
3. Surveys may be completed electronically or on paper. Completed hard copies can be submitted in a sealed envelope to the Executive Assistant (EA) to the Board of Health and/or the EA to the MOH/CEO.
4. Survey results are reported to the Governance Committee anonymously, without any identifying information, to inform recommendations for improvements in Board effectiveness and engagement.
5. The assessment findings and the Governance Committee's recommendations are submitted to the Board of Health for approval.

Next Steps

The Governance Committee, with the assistance of Health Unit staff, will administer the Board of Health Self-Assessment Tool and review anonymized results to identify recommendations for improvement in Board effectiveness and engagement.

The assessment's findings and the Governance Committee's recommendations will be submitted 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

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

2020 Board of Health Self-Assessment

This survey is expected to take approximately 10-15 minutes. Please complete by [Insert Date].

As part of the Board's commitment to good governance and continuous quality improvement, all Board members are invited to complete this self-assessment survey. High-level results of the survey will be reported to the Governance Committee of the Board in an anonymous form without any identifying information. They will be used to inform recommendations for improvements in Board effectiveness and engagement.

Your participation is voluntary and you may choose not to participate or not to respond to any question. The questionnaires will be kept confidential in our records for seven years to comply with our Middlesex-London Health Unit (MLHU) Retention Schedule.

You can complete the survey electronically or on paper. If you complete the paper version please return it in a sealed envelope to Elizabeth Milne, Executive Assistant to the Board of Health or the Executive Assistance to the Medical Officer of Health/Chief Executive Officer.

If you have any questions please contact Elizabeth Milne, 519-663-5317, ext. 3011, elizabeth.milne@mlhu.on.ca or Lynn Guy, 519-663-5317, ext. 2471, lynn.guy@mlhu.on.ca.

Please check Yes, No or Don't know for each question.

Provide additional feedback or comments to elaborate on what the Middlesex-London Board of Health does well, does not do well, or could improve, where relevant.

This information is key to identifying areas for improvement.

1. Am I getting sufficient information to make informed decisions at Board of Health meetings?

- ○ Yes
- ○ No
- ○ Don't know

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Please provide additional feedback or comments below:

2. Am I learning enough, both at Board of Health meetings and elsewhere, about current best practices in public health and governance in order to be an effective Board member?

- ○ Yes
- ○ No
- ○ Don't know

Please provide additional feedback or comments below:

3. Does the Board of Health take all relevant information into consideration when making decisions?

- ○ Yes
- ○ No
- ○ Don't know

Please provide additional feedback or comments below:

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4. Is MLHU accomplishing our strategic priorities as outlined in our strategic plan?

- ○ Yes
- ○ No
- ○ Don't know

Please provide additional feedback or comments below:

5. In the past year, has the Board of Health adequately responded to serious complaints of wrongdoing or irregularities?

- ○ Yes
- ○ No
- ○ Don't know

Please provide additional feedback or comments below:

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6. Does the current relationship between the Board of Health and senior staff result in effective and efficient management of the public health unit?

- ○ Yes
- ○ No
- ○ Don't know

Please provide additional feedback or comments below:

7. Are you satisfied with the reports to the Board of Health made by MLHU staff? For instance, do you think the reports are relevant and provide the correct information?

- ○ Yes
- ○ No
- ○ Don't know

Please provide additional feedback or comments below:

8. Are you satisfied with the presentations made to the Board of Health by MLHU staff? For instance, do you think the time taken for presentations and question and answer sessions is appropriate?

- ○ Yes
- ○ No
- ○ Don't know

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Please provide additional feedback or comments below:

9. Please rank the most important things that the Board should focus on to improve performance (1 – most important, 7 – least important):

	Board Structure (i.e. membership, size, terms of office, reporting relationships)
	Getting sufficient information to make informed decisions
	Learning opportunities for current best practices in public health and governance
	Ensuring all relevant information is taken into consideration when making decisions
	Accomplishing our strategic priorities
	Responding to complaints of wrongdoing or irregularities
	The relationship between the Board of Health and senior staff

10. What is the most important thing that you could recommend for discussion or action in order to improve the Board's performance?

Thank you for taking the time to complete this survey.

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 005-20GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health/CEO

DATE: 2020 February 27

ANNUAL PRIVACY PROGRAM UPDATE

Recommendation

It is recommended that the Governance Committee receive Report No. 005-20GC re: "Annual Privacy Program Update" for information.

Key Points

- Under provincial privacy legislation, the Health Unit is obliged to ensure the rights of individuals with respect to privacy, access to, and correction of records of their personal information and personal health information, as well as the right to access general records that pertain to MLHU operations and governance.
- MLHU's Privacy Program supports compliance with these obligations through education, 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.
- MLHU completes annual statistical reporting to the Information and Privacy Commissioner of Ontario (IPC) in accordance with the requirements set out in the Personal Health Information Protection Act (PHIPA), O. Reg. 329/04, and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA).

Background

MLHU is classified as a "health information custodian" (HIC) under section 3 of PHIPA, and an "institution" under section 2 of MFIPPA. Under this legislation, MLHU and the Middlesex-London Board of Health have obligations to ensure the rights of individuals with respect to privacy, access to, and correction of records of their personal information and personal health information, as well as the right to access general records that pertain to MLHU operations and governance.

MLHU Privacy Program

In accordance with Policy G-100 Privacy and Freedom of Information, the MOH/CEO is the responsible party with respect to freedom of information and protection of individual privacy under MFIPPA. As the designated HIC under PHIPA, the MOH/CEO is specifically responsible for maintaining information systems and implementing policies/procedures for privacy and security, data collection, and records management.

Day-to-day administration and management of MLHU's Privacy Program is operationalized by MLHU's Privacy Officer, and includes the following components:

- Education
- 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 increased awareness and expectations on the part of the public with respect to privacy and access.

Key areas of focus and successes of 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;
- 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 for staff with respect to access, privacy, and information security; and
- Processing of access requests for personal health information and Health Unit general records (freedom of information), including collaboration with the 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 (attached as Appendix A), 2) access and correction requests under PHIPA (attached as Appendix B), and 3) access and correction requests under MFIPPA (attached as Appendix C). All of these reports were submitted to the IPC within the required timelines.

As per the appended reports, MLHU was in compliance with all legislative requirements pertaining to access and correction requests, and had no breaches under PHIPA in 2019.

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 2019

for

Personal Health Information Privacy Breaches

Report run on: 2/10/2020 at 11:49am

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	5196635086
	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)	

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?	
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)	
3.2.2	theft was by a stranger	
3.2.3	TOTAL INCIDENTS	
3.3	**Of the total on line 3.1 indicate the number of privacy breach incidents where:**	
3.3.1	theft was the result of a ransomware attack	
3.3.2	theft was the result of another type of cyberattack	
3.3.3	unencrypted portable electronic equipment (such as USB keys or laptops) was stolen	
3.3.4	paper records were stolen	
3.3.5	theft was a result of something else, by someone else or other items were stolen	
3.3.6	TOTAL INCIDENTS	
3.4	**Of the total on line 3.1 indicate the number of privacy breach incidents where:**	
3.4.1	one individual was affected	
3.4.2	2 to 10 individuals were affected	
3.4.3	11 to 50 individuals were affected	
3.4.4	51 to 100 individuals were affected	
3.4.5	over 100 individuals were affected	
3.4.6	TOTAL INCIDENTS	

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?	
4.2	**Of this total indicate the number of privacy breach incidents where:**	
4.2.1	loss was the result of a ransomware attack	
4.2.2	loss was the result of another type of cyberattack	
4.2.3	unencrypted portable electronic equipment (such as USB keys or laptops) was lost	
4.3	**Of the total on line 4.1 indicate the number of privacy breach incidents where:**	
4.3.4	paper records were lost	
4.3.5	loss was a result of something else or other items were lost	
4.3.6	TOTAL INCIDENTS	
4.4	**Of the total on line 4.1 indicate the number of privacy breach incidents where:**	
4.4.1	one individual was affected	
4.4.2	2 to 10 individuals were affected	
4.4.3	11 to 50 individuals were affected	
4.4.4	51 to 100 individuals were affected	
4.4.5	over 100 individuals were affected	
4.4.6	TOTAL INCIDENTS	

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?	
5.2	**Of this total indicate the number of privacy breach incidents where:**	
5.2.1	unauthorized use was through electronic systems	
5.2.2	unauthorized use was through paper records	
5.2.3	unauthorized use through other means	
5.3	**Of the total on line 5.1 indicate the number of privacy breach incidents where:**	
5.3.4	TOTAL INCIDENTS	
5.4	**Of the total on line 5.1 indicate the number of privacy breach incidents where:**	
5.4.1	one individual was affected	
5.4.2	2 to 10 individuals were affected	
5.4.3	11 to 50 individuals were affected	
5.4.4	51 to 100 individuals were affected	
5.4.5	over 100 individuals were affected	
5.4.6	TOTAL INCIDENTS	

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?	
6.2	**Of this total indicate the number of privacy breach incidents where:**	
6.2.1	unauthorized disclosure was through misdirected faxes	
6.2.2	unauthorized disclosure was through misdirected emails	
6.2.3	unauthorized disclosure was through other means	
6.3	**Of the total on line 6.1 indicate the number of privacy breach incidents where:**	
6.3.4	TOTAL INCIDENTS	
6.4	**Of the total on line 6.1 indicate the number of privacy breach incidents where:**	
6.4.1	one individual was affected	
6.4.2	2 to 10 individuals were affected	
6.4.3	11 to 50 individuals were affected	
6.4.4	51 to 100 individuals were affected	
6.4.5	over 100 individuals were affected	
6.4.6	TOTAL INCIDENTS	

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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 2019

for

Personal Health Information Protection Act

Report run on: 2/10/2020 at 2:05pm

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	5196635086
	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.
- ○ Received only requests for correction of records of personal health information.

Section 2: Uses or Purposes of Personal Health Information

Section 3: Number of Requests Received

		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 received during the reporting year (January – December).	9

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	9
4.2	Over 30 days with an extension	0
4.3	Over 30 days without an extension	0
4.4	Total requests completed (Add Boxes 4.1 to 4.3 = 4.4)	9

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.	9
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)	9

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)).	0
5.5	Number of requests completed in excess of the time limit permitted under the Time Extension Notice (subsection 54(4)).	0

Section 5: Compliance with the *PHIPA*

5.6	Total requests (Add Boxes 5.4 + 5.5 = 5.6)	0

C. Total Completed Requests (sections A and B)

		Personal Health Information
5.7	Total requests (Add Boxes 5.3 + 5.6 = 5.7)	9

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.	1
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	1

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.

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	8
6.2	Partial access provided: provisions applied to deny access	0
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	0
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	9
6.11	Total requests denied access in whole or part where a provision of *PHIPA* was appliedAdd Boxes 6.2 + 6.5 = 6.11	0

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	0
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)	0

Section 8: Fees

		Personal Health Information
8.1	Number of requests for access to records of personal health information where fees were collected	1
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	$30.00
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

What course of action was taken for each request to correct personal health information?

9.2	Correction(s) made in whole	0
9.3	Correction(s) made in part	0
9.4	Correction(s) refused	0
9.5	Correction(s) withdrawn by requester	0

Section 9: Corrections and Statements of Disagreement		
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

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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 2019

for

Municipal Freedom of Information and Protection of Privacy Act

Report run on: 2/10/2020 at 2:22pm

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	5196635086
	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
- ◉ Formal written requests for access to records
- ○ Requests for correction of records of personal information only

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	0	20
3.2	Total number of requests completed during the reporting year	0	20

Section 4: Source of Requests

Enter the number of requests you completed from each source.

		Personal Information	General Records
4.1	Individual/Public	0	8
4.2	Individual by Agent	0	4
4.3	Business	0	0
4.4	Academic/Researcher	0	0
4.5	Association/Group	0	0
4.6	Media	0	8
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)	0	20

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	0	16
5.2	31 - 60 days	0	4
5.3	61 - 90 days	0	0
5.4	91 days or longer	0	0
5.5	Total requests (Add Boxes 5.1 to 5.4 = 5.5)	0	20

BOX 5.5 must equal BOX 3.2

Section 6: Compliance with the Act

In the following charts, please indicate the number of requests completed, within the statutory time limit and in excess of the statutory time limit, under each of the four different situations:

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.	0	16
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)	0	16

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	0
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	0

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	4
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	4

E. Total Completed Requests (sections A to D)

		Personal Information	General Records
6.13	Total requests (Add Boxes 6.3 + 6.6 + 6.9 + 6.12 = 6.13)	0	20

BOX 6.13 must equal BOX 3.2

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	0	13
7.2	Information disclosed in part	0	5
7.3	No information disclosed	0	0
7.4	No responsive records exists	0	2
7.5	Request withdrawn, abandoned or non-jurisdictional	0	0
7.6	Total requests (Add Boxes 7.1 to 7.5 = 7.6)	0	20

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	3
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	2
8.13	Section 14(5) — Refusal to Confirm or Deny	0	0
8.14	Section 15 — Information soon to be published	0	0
8.15	Section 20.1 Frivolous or Vexatious	0	0
8.16	Section 38 — Personal Information (Requester)	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	0	5

[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	$80.00	$80.00
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	$80.00	$80.00
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
11.2	Correction requests carried forward from the previous year	0
11.3	Correction requests carried over to next year	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

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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*