AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

Microsoft Teams
Thursday, February 18, 2021, 5:30 p.m.

1. **ELECTION OF CHAIR, GOVERNANCE COMMITTEE**

2. **DISCLOSURE OF CONFLICTS OF INTEREST**

3. **APPROVAL OF AGENDA –** February 18, 2021

4. **APPROVAL OF MINUTES –**

   4.1. October 15, 2020
   4.2. December 21, 2020 (Special)
   4.3. January 27, 2021 (Special)
   4.4. January 28, 2021 (Special)

5. **NEW BUSINESS**

   5.1. 2021 Reporting Calendar and Terms of Reference (Report No. 02-21GC)
   5.2. Governance Committee Accountability for Policy Review (Report No. 03-21GC)
   5.3. Annual Privacy Program Report (Report No. 04-21GC)
   5.4. 2020 Risk Management Report (Report No. 05-21GC)
   5.5. Strategic Planning Update (Report No. 06-21GC)

6. **OTHER BUSINESS**

   Next meeting date to be determined

7. **CONFIDENTIAL**

The Governance Committee will move in-camera to consider personal matters about an identifiable individual, including municipal or local board employees.

8. **ADJOURNMENT**

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

Thursday, October 15, 2020, 6:00 p.m.
Microsoft Teams

MEMBERS PRESENT: Ms. Aina DeViet (Committee Chair)
Ms. Maureen Cassidy
Ms. Arielle Kayabaga
Mr. Bob Parker
Mr. Ian Peer

OTHERS PRESENT: Dr. Chris Mackie, Medical Officer of Health
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health and Associate Medical Officer of Health (Recorder)
Dr. Alex Summers, Associate Medical Officer of Health
Dr. Michael Clarke, Chief Executive Officer (Interim)
Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance, Interim Director, Healthy Organization
Ms. Cynthia Bos, Manager, Human Resources
Kendra Ramer, Manager Strategic Projects
Ms. Heather Lokko, Director, Healthy Start and Chief Nursing Officer

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

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Mr. Parker, seconded by Mr. Peer, *that the AGENDA for the October 15, 2020 Governance Committee meeting be approved*.

Carried

APPROVAL OF MINUTES

It was moved by Ms. Cassidy, seconded by Ms. Kayabaga, *that the MINUTES of the July 16, 2020 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Governance Policy Review (Report No. 012-20GC)

Dr. Clarke introduced this report. He noted that during a review of the policy review date calendar, it was realized that there was a large backlog of policies that needed review and several more that were coming due. He introduced Ms. Ramer to update the Committee and

Ms. Ramer attended the meeting to assist with explaining the proposed process that will help to work through the policies that need to be reviewed by the Governance Committee. She noted that to spread out the workload, Committee members will be able to provide input prior to meeting. This will also promote engagement between meetings.

Ms. Ramer also noted that there are several Finance and Facilities Committee policies that will be added to the process.

Chair DeViet noted that she has met with Dr. Clarke and Ms. Ramer to discuss the proposed process.

Ms. Ramer noted that policies that are passed due will be reviewed first, followed by the ones that are coming up for review.

It was moved by Ms. Cassidy, seconded by Mr. Peer, *that the Governance Committee recommend to the Board of Health:*

1) *Receive Report No. 0012-20GC re: "Governance Policy Review"*

2) *Approve the new governance policy review process appended to this report (Appendix A); and*

3) *Approve the governance policy appended to this report (Appendix D).*

Carried

OTHER BUSINESS

The next meeting of the Governance Committee: February 18, 2021.

CONFIDENTIAL

At 6:23 p.m. it was moved by Ms. Kayabaga, seconded by Ms. Cassidy, *that the Governance Committee move in-camera to consider matters regarding labour relations and identifiable individuals.*

Carried

At 6:45 p.m. it was moved by Ms. Kayabaga, seconded by Mr. Peer that the Governance Committee return to public session.

Carried

ADJOURNMENT

At 6:45 p.m., it was moved by Ms. Kayabaga, seconded by Ms. Cassidy, *that the meeting be adjourned.*

Carried

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AINA DEVIET
Committee Chair

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CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

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

Monday, December 21st, 2020 at 10 a.m.
Microsoft Teams

MEMBERS PRESENT:
Ms. Aina DeViet (Committee Chair)
Ms. Maureen Cassidy
Ms. Arielle Kayabaga
Mr. Bob Parker

OTHERS PRESENT:
Mr. Matt Reid, Board Member
Mr. Mike Steele, Board Member
Mr. Aaron O'Donnell, Board Member
Dr. Chris Mackie, Medical Officer of Health
Dr. Michael Clarke, CEO (Interim)
Ms. Stephanie Egelton, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Ms. Emily Williams, Director, Healthy Organization
Ms. Heather Lokko, Director, Healthy Start and Chief Nursing Officer
Ms. Kendra Ramer, Manager, Strategic Initiatives

REGRETS:
Mr. Ian Peer

Chair Aina DeViet called the meeting to order at 10:02 a.m.

Ms. Arielle Kayabaga joined at 10:06 a.m.

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Ms. Maureen Cassidy, seconded by Mr. Bob Parker**, *that the AGENDA for the December 21, 2020 Special Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Verbal Update and History on Strategic Planning Process

Dr. Mackie provided a brief context on the previous strategic planning process.

Discussion included:
- Support from the Board in 2014 of a 5-year strategic plan from 2015-2020
- The possibility of focusing the next plan on fewer priorities over a shorter time horizon
- The different core areas of public health that were involved with the 2015-2020 Strategic Planning process at the Middlesex-London Health Unit
- The short-term planning and research needed for a provisional plan

At the December 10, 2020 Public Session of the Middlesex-London Board of Health, the Board directed the Governance Committee to schedule a Strategic Planning Session before the end of January 2021, therefore;

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

A) Approve *Committee Member, Mr. Robert Parker to work with staff to begin process of obtaining consultant options to begin the Strategic Planning process per Middlesex-London Health Unit's Procurement Policy (G-230) and Contractual Services Policy (G-220) and;*
B) Receive *verbal update on the "Strategic Planning Process" for information.*

Carried

OTHER BUSINESS

It was moved by **Mr. Parker, seconded by Ms. Cassidy** *that the Governance Committee direct staff to provide a list of dates and times for a provisional Strategic Planning session with the Board of Health and Senior Leadership Team.*

Carried

ADJOURNMENT

At 10:37 a.m., it was moved by **Mr. Parker, seconded by Ms. Cassidy**, *that the meeting be adjourned.*

Carried

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AINA DEVIET
Committee Chair

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CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

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

Wednesday, January 27th, 2021 at 8:30 a.m.
ZOOM

MEMBERS PRESENT:
Ms. Maureen Cassidy (Chair)
Ms. Aina DeViet (Vice-Chair)
Ms. Arielle Kayabaga
Mr. Bob Parker
Mr. Mike Steele

OTHERS PRESENT:
Mr. Matt Reid, Board Member
Mr. Aaron O'Donnell, Board Member
Ms. Tino Kasi, Board Member
Dr. Chris Mackie, Medical Officer of Health (Secretary-Treasurer)
Ms. Stephanie Egelton, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Ms. Kendra Ramer, Manager, Strategic Projects
Ms. Svetlana Mutlak, Executive Assistant, Healthy Organization
Ms. Victoria Mazzarolo, Student, Healthy Organization
Dr. Alexander Summers, Associate Medical Officer of Health
Ms. Emily Williams, Director, Healthy Organization
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Ms. Maureen MacCormick, Director, Healthy Living
Ms. Heather Lokko, Director, Healthy Start and Chief Nursing Officer
Dr. Michael Clarke, Interim CEO
Ms. Maria Sánchez-Keane, Principal, Centre for Organizational Effectiveness
Ms. Kathleen Schreurs, Research and Communications Associate, Centre for Organizational Effectiveness
Ms. Kate Dubinski, CBC News
Ms. Rebecca Zandbergen, CBC News

REGRETS:
Mr. John Brennan
Ms. Kelly Elliott

Chair Aina DeViet called the meeting to order at **8:36 a.m.** via ZOOM.

Mr. Aaron O'Donnell joined the meeting at **9:02 a.m.**

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Mr. Bob Parker, seconded by Ms. Maureen Cassidy**, *that the AGENDA for the January 27, 2021 Special Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Ontario Health Unit Organization Structures: Medical Officer of Health and Chief Executive Roles (Report No. 01-21GC)

Dr. Michael Clarke, Interim CEO and Ms. Emily Williams

It was moved by **Mr. Parker, seconded by Ms. Cassidy**, *that the Governance Committee receive Report No. 01-21GC re: "Ontario Health Unit Organizational Structures: Medical Officer of Health and Chief Executive Officer Roles" for information.*

Carried

Ms. Dubinski and Ms. Zandbergen left the meeting at **8:52 a.m.**

Provisional Strategic Plan Discussions

The first part of the Provisional Strategic Plan discussions occurred, and were facilitated by Maria Sánchez-Keane, Principal, Centre for Organizational Effectiveness.

Attendees were placed into breakout rooms via Zoom, composed of no more than two (2) governance committee members each.

Topics discussed in breakout sessions included:

- Public Health Modernization
- Structure of the Middlesex-London Health Unit
- Racism as a Public Health Issue

OTHER BUSINESS

- Next session is tomorrow (Thursday, January 28th at 1 p.m.)

ADJOURNMENT

At **11:56 a.m**., it was moved by **Mr. Parker, seconded by Mr. Mike Steele,** *that the meeting be adjourned.*

Carried

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AINA DEVIET **CHRIS MACKIE**
Chair **Secretary-Treasurer**

DRAFT

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

Thursday, January 28th, 2021 at 1 p.m.
ZOOM

MEMBERS PRESENT:	Ms. Maureen Cassidy (Chair) Ms. Aina DeViet (Vice-Chair) Ms. Arielle Kayabaga Mr. Bob Parker Mr. Mike Steele
OTHERS PRESENT:	Mr. Matt Reid, Board Member Mr. Aaron O'Donnell, Board Member Ms. Tino Kasi, Board Member Dr. Chris Mackie, Medical Officer of Health (Secretary-Treasurer) Ms. Stephanie Egelton, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Ms. Kendra Ramer, Manager, Strategic Projects Ms. Svetlana Mutlak, Executive Assistant, Healthy Organization Ms. Victoria Mazzarolo, Student, Healthy Organization Dr. Alexander Summers, Associate Medical Officer of Health Ms. Emily Williams, Director, Healthy Organization Mr. Stephen Turner, Director, Environmental Health and Infectious Disease Ms. Maureen MacCormick, Director, Healthy Living Ms. Heather Lokko, Director, Healthy Start and Chief Nursing Officer Dr. Michael Clarke, Interim CEO Ms. Maria Sánchez-Keane, Principal, Centre for Organizational Effectiveness Ms. Kathleen Schreurs, Research and Communications Associate, Centre for Organizational Effectiveness
REGRETS:	Mr. John Brennan Ms. Kelly Elliott

Chair Aina DeViet called the meeting to order at **1:03 p.m.** via ZOOM.

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Mr. Bob Parker, seconded by Ms. Maureen Cassidy**, *that the AGENDA for the January 28, 2021 Special Governance Committee meeting be approved.*

Carried

PREVIOUS BUSINESS

Provisional Strategic Plan Discussions

The second half of the Provisional Strategic Plan discussions occurred, and were facilitated by Maria Sánchez-Keane, Principal, Centre for Organizational Effectiveness.

Attendees were placed into breakout rooms via Zoom, composed of no more than two (2) governance committee members each.

Topics discussed in breakout sessions included:

- Pandemic Management
- Priority Recovery Issues
- Mental Health of Staff
- Digital Strategy

OTHER BUSINESS

- Next Governance Committee meeting is Thursday, February 18th at 6 p.m.

ADJOURNMENT

At **4:21 p.m**., it was moved by **Mr. Parker, seconded by Mr. Mike Steele**, *that the meeting be adjourned.*

Carried

AINA DEVIET	**CHRISTOPHER MACKIE**
Chair	**Secretary-Treasurer**

DRAFT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 02-21GC

TO: Chair and Members of the Governance Committee

FROM: Chris Mackie, Medical Officer of Health
Michael Clarke, Chief Executive Officer (Interim)

DATE: 2021 February 18

GOVERNANCE COMMITTEE REPORTING CALENDAR & MEETING SCHEDULE

Recommendation

It is recommended that the Governance Committee:
1) ***Receive Report No. 02-21GC re: "Governance Committee Reporting Calendar & Meeting Schedule";***
2) ***Recommend that the Board of Health approve the 2021 Governance Committee Reporting Calendar (Appendix B).***

Key Points

- The 2021 Governance Committee Reporting Calendar (Appendix B) provides a framework for activities to be undertaken in the current year.
- Additional Governance Committee meetings are required to report on deferred items from 2020 and focus on the development and approval of the MLHU strategic plan.
- The 2021 Reporting Calendar has been amended to align with a proposed change to the meeting schedule that will allow for the Committee to convene more frequently in 2021.
- It is recommended that the Board of Health approve the proposed 2021 Committee Reporting Calendar and meeting schedule.

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 (Appendix A).

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 was last done in 2020. The Reporting Calendar (Appendix B) is reviewed and approved annually.

Amendments to the Reporting Calendar and Meeting Schedule

In 2020 the Governance Committee was scheduled to meet three times per year with additional meetings occurring as needed at the call of the Chair of the Committee. Several items to be reported to the Governance Committee in 2020 were deferred to allow MLHU to focus on responding to the COVID-19 pandemic. The table below summarizes the items that were deferred.

Report	Rationale for Deferring in 2020	2021 Status
Board of Health Orientation and Development	Initial orientation completed for new member with Dr. Mackie. Ongoing orientation and development were deferred due to the focus on the pandemic response.	Board of Health Orientation initiated during the Strategic Planning sessions in January 2021 and will continue throughout the development of the strategic plan.

		Board of Health Development will be informed by the Board of Health Self-Assessment to be administered in Q2 2021.
Board of Health Self-Assessment	Administered in early March 2020 – insufficient response for analysis/recommendations. No further follow-up due to focus on pandemic response.	Board of Health Self-Assessment to be administered in Q2 2021.
Medical Officer of Health Performance Appraisal	Deferred due to focus on pandemic response.	To be administered in Q2 2021.
Report on Public Health Funding and Accountability Agreement Indicators	Ministry reporting deferred due to pandemic.	Await direction from the Ministry – prepare for reporting in Q3 2021.
Review Governance By-Laws and Policies	Deferred due to redeployments during pandemic response.	Resume accountabilities for policy review throughout 2021.
Report of Board of Health Risk Assessment	Deferred due to focus on pandemic response.	Report in Q1 2021.
Report on Strategic Plan and Balanced Scorecard Performance Indicators	Deferred due to redeployments during pandemic response.	Report in Q1 2021 and align with the development of MLHU's Provisional Plan.

In order to report on the above deferred items from 2020 it is proposed that the Governance Committee meet every other month, for a total of at least five (5) times this year.

Subsequently, the 2021 Reporting Calendar (Appendix B) has been amended to align with a proposed change to the meeting schedule by increasing the number of times the Committee convenes in 2021.

Next Steps

The Governance Committee has the opportunity to review the appended Reporting Calendar and meeting schedule for 2021.

Once the Governance Committee is satisfied with its review, the Reporting Calendar will be forwarded to the Board of Health for approval.

This report was prepared by the Healthy Organization Division.

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

Michael Clarke, PhD
CEO (Interim)

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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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2021 Governance Committee Reporting Calendar

Q1 (Jan 1 to Mar 31) Meeting: February	Q2 (Apr 1 to Jun 30) Meetings: April & June
• Approve Reporting Calendar • Initiate Terms of Reference Review (every two years) • Annual Declarations – Confidentiality and Conflict of Interest • Initiate Board of Health Orientation • Report on Strategic Plan and Balanced Scorecard Performance Indicators • Report on Privacy Program • Report on Board of Health Risk Assessment • Review Governance By-laws and Policies	• Initiate Medical Officer of Health Performance Appraisal • Initiate Board of Health Self-Assessment • Report on Board of Health Self-Assessment • Continue Board of Health Orientation • Initiate Board of Health Development • 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) **Meeting: September**	**Q4 (Oct 1 to Dec 31)** **Meeting: November**
• Continue Board of Health Orientation and Development • Report on Public Health Funding and Accountability Agreement Indicators • Report on Strategic Plan and Balanced Scorecard Performance Indicators • Review Governance By-laws and Policies	• Complete Board of Health Orientation and Development • 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.)

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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.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 03-21GC

TO: Chair and Members of the Board of Health

FROM: Chris Mackie, Medical Officer of Health
Michael Clarke, Chief Executive Officer (Interim)

DATE: 2021 February 18

GOVERNANCE COMMITTEE ACCOUNTABILITY FOR POLICY REVIEW

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to receive Report No. 03-21GC re: "Governance Committee Accountability for Policy Review".

Key Points

- The Board of Health (BOH) is responsible for establishing the general policies and procedures that govern the operation of the health unit and provide guidance to those managing its operations.
- The BOH for MLHU must be committed to the principle of establishing policies, making decisions and monitoring performance relating to the key dimensions of the business of MLHU and to the BOH's own effectiveness.
- On October 15, 2020, the Governance Committee approved a new policy review process (included as Appendix A to this report) to better support the Committee in carrying out its duties.
- Evaluation of the policy review process is required post-implementation.
- It is recommended that the Chair of the Governance Committee solicit feedback from its members on the policy review process and to work with MLHU staff to implement required changes.

Background

According to the Association for Local Public Health Agencies (alPHa) the Board of Health (BOH) is considered the *"governing body and policy maker of the health unit"*. The BOH is responsible for establishing the policies that govern the operation of the health unit and provide guidance to those managing its operations.

Furthermore, to align with the Association for Local Public Health Agencies (alpha) *2018 Orientation Manual for Boards of Health* a member of a Board of Health (BOH) should:

- commit to and understand the purpose, policies and programs of the health unit;
- attend board meetings, and actively participate on committees and serve as officers;
- actively participate in setting the strategic directions for the organization;
- acquire a clear understanding of the financial position of the health unit and ensure that the finances are adequate and responsibly spent;
- serve in a volunteer capacity without regard for remuneration or profit;
- be able to work and participate within a group, as a team;
- be supportive of the organization and its management;
- know and maintain the lines of communication between the board and staff;
- take responsibility for continuing self-education and growth;
- represent the public health of the community;
- be familiar with local resources;
- be aware of the changing community trends and needs;

- attend related community functions;
- have a working knowledge of parliamentary procedure; and
- be aware of the definition of conflict of interest and declare it.

In accordance with Policy G-260 Governance Principles and Accountability the BOH for MLHU must be committed to the principle of establishing policies, making decisions and monitoring performance relating to the key dimensions of the business of MLHU and to the BOH's own effectiveness.

Duties & Accountabilities of Governance Committee Members

According to the Governance Committee Terms of Reference (Policy G-290 Standing and Ad Hoc Committees), the accountability for making recommendations on governance policy and by-law development and review resides with the members of the Governance Committee.

On October 15, 2020, the Governance Committee approved a new policy review process (included as Appendix A to this report) to better support the Committee in carrying out its duties. The revised process was developed to adhere to the duties and accountabilities of the BOH and its members as guided by alPHa. In addition, the purpose of implementing a new process was to increase efficiency and address the workload required of the Governance Committee members by spacing out the time period for reviewing policies that are due for review.

Policy Review Process Evaluation

Introducing a new process requires the need to evaluate its effectiveness post-implementation. The Governance Committee members are asked to identify any key challenges with the policy review process as it relates to the following:

a) Ability to meet their duties and accountabilities as an effective member of the Governance Committee; and
b) Adhere to the principle of establishing policies as it relates to the key dimensions of the business of MLHU and its BOH's effectiveness.

Next Steps

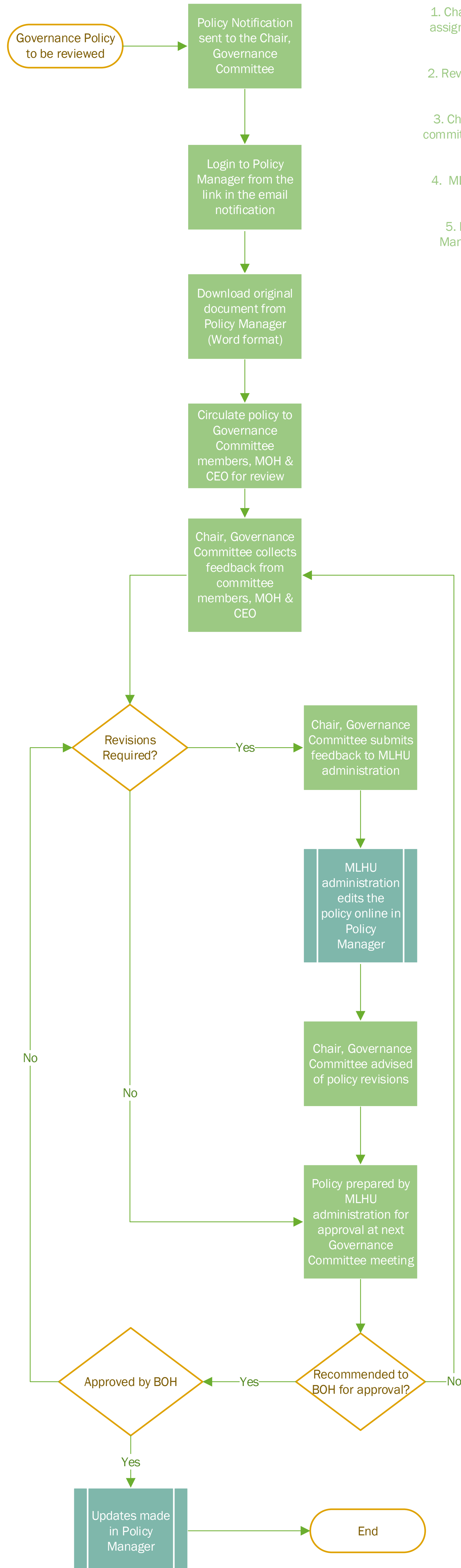
It is recommended that the Chair of the Governance Committee solicit feedback from the Governance Committee members on the policy review process and to work with MLHU staff to implement any required changes.

This report was prepared by the Healthy Organization Division.

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

Michael Clarke, PhD
CEO (Interim)

Appendix A: 03-21GC



Notes

1. Chair, Governance Committee and Manager, Strategic Projects assigned to the "Governance Committee" team in Policy Manager and designated as a reviewer.

2. Reviewers receive notifications when policies are due for review on the 25th of every month.

3. Chair, Governance Committee will circulate the policy to other committee members via email and collect feedback by the 1st of the month.

4. MLHU administration may be the Manager, Strategic Project / Manager, Privacy, Risk & Governance.

5. MLHU administration is responsible for the edits in Policy Manager and oversees the publishing of all approved policies.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 04-21GC

TO: Chair and Members of the Governance Committee

FROM: Christopher Mackie, Medical Officer of Health
Michael Clarke, CEO (Interim)

DATE: 2021 February 18

ANNUAL REPORT ON PRIVACY PROGRAM

Recommendation

It is recommended that the Governance Committee receive Report No. 04-21GC re: "Annual Report on Privacy Program" for information.

Key Points

- The Middlesex-London Health Unit (MLHU) has obligations under provincial privacy legislation to ensure the rights of individuals with respect to privacy, access 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 policy and procedure development, education, assessment and mitigation of privacy risks, facilitation of access and correction requests, and management of breaches and complaints.
- MLHU completes annual statistical reporting to the Information and Privacy Commissioner of Ontario in accordance with 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 a 'health information custodian (HIC)' in accordance with section 3 of *the Personal Health Information Protection Act (PHIPA)*, and an 'institution' in accordance with section 2 of the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*. Under this legislation MLHU and the Middlesex-London Board of Health have obligations to ensure the rights of individuals with respect to privacy, access and correction of records of their personal information and personal health information, and access to general records that pertain to MLHU operations and governance.

MLHU Privacy Program

In accordance with Policy G-100 Privacy and Freedom of Information, the Medical Officer of Health (MOH) and Chief Executive Officer (CEO) have the delegated duties and powers of the head with respect to freedom of information and protection of individual privacy under MFIPPA. The MOH serves as the health information custodian (HIC) for the purposes of PHIPA (s. 3 (1)). Together, the MOH and CEO are responsible to maintain information systems and implement policies/procedures for privacy and security, data collection and records management.

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

- Policy and procedure development
- Education
- 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, decisions and orders issued by provincial and federal Privacy Commissioners, new technology, emerging best practices, and increasing awareness and expectations by the public with respect to privacy and access.

Successes over the past year include:

- Implementation of a new annual online privacy education module for MLHU staff to increase awareness and compliance with legislative requirements;
- Privacy impact assessment and risk mitigation to support implementation of new technologies, processes and agreements in response to information sharing and collaboration requirements created by the pandemic (e.g., rapid deployment of remote teams, data sharing agreements with external partners, secure web-based transmission of COVID-19 test results, adoption of provincial COVID-19 case and contact management solution); and
- Completion of all formal written requests for access to records of personal information or personal health information or general records within the statutory time limits, despite the operational impacts of the pandemic. In addition to responding to formal written requests, MLHU responded to a high volume of requests for COVID-19 test results and epidemiological data pertaining to COVID-19.

MLHU experienced a total of five privacy breaches in 2020, including one that met the threshold for notification of the Information and Privacy Commissioner/Ontario (IPC). MLHU worked closely with the IPC to address the breach (the "50 King St. Breach") and ensure that the necessary steps were taken to comply with PHIPA and MFIPPA. The IPC closed its file on January 15, 2021, indicating that their office was satisfied with the actions taken by MLHU and no orders were issued. (Refer to Appendix A for summary data for all breaches that occurred in 2020.)

Priorities for the coming year include further assessment and mitigation of risks associated with new technologies and processes that support online collaboration and communication/information sharing among MLHU staff and with clients and external partners.

Provincial Oversight

MLHU is required to submit annual statistical reports to the IPC with respect to:

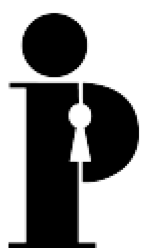
- Confirmed privacy breaches under PHIPA (attached as Appendix A);
- Access and correction requests under PHIPA (attached as Appendix B); and
- Access and correction requests under MFIPPA (attached as Appendix C).

All of these reports were submitted to the IPC within the required timelines.

This report was prepared by the Healthy Organization Division.

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

Michael Clarke, PhD
CEO (Interim)



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

Statistical Report of
Middlesex-London Health Unit
for the Reporting Year 2020
for
Personal Health Information Privacy Breaches

Report run on: 1/21/2021 at 3:00pm

Section 1: Identification

Appendix A: 04-21GC

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	110-355 Wellington Street
	Primary Contact Mailing Address 2	
	Primary Contact Mailing Address 3	
	Primary Contact City	London, Ontario
	Primary Contact Postal Code	N6A 3N7
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)	5

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
3.1	What was the total number of privacy breach incidents where personal health information was stolen?	0
3.2	**Of this total indicate the number of privacy breach incidents where:**	
3.2.1	theft was by an internal party (such as an employee, affiliated health practitioner or electronic service provider)	0
3.2.2	theft was by a stranger	0
3.2.3	TOTAL INCIDENTS	0
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	0
3.3.2	theft was the result of another type of cyberattack	0
3.3.3	unencrypted portable electronic equipment (such as USB keys or laptops) was stolen	0
3.3.4	paper records were stolen	0
3.3.5	theft was a result of something else, by someone else or other items were stolen	0
3.3.6	TOTAL INCIDENTS	0
3.4	**Of the total on line 3.1 indicate the number of privacy breach incidents where:**	
3.4.1	one individual was affected	0
3.4.2	2 to 10 individuals were affected	0
3.4.3	11 to 50 individuals were affected	0
3.4.4	51 to 100 individuals were affected	0
3.4.5	over 100 individuals were affected	0
3.4.6	TOTAL INCIDENTS	0

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
4.1	What was the total number of privacy breach incidents where personal health information was lost?	1
4.2	**Of this total indicate the number of privacy breach incidents where:**	
4.2.1	loss was the result of a ransomware attack	0
4.2.2	loss was the result of another type of cyberattack	0
4.2.3	unencrypted portable electronic equipment (such as USB keys or laptops) was lost	0
4.3	**Of the total on line 4.1 indicate the number of privacy breach incidents where:**	
4.3.4	paper records were lost	1
4.3.5	loss was a result of something else or other items were lost	0
4.3.6	TOTAL INCIDENTS	1
4.4	**Of the total on line 4.1 indicate the number of privacy breach incidents where:**	
4.4.1	one individual was affected	0
4.4.2	2 to 10 individuals were affected	1
4.4.3	11 to 50 individuals were affected	0
4.4.4	51 to 100 individuals were affected	0
4.4.5	over 100 individuals were affected	0
4.4.6	TOTAL INCIDENTS	1

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
5.1	What was the total number of privacy breach incidents where personal health information was used (e.g. viewed, handled) without authority?	0
5.2	**Of this total indicate the number of privacy breach incidents where:**	
5.2.1	unauthorized use was through electronic systems	0
5.2.2	unauthorized use was through paper records	0
5.2.3	unauthorized use through other means	0
5.3	**Of the total on line 5.1 indicate the number of privacy breach incidents where:**	
5.3.4	TOTAL INCIDENTS	0
5.4	**Of the total on line 5.1 indicate the number of privacy breach incidents where:**	
5.4.1	one individual was affected	0
5.4.2	2 to 10 individuals were affected	0
5.4.3	11 to 50 individuals were affected	0
5.4.4	51 to 100 individuals were affected	0
5.4.5	over 100 individuals were affected	0
5.4.6	TOTAL INCIDENTS	0

		PERSONAL HEALTH INFORMATION PRIVACY BREACHES
6.1	What was the total number of privacy breach incidents where personal health information was disclosed without authority?	4
6.2	**Of this total indicate the number of privacy breach incidents where:**	
6.2.1	unauthorized disclosure was through misdirected faxes	0
6.2.2	unauthorized disclosure was through misdirected emails	1
6.2.3	unauthorized disclosure was through other means	3
6.3	**Of the total on line 6.1 indicate the number of privacy breach incidents where:**	
6.3.4	TOTAL INCIDENTS	4
6.4	**Of the total on line 6.1 indicate the number of privacy breach incidents where:**	
6.4.1	one individual was affected	2
6.4.2	2 to 10 individuals were affected	1
6.4.3	11 to 50 individuals were affected	0
6.4.4	51 to 100 individuals were affected	0
6.4.5	over 100 individuals were affected	1
6.4.6	TOTAL INCIDENTS	4

Note:

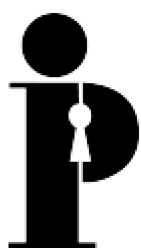
This report is for your records only and should not be faxed or mailed to the Information and Privacy Commissioner of Ontario in lieu of online submission. Faxed or mailed copies of this report will NOT be accepted. Please submit your report online at: https://statistics.ipc.on.ca.

Thank You for your cooperation!

Declaration:

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

Signature	*Date*



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

Statistical Report of
Middlesex-London Health Unit
for the Reporting Year 2020
for
Personal Health Information Protection Act

Report run on: 1/21/2021 at 3:09pm

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	110-355 Wellington Street
	Primary Contact Mailing Address 2	
	Primary Contact Mailing Address 3	
	Primary Contact City	London, Ontario
	Primary Contact Postal Code	N6A 3N7
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).	3

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	3
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)	3

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.	3
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)	3

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*

Appendix B: 04-21GC

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)	3

BOX 5.7 must equal BOX 3.1

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

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

section 5a: Contributing Factors

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

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	3
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	0
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	3
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	0
8.2	Number of requests where fees were waived - in full	0
8.3	Number of requests where fees were waived - in part	0
8.4	Total Number of requests where fees were waived (Add Boxes 8.2 + 8.3 = 8.4)	0
8.5	Total dollar amount of fees collected	$0.00
8.6	Total dollar amount of fees waived	$0.00

Section 9: Corrections and Statements of Disagreement

		Personal Health Information
9.1	Correction requests completed	0

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

Note:

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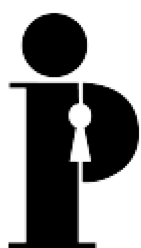
Thank You for your cooperation!

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 2020 for *Municipal Freedom of Information and Protection of Privacy Act*

Report run on: 1/26/2021 at 9:21am

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	110-355 Wellington Street
	Primary Contact Mailing Address 2	
	Primary Contact Mailing Address 3	
	Primary Contact City	London, Ontario
	Primary Contact Postal Code	N6A 3N7
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	6	2
3.2	Total number of requests completed during the reporting year	6	2

Section 4: Source of Requests

Enter the number of requests you completed from each source.

		Personal Information	General Records
4.1	Individual/Public	1	0
4.2	Individual by Agent	2	0
4.3	Business	0	0
4.4	Academic/Researcher	0	0
4.5	Association/Group	0	0
4.6	Media	0	2
4.7	Government (all levels)	3	0
4.8	Other	0	0
4.9	Total requests (Add Boxes 4.1 to 4.8 = 4.9)	6	2

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	6	2
5.2	31 - 60 days	0	0
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)	6	2

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:

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.	6	2
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)	6	2

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	0
6.11	Number of requests completed in excess of the time limit permitted by the Notice to Affected Person (s.28(1)).	0	0
6.12	Total requests (Add Boxes 6.10 + 6.11 = 6.12)	0	0

E. Total Completed Requests (sections A to D)

		Personal Information	General Records
6.13	Total requests (Add Boxes 6.3 + 6.6 + 6.9 + 6.12 = 6.13)	6	2

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	4	1
7.2	Information disclosed in part	2	0
7.3	No information disclosed	0	1
7.4	No responsive records exists	0	0
7.5	Request withdrawn, abandoned or non-jurisdictional	0	0
7.6	Total requests (Add Boxes 7.1 to 7.5 = 7.6)	6	2

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	0
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	0
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)	2	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	1
8.19	Section 53 — Other Acts	0	0
8.20	PHIPA Section 8(1) Applies	0	0
8.21	Total Exemptions & Exclusions Add Boxes 8.1 to 8.20 = 8.21	2	1

[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	$10.00	$10.00
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	$10.00	$10.00
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

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

BOX 11.4 must equal BOX 11.9

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

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

BOX 11.9 must equal BOX 11.4

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

		Personal Information
11.10	Number of statements of disagreement attached:	0

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

		Personal Information
11.11	Number of notifications sent:	0

Note:

Appendix C: 04-21GC

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

Thank You for your cooperation!

Declaration:

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

Signature	_Date_

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 05-21GC

TO: Chair and Members of the Governance Committee

FROM: Chris Mackie, Medical Officer of Health, Michael Clarke, CEO (Interim)

DATE: 2021 February 18

2020 RISK MANAGEMENT REPORT

Recommendation

It is recommended that the Governance Committee:

1) ***Receive Report No. 05-21GC for information;***
2) ***Recommend that the Board of Health approve the 2020 Middlesex-London Health Unit Risk Management Report (Appendix A).***

Key Points

- In September 2018, the Ministry of Health and Long-Term Care announced that public health units would be required to submit a new Risk Management Report as part of the Q3 Standards Activity Report (SAR).
- The purpose is for boards of health to report in a standardized manner the high risks that are currently being managed at each board of health. The report is in alignment with board of health requirements under the Ontario Public Health Standards (OPHS) and the approved Middlesex-London Health Unit (MLHU) Risk Management Policy (G-120).
- The 2020 MLHU Risk Management Report (Appendix A) was prepared by staff and submitted to the ministry on February 12th in draft form, pending Board of Health approval. Through successful mitigation, seven (7) of the high risks identified in 2019 no longer constitute a high risk to organizational objectives. A summary of current and previous high risks and key mitigations are included in Appendices A and B respectively.

Background

In January 2018, the Ministry of Health (MoH) implemented modernized Ontario Public Health Standards (OPHS) and introduced new accountability and reporting tools required under the Public Health Accountability Framework.

The ministry has continued to evaluate and refine the accountability and reporting tools, and in September 2018, announced that a new annual Risk Management Report would be required as part of the Q3 Standards Activity Report.

The OPHS require boards of health to have a formal risk management framework in place that identifies, assesses, and addresses risks. The new Risk Management Report summarizes high risks and key mitigations reported to the Board of Health as required by the OPHS.

Due to the COVID-19 pandemic, organizational capacity challenges necessitated a request to the MoH to delay the timing of the Q3 Risk Management report submission, which was granted until the end of Q1 2021.

Risk Assessment

Risk assessment and mitigation occurs at the organization, program, and project levels on a continuous basis according to the process outlined in the approved MLHU Risk Management Policy (G-120), and the Board of Health is kept informed of identified high risks and key mitigations.

In preparing the 2020 MLHU Risk Management Report, previously identified high risks were re-assessed to determine the current residual risk and mitigations, and consultation occurred to identify any new high risks.

A total of seven (7) high risks were identified in the 2020 MLHU Risk Management Report (Appendix A), in contrast to eight (8) high risks the previous year. Through successful mitigation or significant changes in the external landscape in 2020, seven (7) of the high risks identified in the 2019 MLHU Risk Management Report no longer constitute a high risk to organizational objectives. These will need to be reevaluated in an ongoing way given the constantly-changing political landscape and the context of the current COVID-19 pandemic. Appendix B provides a summary of previous high risks and key mitigations.

Next Steps

The Governance Committee has the opportunity to review the 2020 MLHU Risk Management Report included with this report. Once the Governance Committee is satisfied with its review, the Risk Management Report will be forwarded to the Board of Health for approval.

This report was prepared by Healthy Organization Division.

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

Michael Clarke, PhD
CEO (Interim)

Appendix A: 05-21GC

The Board of Health for the Middlesex London Health Unit

2020 Standards Activity Reports
as of September 30, 2020

Risk Management

Ref. #	Description	Category	Impact	Likelihood	Overall Risk Rating		Key Risk Mitigations	Date reported to the Board
A	B	C	D	E	F = D x E		G	H
1	Uncertainty around timing and allocation of additional funding to cover COVID-related expenditures (staffing and technology costs) creates a risk of cash shortfall that may exceed our line of credit limit	Financial	5	5	●	High	Temporary use of the line of credit will help offset the timing of transfers from the province. Non-COVID program spending is reduced due to limited services provided in the community.	21-May-20 16-Jul-20 05-Nov-20 26-Nov-20
2	Core public health services below essential levels due to pandemic response	Operational / Service Delivery	4	5	●	High	Continued review and prioritization of public health services with ongoing decisions regarding which services must be maintained (even if modified). Strategic planning in the midst of the pandemic will help to focus on what priorities the organization should start, stop or continuing doing in order to meet the evolving needs of the community. Adapting the strategic priorities and roadmap to be more agile, flexible, and directional will be crucial for service delivery planning	18-Jun-20 16-Jul-20 17-Sep-20 26-Nov-20
3	Lack of resources to respond to emerging and exacerbated public health issues as a result of the pandemic, including food insecurity, domestic violence, racism, substance misuse and mental health	Equity	4	5	●	High	Mitigation strategies identified for risk # 2 above are applicable to this risk as well. Recommendations identified by Chief Nursing Officer and recovery planning group to be reviewed and prioritized to confirm feasible actions in these areas at this time. Forthcoming recommendations from consultants working with the Healthy Equity team (Diversity and Inclusion Assessment; Anti-Black Racism Plan) will also be used to guide and prioritize work.	18-Jun-20 17-Sep-20 26-Nov-20
4	Staff burnout due to high workload and demands related to pandemic response, including role and scheduling changes (type of work, length of shifts, seven day/week extended hours)	People / Human resources	4	4	●	High	An additional pool of staff have been redeployed to the COVID response teams. The maximum number of 50 Contact Tracers have been hired to take workload off of Case Investigators. The School Health teams have also moved to a full COVID response model on a 7 day per week schedule. Process efficiencies and updates to roles continue to be implemented to reduce workload. Recovery recommendations related to individual and organizational wellbeing are forthcoming and may prove helpful to address this risk. EFAP resources and support continue to be made available to staff and are being reevaluated at renewal to ensure the most-meaningful services	15-Oct-20 26-Nov-20

5	High demand for limited pool of public health professionals	People / Human resources	4	4		**High**	Implementation of advanced hiring by posting full-time roles for some of the temporary funding based on projected attrition in order to attract external candidates. Hiring of student PHNs and PHIs following their practicums under a temporary licence. Posting for general public health professional roles to build a pool of qualified candidates for when positions are available	18-Jun-20 16-Jul-20
6	Collective agreement negotiations in 2021 could have potential impacts on business continuity in the event of a labour disruption	People / Human resources	5	3		**High**	Business continuity/labour disruption planning in progress. SLT has already prioritized the key public health work that needs to be covered. Regular prioritization of labour relations issues through weekly collaboration with the union partners.	18-Jun-20
7	Rapid implementation of new technology and applications to facilitate pandemic response introduces new privacy and information security risks	Privacy	4	4		**High**	Implementation of biennial privacy education program for staff. Agency privacy and information security policies reviewed and updated, including implementation of new virtual care policy. Encrypted tools to support remote work and data transfer. Cyber risk insurance in place. Assessment and mitigation of identified risks ongoing	18-Jun-20 16-Jul-20
8								
9								
10								

Table 1 - Risk Categories

Risk Category	Definition
Compliance Legal	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, and/or contracts. May expose the organization to the risk of fines, penalties, and/or litigation.
Environment	Uncertainty usually due to external risks facing an organization including air, water, earth, and/or forests.
Equity	Uncertainty that policies, programs, and services have an equitable impact on the population.
Financial	Uncertainty of obtaining, using, maintaining economic resources, meeting overall financial budgets/commitments, and/or preventing, detecting, or recovering fraud.

Governance / Organizational	Uncertainty of having appropriate accountability and control mechanisms such as organizational structures and systems processes, systemic issues, culture and values, organizational capacity commitment, and/or learning and management systems,
Information / Knowledge	Uncertainty regarding the access to or use of accurate, complete, relevant and timely information. Uncertainty regarding the reliability of information systems.
Operational / Service Delivery	Uncertainty regarding the performance of activities designed to carry out any of the functions of the organization, including design and implementation.
People / Human resources	Uncertainty as to the organization's ability to attract, develop, and retain the talent needed to meet its objectives.
Political	Uncertainty of the events may arise from or impact any level of the government including the Offices of the Premier or Minister (e.g., a change in government political priorities or policy direction).
Privacy	Uncertainty with regards to the safeguarding of personal information or data, including identity theft or unauthorized access.
Security	Uncertainty relating to physical or logical access to data and locations (offices, warehouses, labs, etc.).
Stakeholder / Public Perception	Uncertainty around the expectations of the public, other governments, media or other stakeholders. Maintaining positive public image; ensuring satisfaction and support of partners.
Strategic / Policy	Uncertainty that strategies and policies will achieve required results or that policies, directives, guidelines, legislation will not be able to adjust necessarily.
Technology	Uncertainty regarding alignment of IT infrastructure with technology and business requirements. Uncertainty of the availability and reliability of technology.

Board of Health for the Middlesex-London Health Unit

2019 Standards Activity Reports as of October 31, 2019

Risk Management

A	B	C	D	E	F = D x E		G	H
1	Potential loss of expected funding sources (i.e. Community Health Capital Programs) to build out new location could result in significant long-term financial impact (incurring of debt and depletion of reserves).	Financial	5	5	●	**High**	Use of consultants and project management methodology and controls to monitor costs. Consistently seeking opportunities to reduce forecasted costs wherever possible. **Resolution:** Financing was obtained to cover residual location costs.	17/10/2019 RAC 17/10/2019 BOH
2	Changes in government funding could result in loss of programs/services to the community.	Financial	5	5	●	**High**	Use of Program Budgeting and Marginal Analysis (PBMA) process to ensure changing priorities are considered. Organization continues to spend resources on community health needs of greatest priority based on Annual Service Plan (ASP) and public health standards. Maximum downloading requested from Municipalities. **Resolution:** One-time mitigation funding has been received from the province, off-setting previously communicated reduction in funding.	05/09/2019 FFC 19/09/2019 BOH
3	Changes to Board membership and structure as a result of amalgamation announcements by the Provincial government could result in challenges advancing priorities and delivering on organizational mandate.	Governance / Organizational	5	5	●	**High**	Completed renewal of governance policy manual which may assist with regional alignment of processes/requirements for decision making. **Resolution**: Almagamation planning has been put on hold by the Ministry.	16/05/2019 BOH 20/06/2019 BOH 18/07/2019 BOH 19/09/2019 BOH 17/10/2019 BOH
4	Current policitical environment, uncertainty and threat of job loss has resulted in difficulty recruiting staff and management and increased resignations and retirements. This is compounded by the high number of eligible retirements and limited pool of qualified candidates for public health nursing and managers.	People / Human Resources	4	4	●	**High**	Implement succession planning. Promote public health nursing practicums. Planned implementation of enterprise resource planning (ERP) software solution (HRIS) will facilitate recruitment, performance development and succession planning. **Risk continues to 2020.**	12/12/2018 BOH 03/21/2019 GC 03/21/2019 BOH 20/06/2019 GC 20/06/2019 BOH 17/10/2019 BOH
5	Changes in provincial policy could impact support for some public health initiatives/programs and our ability to deliver services in the community.	Political	5	4	●	**High**	Change in provincial government, along with the proposed amalgamation of health units provides an opportunity to take a regional approach to enable healthy public policy adaptation. An opportunity also exists to explore best practices for informing healthy public policy within a regional lens once the new regional health unit is operating. Teams within the Health Unit will continue local and provincial knowledge exchange and policy adoption with partners and municipal governments. **Resolution**: Almagamation planning has been put on hold by the Ministry.	16/05/2019 BOH

6	Combination of paper-based records and a variety of databases with client information, with limited controls and auditing processes could result in privacy breach (unauthorized access). Decentralized mixed records can also make it challenging to locate complete records for client care or access requests.	Privacy	4	3	●	**High**	Implementation of an electronic client record (ECR) will enhance service delivery capacity (automate client records and workflow processes). Program staff will be able to access the client record to inform care and document the client interaction. Access to client records will be controlled by security functions, including role-based permissions, and monitored through auditing. Records inventory underway with records destruction or secure storage as appropriate. Privacy education and policy development being provided as part of ECR implementation. **Resolution**: ECR implementation for 2020 was placed on hold due to COVID-19.	20/06/2019 GC 20/06/2019 BOH
7	Onsite housing of IT infrastructure could impair ability to complete full recovery in the event of a power disruption or infrastructure failure.	Technology	4	3	●	**High**	Infrastructure move to offsite data centre 50% complete. Email services have been moved to national environment. **Resolution:** Server infrastructure move to offsite data centre now 100% complete.	07/02/2019 FFC 21/02/2019 BOH 17/10/2019 BOH
8	Increased prevalence of phishing, ransomware and cyber threats may result in financial loss or privacy breach.	Technology	5	4	●	**High**	In addition to cyber threat insurance, Integrate current mitigation strategies into a comprehensive cyber threat protection strategy encompassing end users, infrastructure and data security. **Resolution:** Cybersecurity insurance obtained and cyber threat protection strategy implemented including end user education.	17/10/2019 BOH

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 06-21GC

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Michael Clarke, Chief Executive Officer (Interim)

DATE: 2021 February 18

PROVISIONAL STRATEGIC PLANNING UPDATE

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to:
1) ***Receive Report No. 06-21GC re: "Strategic Planning Update";***
2) ***Approve the Strategic Priorities and Objectives included as Appendix B; and***
3) ***Direct MLHU staff to work with the Governance Committee as required to set goals that meet these objectives and finalize the MLHU Provisional Strategic Plan.***

Key Points

- On January 27 & 28, 2021 the Board of Health and the Senior Leadership Team participated in two half-day virtual retreats facilitated by Ms. Maria Sanchez-Keane from the Centre for Organizational Effectiveness.
- On February 5, 2021, Ms. Sanchez-Keane provided a summary report (Appendix A) of the dialogue as it relates to the context of strategic planning.
- Recommended Strategic Priorities and Objectives, as refined by the Senior Leadership Team, has been included as Appendix B.
- The Senior Leadership Team will work with the Strategic Projects team to set measurable goals that meet the objectives contained within Appendix B to finalize the Provisional Strategic Plan.

Background

At its meeting on January 21, 2021, the Board of Health endorsed the development of a condensed provisional strategic plan process that included two half-day virtual retreats with the Board of Health and the Senior Leadership Team.

The two-half day virtual retreats took place on January 27 & 28, 2021 and were facilitated by Ms. Maria Sanchez-Keane from the Centre for Organizational Effectiveness. In addition to facilitating the sessions, Ms. Sanchez-Keane's scope of work included the following:

- Gathering key background information to prepare for the sessions
- Developing draft outcomes and agenda for review
- Designing the sessions to create an environment for full, active participation
- Using interactive and engaging online technology
- Preparing a summary report to capture dialogue and decisions made during the half-day sessions

Summary Report & Draft Strategic Priorities

On February 5, 2021, Ms. Sanchez-Keane provided a summary report to Middlesex-London Health Unit (MLHU), which has been included as Appendix A. The report summarizes the dialogue from the two half-day sessions as it relates to the strategic priorities that were discussed.

The Senior Leadership Team met to discuss the summary report and made further refinements to the strategic priorities and objectives drafted for consideration. These proposed changes are included in a summary table (Appendix B) highlighting the strategic priorities and objectives that will inform the MLHU Provisional Strategic Plan.

Next Steps

The Governance Committee recommend that the Board of Health approve the MLHU Strategic Priorities and Objectives included as Appendix B to this report. The Senior Leadership Team will work with the Strategic Projects team to set goals that meet these objectives and finalize the MLHU Provisional Strategic Plan.

MLHU staff will continue to engage with members of the Governance Committee as required and submit the MLHU Provisional Strategic Plan to the Board of Health for approval.

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

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

Michael Clarke, PhD
CEO (Interim)

Provisional Strategic Planning Sessions

2021 01 27 & 28

Summary Report

Introduction

On January 27 and 28,2021 the Board of Health and the Senior Leadership Team met to discuss developing a *Provisional Strategic Plan* that would serve to guide the direction of the Middlesex London Health Unit over the next 18-24 months. Given the reality of the Covid 19 Pandemic, the Board of Health decided on this approach, with the hope of entering into a more fulsome strategic planning process in 2022. This *Provisional Strategic Plan* will continue to anchor on the current strategic plan and will have relevant strategic priorities to ensure the work of MLHU continues to be forward thinking.

To this end, seven topic areas were named as important areas for dialogue related to the *Provisional Strategic Plan*. These were:

- Modernization of Health Unit
- Senior Leadership Structure (CEO/MoH)
- Racism as a Public Health Concern
- Pandemic Management
- Priority Recovery Issues
- Mental Health of Staff
- Digital Strategy

For each topic, participants were provided background reading and reflection questions ahead of the session. During the session, participants broke into small groups for discussion. A facilitator and notetaker assisted in capturing the dialogue. Each group was asked to provide their top 3-5 most salient points. These were reported out in the large group. Participants were then asked to vote on the top 3 most important points from the cumulative list.

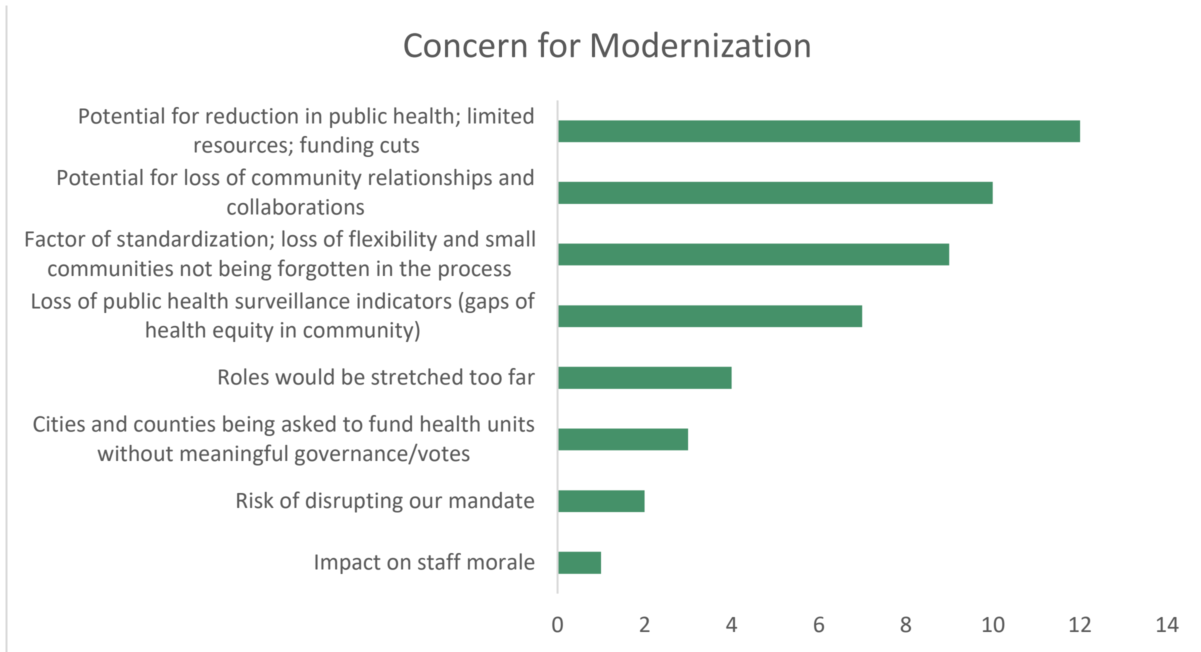
This report summarizes the dialogue that occurred during the session under each of the topic areas including the cumulative list and votes. As well, at the end of the report, draft set of strategic priorities is provided for MLHU's Governance Committee's recommendations.

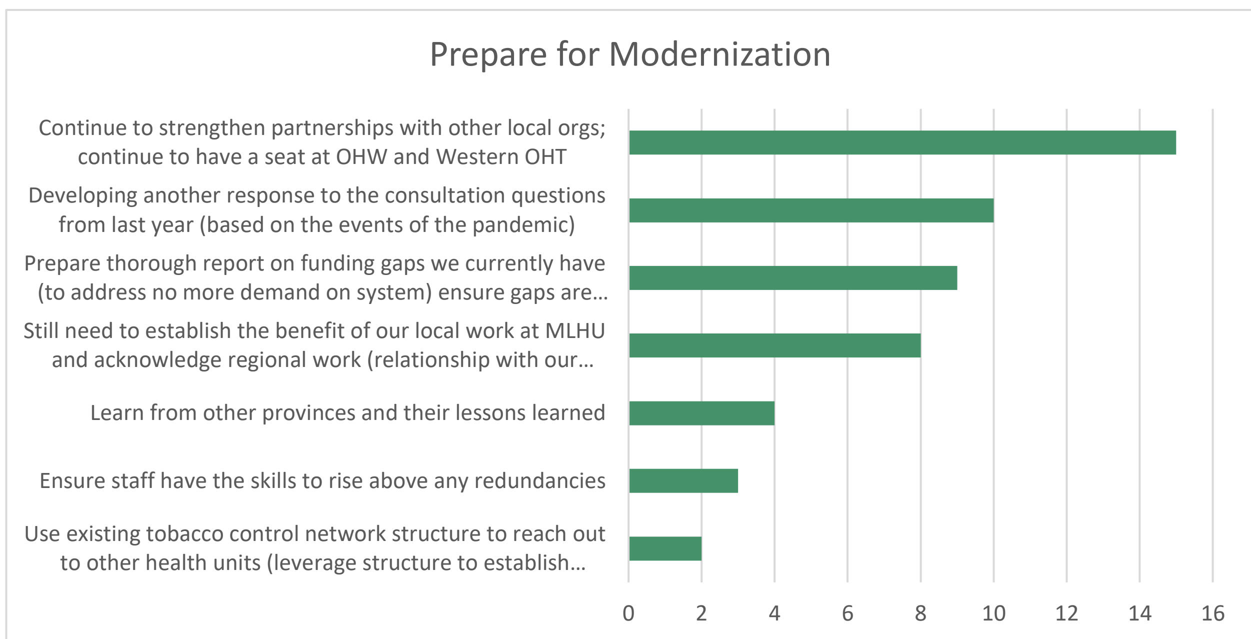
The session was facilitated by Maria Sanchez-Keane, Centre for Organizational Effectiveness Inc.

Topic 1: Modernization

Working Definition: This issue speaks to 'amalgamating' health units within Ontario to make for fewer total number of health units in the province.

Top Priorities from each small group and participant votes on most important





Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed were appropriate

1. What do you see as opportunities of modernization?

- Potential cost saving
- Province saw cost-cutting (cost-efficiencies)
- Efficiencies (financial)
- Gaining efficiencies.
- Economies of scale, sharing of resources that come with having larger organizations
- Modernization report written a year ago, Dr. Summers was primary author. Still articulates today (Feb 2020 report)
- Leveraging strengths in different areas (ie: Dr. Summers assisting in Windsor, sharing his strengths)
- True opportunities are scalable building of strengths: aspect of corporate service, FST in PH, build critical capacity: IT, HR….but still requiring local infrastructure (like common infrastructure)
- Opportunities to work together as a larger region, e.g. Healthy Public Policy.
- Strengthen legislation, stronger collective voice of public policies
- Standardization (public policies)
- Synergies – health promotion campaigns done at a regional or provincial level, ensure greater consistency across health units
- Coordination between direction of the health units.
- Centralization of data/surveillance
- Access to shared data, race based data
- Standardization - to share resources with other health units (IT, epidemiology)
- Looking at public health's roles in the system – informing priorities and activities of the government at all levels.
- Strengthen certain roles and organizations – e.g. CNO, PHO (having a stronger role in providing provincial support)
- Stronger performance indicators across all health units/integration
- Provides better support to smaller health units.
- Benefit to small health units – less benefit to MLHU
- Local collaboration.
- Supporting neighbouring communities to address social and economic determinants of health
- Leveraging digital tech for innovations
- Learning to adapt to change

2. What do you see as concerns about modernization?

- Already assisting other HUs in response
- No evidence that this would be cost efficient
- Large public debt in aftermath of pandemic, funding going down and taxes for residents
- Most public amalgamations have actually been more costly (realized concerns)
- Funding cuts and instability
- Funding friction – putting pressure on municipal governments.
- Potential for reduction in funding for public health.
- Public health being fully amalgamated with Ontario Health and losing public health funding.
- MOH role: hard to give them this amount of work
- Willingness to share resources may be a challenge (being told to work together vs. wanting to work collaboratively)
- Form and maintain local partnerships
- Potential for community relationships and collaborations to be lost is a significant concern
- Loss of community specificity
- Navigating with health units of differing size (such as London-Chatham)

- Need to talk system to system – loss of connections and spend too much time to rebuild them
- MLHU is the right size
- What needs to be local, regional, provincial?
- Tailoring programs to the needs of the local populations
- Not having public health surveillance indicators, not knowing the gaps that remain/exist in health equity
- Having issues and concerns being swallowed up by the larger health units – taking focus away from the rural areas.
- Loss of ability to work directly with subpopulations within communities, risk to existing groups
- Too large, could lose localization
- Not matching health units appropriately – just based on geography will be problematic.
- Cities and counties could be asked to fund health units without votes and meaningful governance
- Risk of becoming too large and bureaucratic – harder to reach smaller communities
- Standardization (lose flexibility to ensure local communities not forgotten)
- Potential loss of community needs assessments
- Making organization bigger, does not always mean more productive/effective/efficient
- March to efficiency at the expense of effectiveness
- Engagement at the person to person level
- Creating chaos in the sector
- No real "round table" from public health about the understanding of what goes on behind the scenes in health units (gov. siloed)
- Messaging
- Risk of disrupting our mandate
- Staff morale

3. What are 2-3 things that we can do to be proactive about modernization to:

a) Express concern (if you think there are concerns)
   1. Stretching roles too far
   2. Demonstrate strong partnerships with other organizations/health units
   3. Strategically pre-empting the government (functional partnerships, staff exchange)
   4. Limited resources to begin with
   5. Develop another response to the consultation questions from last year (early 2020) based on the events of this past year and the pandemic response – refresh response provided previously
   6. Continue to have a seat at the Ontario Health West and Western OHT
   7. Continue to engage in political advocacy
   8. Using Tobacco Control Network structure in application for other projects (reach out)
   9. Structure and geography analysis

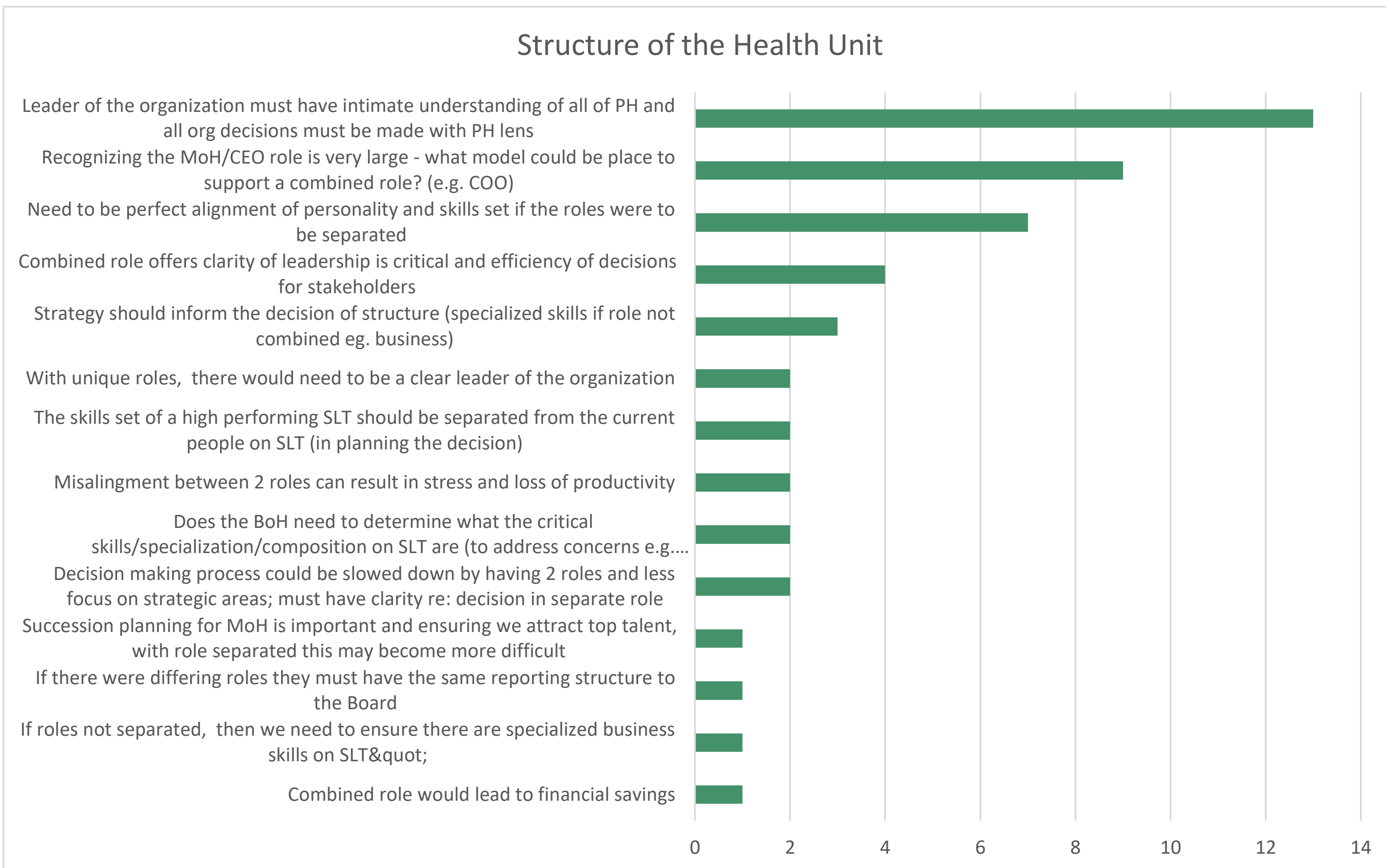
b) Prepare to do what we may be 'forced' to do; and be proactive about it
   1. Establish benefit of local work, but acknowledge regional work (relationships between units)
   2. Alignment of other health units
   3. Stronger communication with other health units to see what is working
   4. AlPHa take on a new mandate to ensure ministry is part of "new round table" discussions
   5. Continue to strengthen the partnerships with other local organizations and identify opportunities in ways in which MLHU can support where they have need – strengthen relationships with local communities
   6. Create stronger collective voice (with formation of coalition with local organizations)
   7. Sharing resources with neighbouring health units (e.g. personnel)
   8. Preparing for modernization but not knowing what to prepare for – learning from other provinces and lessons learned
   9. Ensure staff have the skills and are well positioned to rise above any redundancies

10. Redo SWOT analysis for the organization – what have we learned from COVID-19, look at how we maintained operations or what we discontinued
11. Identify existing funding needs in order to sustain anticipated modernization – ex. COVID funding needs

Topic 2: Leadership Structure of the Health Unit

Working Definition: Strengthen organizational infrastructure, including governance policies, budget processes, purchasing and contract procedures, and other issues.

Top Priorities from each small group and participant votes on most important



Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed were appropriate

	Advantages	Disadvantages
Combine Role MoH/CEO	• Lower expense (Salary) • Less financial strain on the organization • Financial savings • Definitive "captain of ship" • Clarity of leadership • Clarity on who is in charge of the organization • Clarity of leadership and efficiency of decision making – critical • Ease of decision making for public health • One final decision-maker as opposed to having two • Make it easy to move things forward • Critical to have CEO with strong public health understanding – may not need to be a physician; public health physicians do have a solid understanding of public health. • Ability to act more quickly – responding to a crisis in the moment • Focused on the mission • Org priorities are embedded in the org purpose – MOH steering the direction of the org and ensures things head in the same direction. • Continuity	• Is it too much work for 1 person? • Can one person do it all with respect to modernization? • Workload • Overworked/overburdened, organizational culture may be put on sidelines because medical role takes priority • Not always are physicians trained in running an organization • Balancing the qualifications of MOH and a CEO role equally • Succession planning for a combined role may be difficult • Role description and responsibilities not clearly specified • Time spent on projects with HU vs. dealing with PH concerns within community • An organization being swayed by one person's agenda
Separate Roles MoH/CEO	• CEO should be someone from public health who has experience and the right background to do the jobs effectively • More manageable workload • Focused and specialized skills set • Allows an organization to have someone with a specialized business/HR background • Skillset for each role may be different • Less burden on roles (could there be a COO role?)	• Separation could be an issue regarding what the board's role is (re: public health vs. governance) • Succession planning for own roles may be difficult. • Potentially limiting recruitment for succession planning • Lack of role clarity • Dyad executive leadership can be unclear (relationship between the 2 execs MOH and CEO)

	• Clear line of distinction on topics (public health vs. governance/ corporate services) • Balance from each perspective from financial, admin, public health POV and work together to reach goals • Less chance of lines of sight to be missed • Being abled to have your MOH do focused public health thinking, as opposed to something like accounting • Expertise split across different areas/projects of the HU • (administrative vs. legislative duties) • Ability to have checks and balances in place at the operational level. • Clear "leader of the ship"	• Misalignment between two roles can result in stress within the organization and loss of productivity. • Lots of time spent on admin duties vs. strategic planning priority setting, program evals • Who has the final say, solid understanding on who is making final decisions, chain of command • Decisions could take longer • Slows decision making – need to consult with another person • Decisions making process time • Risk of decisions being made that are not best for community • Battle of personalities (issues and people could be siloed) • Requires the right compliment of people and that could happen by chance. • Increase in costs

What are the 3-5 most salient points from your discussion that you want to share with the large group

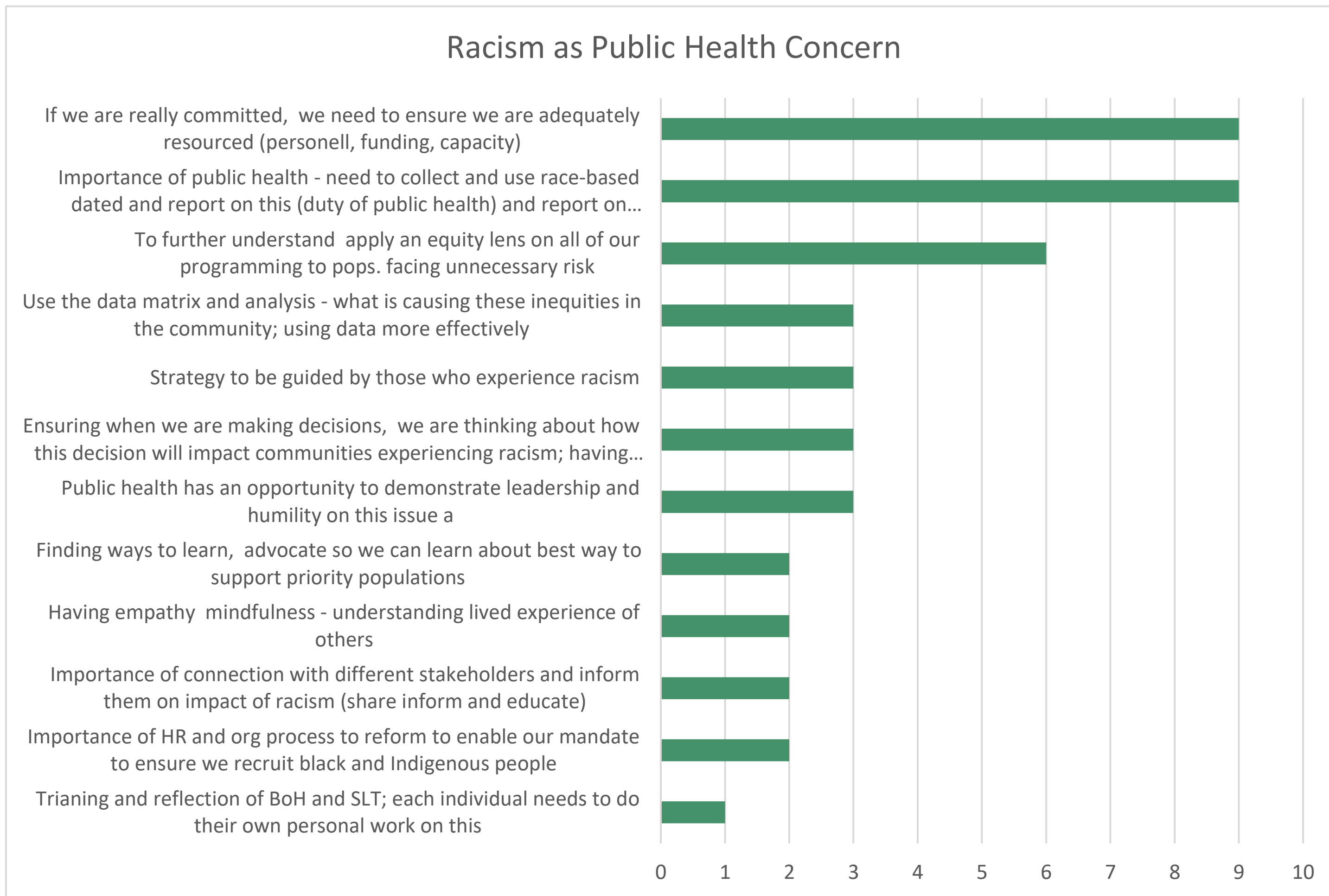
1. MLHU should be leader in public health, not just with prospect of modernization but with collaboration within HU, internal org structure and management process
2. Clear leader of the organization (with unique roles)
3. Leader of the organization must have an intimate understanding of public health and all organizational decisions must be made with a public health lens
4. Need clarity on who is in charge of the organization and one final decision-maker as opposed two
5. Clarity of leadership and efficiency of decision
6. A line of communication and decision making for the roles: who makes what decision (with unique roles)?
7. Decision making process time and how these decisions will effect the community, potential disadvantage of balance of time spent on admin tasks vs strategic priority setting
8. There needs to be perfect alignment of personalities and skill set between the two roles if they were to be separated
9. Strategy should inform the decision of the structure which could allow the opportunity to have someone with specialized business skills if the roles were not combined
10. MLHU SLT acts as a team – able to leverage the strengths of the team - it's important to make sure there are specialized business skills on the SLT team if the roles were not separated
11. Combined MOH/CEO role is big: what are the models to support the work? It's a big role that requires support! What could the structure look like to support a combined role?
12. Ensure with differing roles, they have the same boss and report to the board (board chair to moderate and resolve issues)

13. Misalignment between two roles can result in stress within the organization and loss of productivity and loss of confidence from staff, the community and the Board
14. If we were to have 2 roles, the CEO should be someone from public health with relevant knowledge and experience in order to get the job done
15. Workload needs to be considered and the appropriate delegation of duties
16. Financial savings
17. Assists in attracting top talent
18. Change coming in the community with respect to community demographics & staffing issues and making sure organization can manage this changing nature

Topic 3: Racism as Public Health Concern

Working Definition: Beyond a recovery issue, racism has an impact on every aspect of the work we do. In the summer, the Board of Health Directors voted to acknowledge that racism is a public health issue. We need more clarity on this as a strategic issue moving forward.

Top Priorities from each small group and participant votes on most important



Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed were appropriate

1.What is emerging here for you? What connections are you making?

- COVID has challenged health equity in our communities
- 17% of COVID cases were in minority communities – systematic issue. There are communities where great relationships can be established, makes it easier to have that access when you have representation from these communities
- How large some of the inequities are and where current inequities are
- Connections of certain morbidities and geographic areas in the community
- Are people marginalized because of race?
- Review of services where racism has impacted historically service delivery and what has been implemented to resolve?
- Link between poverty and racism, interconnection between systemic racism and poverty – impacts public health
- To understand and prevent death in the community and have understanding as to why these certain groups have higher mortality and more health concerns: where is the inequity stemming from?
- Overwhelming knowing where to start, adequately resource where to change
- Strategy has to be driven by the communities that are experiencing racism
- Bringing people to the organization with diverse backgrounds and lived experiences, this diversifies our perspectives and our understandings of the world
- We need to be specific around which communities we are missing at the table – hire these people
- Require recommendations from our diversity and inclusion assessment
- Our system hasn't caught up with our desire. What does it mean to recruit for diversity and how do we do that?
- Approach this from a Social Determinants of Health perspective
- How do we enter communities and assist with communicating with them in a public health lens?
- We need to have labels on what is a problem/identifying the problem, then we are able to attack it
- If fully committed to moving this priority forward, we need to ensure we are adequately resourced (including funding) to do so
- Long term connection is needed and needing more funding and outreach for changes to emerge

2. What is possible here from a public health perspective?

- Communities are being affected by COVID more than others (Indigenous community)
- Impact on different populations after Covid and why those inequities are existing (i.e., income disparities, indigenous communities)
- Why people of colour seem to be more effected by Covid and other adverse outcomes in the community (why is that?)
- The work is central to public health and there is starting to be recognition on the governance side (municipal, provincial, federal) and public health has the opportunity to be the leader and learn along the way
- Large part of MLHU's Health Equity work
- Programming to help understand racism as a public health issue and what is causing some of these inequities, equity lens on our programming focusing on populations that are facing unnecessary risk
- Offering additional training to the Board and to staff – e.g. Workshop on white privilege to the Board as a learning/development opportunity

- The health unit working with the school boards and the police board to be able to support or help inform to address anti-black and anti-indigenous
- Public health respected, and might be able to bring groups together but need to understand the situation and what caused it
- Understanding how to improve the accessibility from different community groups to health services
- Data metrics and analysis to understand or have a concentrated effort to collect and learn from this information
- Need to consider the prioritization of our work and having this as a Board priority will help to gain focus on how to carry out the work
- Our Board should be accountable on reporting the impacts of racism on individuals and our communities
- Having a regular reporting cycles helps us frame the conversations

3. *What more do we need to learn here?*

- The path to equity and how do we define that
- Continue to build positive health outcomes
- Reaching out to priority populations and ask how we can treat racism in respect to their priority (ex: racism in homelessness), having a lens for priority populations
- We need to learn more from our diverse communities
- Increases our internal organization understanding of what racism in public health means, being more educated
- Continue to carry out assessments to understand the needs
- Keep having difficult and uncomfortable conversations to be able to learn from one another
- Having empathy and mindfulness in understanding the lived experience of others
- Openness in order to do our own work
- Having a data lens and understanding the data to tell the story
- Identify what is causing the inequities in health in order to incorporate those into the strategic plan, more qualitative data
- Racism as part of health equity; SLT and the Board needs to be fully engaged in understanding racism, white privilege and the actions we can take as public health to make a difference – Board/SLT needs to do it own personal work.
- How do we operationalize the idea of "why is racism a public health issue"
- What is causing these disparities in health with community and why effecting groups of people of colour
- There is no race based data collection across different sectors and this doesn't help inform different decisions that public health can take to address certain issues
- There needs to be more race based data – specific focus on black and indigenous communities – being able to tailor this information for these communities, there have been situations where outreach may not be possible
- Important to be specific on the type of data we are looking for
- Knowing which groups to leverage and being open to innovative ideas and engaging with others
- Structural, political issues and the issues these communities are in
- Understand implications of decision-making

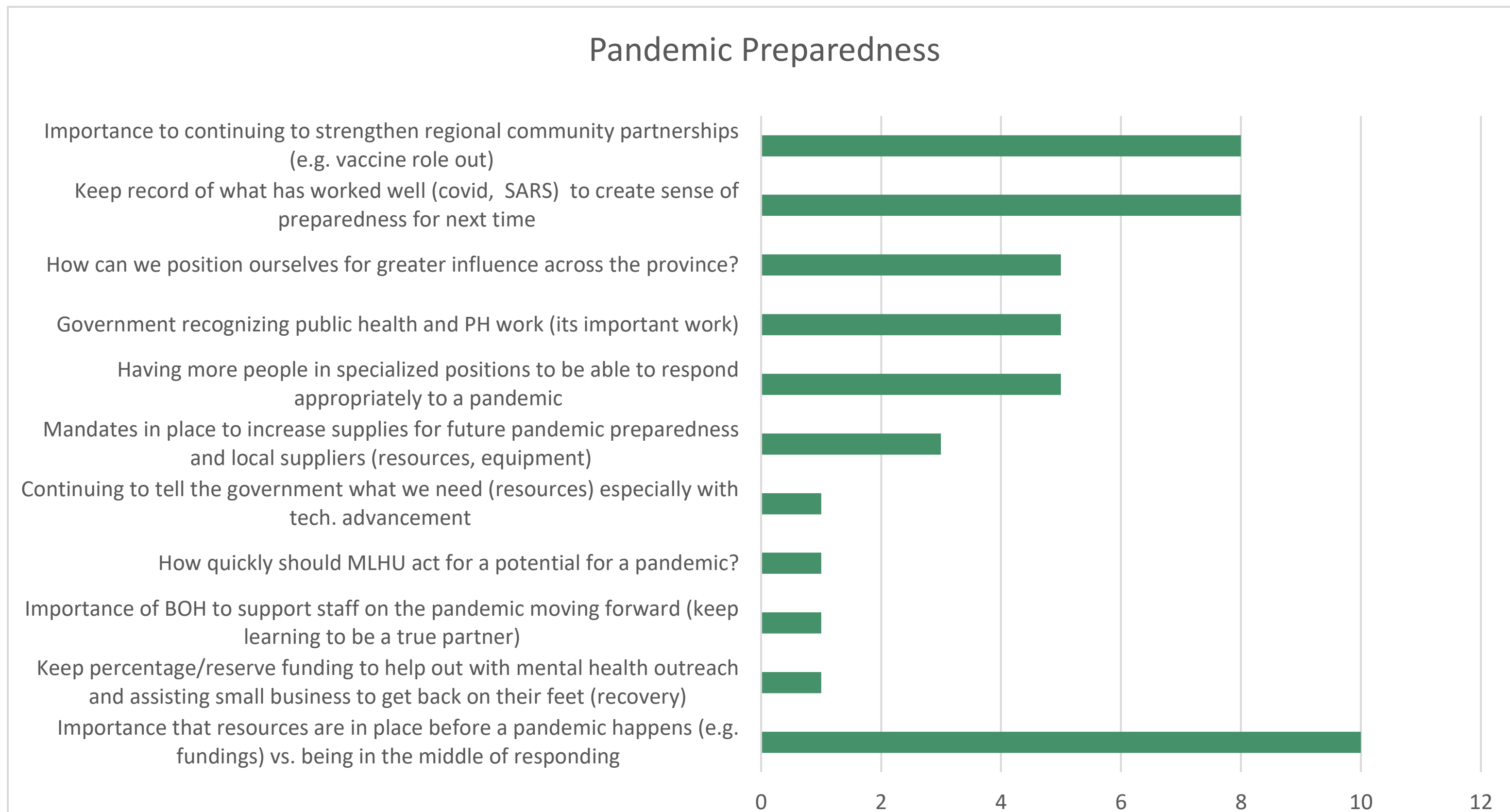
What are the 3-5 most salient points from your discussion that you want to share with the large group

1. Public Health has a duty to advocate and collect race-based data and to report on impacts of racism
2. Ensuring MLHU has access and ways to get epi data to tell the story of how to reach priority populations
3. Data metrics and analysis to understand or have a concentrated effort to collect and learn from this information
4. Continue to carry out assessments in a meaningful way in order to truly understand the needs and experiences of the community.
5. Having empathy and mindfulness in understanding the lived experience of others
6. Thinking broadly about why people of colour seem to be more effected by Covid and other adverse health outcomes in the community (why is that?)
7. Advocate with/for community stakeholders to learn how we can further assist these groups (ie: language/social translator, a specific advocate for that group, someone with lived experience)
8. Strategy needs to be guided by those who experience racism
9. Being really specific in identifying anti-black and anti-indigenous racism strategies
10. Thinking: does this decision implicate race or involve race? (similar to having a financial lens on ideas)
11. If we are fully committed to moving this priority forward, we need to ensure we are adequately resourced (personnel, funding, capacity, etc.) to do so
12. Promoting health professions and training to diverse communities – long term strategy
13. HR Organizational process reform needs be a priority to enable this mandate and strategy in order to recruit black and indigenous people
14. Covid has highlighted the inequities that exist and having that dialogue about racism in public health is key, overwhelming to know where to start, adequately resource where to change
15. Training and reflection to be part of the work of the Board/SLT– each individual needs to do their own personal work on this.
16. Increases our internal organization understanding of what racism in public health means, being more educated
17. Public health has an opportunity to demonstrate leadership and humility
18. The connection between different stakeholders, representatives at different tables to collect information (police boards, housing, harm reduction, gender-based violence)

Topic 4: Pandemic Management

Working Definition: This involves strategies moving forward for any future Pandemic (not just COVID-19), however lessons learned from the current Pandemic shall serve as a foundation for this strategy.

Top Priorities from each small group and participant votes on most important



Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed where appropriate

1. *What are our communities' and our expectations about capturing lessons learned from this pandemic?*
   - Transparency and honesty from all levels of government
   - Lessons learned regarding the importance of communication between all levels of public health, massive amounts of communication with multiple stakeholders
   - No external engagement was done, this could be something that we want to consider in the next round - would be great to get other perspectives
   - Examine how provincial capacity is deployed and governance structure
   - Documenting the decisions taken at MLHU's IMS Table, and measuring the outcomes
   - Placing MLHU in the position of being the source of trust in the community
   - Information is everything and need to give community access to adequate information

- The doubt that comes from mixed messaging, and importance of general education of the public using scientific proof/research
- Who should be involved?
    - Public health officials
    - School boards
    - Front line health workers
- Early work done to capture lesson learned – translated into helpful resources, there will be more since then
- We did a lot of work internally and recommendations were put into practice as we prepared for the second wave of the pandemic – there's a number of recommendations. They cover areas of process, technological, communication processes, HR – some are underway already
- Learning and adapting to changes as we went along, how to deal with uncertainty and change
- SARS should have been a learning moment – should have positioned us to inform the response to COVID
- Preparedness plan were not well developed across Canada – does not contain standard operating procedures on a national level.
- Revisit the process followed to see what else needs to be captured
- Strategic planning around resources (such as PPE) and realistic knowledge towards its
- Mandates to increase supplies; as we get further from pandemic, those supplies "age out" and expire, leaving stockpiles obsolete, needing to keep this a priority in the years to come so we are prepared
- Recognizing what is beyond our control and what we can impact in regarding the pandemic (public health would have been in a better position if there was access to data earlier on)
- Anticipating how difficult handling this pandemic would be and the challenges it posed with regards to response (prioritizing supply chain)
- Michael worked with staff to complete a real time evaluation at the time of the pandemic. There will be a follow up to the work but at this time it is not possible – some follow up measures were implemented but not as rigorous
- Focus groups with staff and building on previous work and exploring new lessons learned.
- Operational bread and butter – what worked and what didn't
- Needs to be reflection on how the year before the onset of the pandemic public health funding was on the brink of experiencing cuts – need to build up the resources to be able to manage it appropriately. Funding envelope reduces capacity for public health. If we expect a world class pandemic response then you get what you pay for
- Loopholes and gaps are a result of the funding cuts to public health
- Digital discrimination – those who are in rural areas do not have strong access to internet, funding cuts made to libraries and other hot spots where people experience poverty.
- Crisis Management plans need to be put in place at a leadership level
- Human compassion and fairness, especially where small businesses are concerned, need more of a level playing field (can create mental health issues)

Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed were appropriate

1. What is the BoH and senior leadership expectations about pandemic preparedness moving forward? (internally and role within the community)

- Having a "playbook" or "manual" in place to show what worked, what didn't, positives and negatives etc.
- Having a record of what worked well with previous pandemics, helped to ensure what tools and steps to put in place, sense of preparedness

- How quickly should MLHU act on a potential for a pandemic?
- Public health's response is about building resilience in regards to many issues – pandemic preparedness is not just about public health.
- Strengthen our preparedness in a way that does not jeopardize or limit any of our other public health programming – this would require additional resources across the organization.
- MLHU worked really well with the unions with future pandemics, how do we work with the union so they aren't causing different roadblocks? Thinking about this for future contract negotiations. There needs to be a set of expectations to support future emergency situations, we are looking at how we can build it into contract negotiations
- The staff at the health unit as we go forward and that was without knowing who was going to be responsible. The work that was done was good because we didn't know what was going to happen – this allowed the health unit to pivot right away
- The government should also be recognizing public health, the work has not been recognized
- Take a comprehensive approach to lessons learned to determine how it has influenced our approach.
- Integrated approach, cannot be done in isolation
- Local public health has become a reliable resource
- Expectation from the health unit for leadership, such as making masking mandatory, we looked at Chris. This was handled well and a by-law was put into place based on Chris' recommendation. "Tell us what to do and what you think we should?"
- Unions, funders, third party organizations should be part of these conversations and also with the general public
- Communication strategy to be reflected on – needs to be consistency of communication.
- Messaging about how to navigate through change in different sectors
- Lack of clarity on the governance structure that played a role
- The strength of the regional partnerships were important. We also continued with a regionalized approach. Expectations are that we continue to lead that way with a regional lens. Important to continue community partnerships and SLT should continue to push the provincial government (with being behind with technological advancements). Keep up with the noise
- Investment in technology is a key strategy for being well prepared
- Media briefings are helpful for the community to obtain factual information
- Using scientific literacy to provide the details about the reality of the situation to inform the public
- Need to ensure information is clear and concise – share message with the community to increase knowledge and understanding
- Open and transparent with the local community about risks and bringing awareness on severity of pandemic
- Safety nets in terms of domestic capacity of supplies, support from government policy, FIFO method of inventory management
- Connect with local distributors in other fields for backup supply of equipment and resources
- Homelessness – could have done a better job if we had a more robust plan
- There is continued expectation to lead as the province pivots into vaccines – connect it into expectations and learning, creating capacity and redundancy
- Going forward, having a plan regarding procurement of vaccines and having expertise in creating the vaccine in Canada
- Canada to have its own plan regarding vaccination
- Small percentage/reserve funding for mental health outreach after pandemic has subsided, trickle down effects

3. What are your groups 2-3 key points regarding capturing learnings?

1. Recognizing what is beyond our control and what we can impact in regarding the pandemic (public health would have been in a better position if there was access to data earlier on
2. MLHU completed internal work to produce several recommendations
3. Documenting the decisions taken at MLHU's IMS Table, and measuring the outcomes
4. Revisit the early work that was done to capture lesson
5. A real time evaluation of the pandemic and the capacity of when to engage in it
6. Learning and adapting to changes as we went along, how to deal with uncertainty and change in terms of supply chain
7. Transparency and honesty from all levels of government, and keeping mind of ambiguity
8. The doubt that comes from mixed messaging, and importance of general education of the public using scientific proof/research and being transparent with the community
9. Lessons learned are looked at a provincial/systemic and governance level.
10. Engage multiple stakeholders and at many levels, including the public.
11. Engaging external stakeholders
12. Human compassion and fairness, especially where small businesses are concerned, need more of a level playing field (can create mental health issues)

4. What are your groups 2-3 key points regarding expectations about pandemic preparedness moving forward

1. Increased funding is required for public health – putting resources in place before a pandemic happens.
2. Small percentage/reserve funding for mental health outreach after pandemic has subsided, trickle down effects as well as assisting small businesses get back on their feet
3. More people in specialized positions to be able to plan for and respond appropriately to a pandemic.
4. BOH continue to support staff and plans going forward – the Board needs to be educated and learning about the pandemic so that the Board can be a true partner
5. Continue to strengthen regional and community partnerships
6. Having a record of what worked well with previous pandemics, helped to ensure what tools and steps to put in place, sense of preparedness
7. Using scientific literacy to provide the details about the reality of the situation to inform the public

Topic 5: Priority Recovery Issues

Working Definition: There will be program areas that will be impacted related to things such as food security, domestic violence, racism, mental health and substance use.

Top Priorities from each small group and participant votes on most important

Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed were appropriate

1. What do we know so far about the intersection of these issues and public health?

- Public health is a broad domain – question is why does local public health have opportunities to intersect with these issues? In these areas we'll have to look at root causes to determine what will impact these issues? Have focused on disease outcome as opposed to the societal determinants. What are the underlying societal/structural determinants of health that we want to target? Speaks to a different way in which we do our work. All of the issues contribute to chronic disease. Start at the cause as opposed to the disease. Change the way in which we do our work
- A lot!!! Fundamental intersecting issues in public health, foundations of public health (e.g.: social determinants of health during COVID)
- Mental health, substance misuse, racism, domestic violence (IPV and child abuse), food insecurity – intersection with COVID and with each other
- Economic disparities and opportunities: as we recover, what are these recoveries (what do they look like)?
- Long standing/higher income businesses/work are now experiencing an economic disparity that this group never experienced before
- FTE allocation – fully invest in the appropriate program areas?
- Surgeries being cancelled has long term consequences for the population and public health as a whole
- The pandemic has highlighted these community issues
- Continue to receive new information as more research is being done
- What are the tables that public health needs to be at to fix these issues?
- These issues are complex – understatement
- Implications need to be recognized at all levels of governance
- Ability to provide information and indicators and to leverage/signal to other levels to send to public health and get support
- These are issues that the health unit supports but the health unit can't do it alone, may need to rely on partnerships and the health unit needs to be part of multi sector tables in the community
- Foundational principle of health equity and recovery will burden some who have greater pressure in health inequity (i.e., racialized communities, small businesses)
- Prioritize to focus resources in the area that is most in need to have an impact on these priority issues
- Social justice element, more work to do for certain groups and what the health unit can do to help tackle some of these problems, public health's issue to address these issues and educate
- Having a better understanding with which settings were hit harder with the pandemic and expectations about who was most vulnerable, being clear on which populations to target in our community based on the issues of homelessness etc.
- The priority areas that were identified previously have now been exasperated, these areas can only get worse. How do we actually get the resources, keep them at the forefront? These require long term solutions and collaboration among a wide variety of stakeholders and influence public health policies
- Keep the magnifying glass on the problems so that the public and community agencies continue to see the issues so that there's pressure to make changes

2. *What do we still need to learn?*

- We are learning about what populations are at risk, and focusing our public health interventions on these populations
- How to influence actions earlier to help those disadvantaged populations so that they can come through better in the next pandemic, being more proactive in planning
- What impacts of outside factors (such as no insurance, someone losing a job that was secure etc.) could do to a population?
- Much to be learned about racism and the gaps that are present and more research needs to be funded to understand systemic racism in our communities.
- Accurate data is required for marginalized populations, race based data is needed
- Need to be open to the fact that we need to learn from the community, MLHU doesn't need to be the experts for everything
- Need to continue to seek information that is arising to fully understand the extent to which these issues are occurring in our community
- We need to work with our community partners
- How we can best structure and position ourselves to address the issues effectively
- Our community needs to learn how to build capacity in our programs, so that the most vulnerable are not hit the hardest
- We are getting caught up with the day to day stuff, we may not be properly advocating with the government at times, we need to be aware of that. Public Health has huge resources that we may not be tapping into
- We need to learn that if we only have only a few FTEs available, then there may not be enough resources to make a significant change, we need to make a big shift and reinvest
- Massive organizational change and shift, its difficult to return to "normal" operations, reallocating staff and redistributing staff based on qualifications and abilities, intense work
- How to make better decisions, when these decisions are difficult to make (taking ethics into consideration)
    - Do we have the capacity to make these decisions (ie staffing)
- What health issues will arise after the pandemic is declared over?
- To have that backup in funding to assist in mental health/small businesses
- How do we shift government funding to us? How do we continue to be the leaders in health promotion?
- How to utilize IMS in the most effective ways (liaison work)

3. *What are your expectations about MLHU's involvement in these priority recovery issues?*

- We need to be able to switch gears when we are nearing the end of our recovery stage, in order to move business along
- Getting in early to congregate settings in the pandemic to prevent spreading and do damage control earlier
- Remain proactive and upstream as possible
- Look at multiple levels of intervention and ensure multiple strategies are implemented to address these issues
- Multiple strategies to address what we do and how we do it – enable by telling stories, bring people into the conversation, enable community action
- Playing a bit of catch up because we had to suspend some of our services during Covid, getting back into the swing of things to help continue to build a healthy community, assets will be needed for this
- Ensuring we have the resources in place (supplies, equipment) before the pandemic hits, inventory management system monitoring

- That data, research, plans, etc. get actioned and addressed (not sitting on a shelf)
- Expectation that public health collaborates with other agencies – public health cannot do this work alone.
- Continued leadership, we need to create even more partnerships, and MLHU is trusted at the table
- Continue to build strong relationships between our outreach team and clients in the communities in dealing with outbreaks
- Continuing to build on our partnerships and offer multiple services to the community in order to deal with the recovery process (women shelters, food insecurity programs etc.)
- Identify where others are doing the work so that public health does not duplicate it.
- Leveraging our current profiles, public health is at the forefront of people's minds during the pandemic
- Strategic communications so that the media reports on what it's important. Public health is very modest about what we accomplish, other organizations may be more strategic about that
- MLHU providing public definitions on what some of the terms mean involved in the pandemic, clarifications to the public
- Can we really do all things at once? What are our expectations? Importance of setting the foundation for years from now

4. What are the 3-5 most salient points from your discussion that you want to share with the large group?

1. Economic disparities and opportunities: as we recover, what are these recoveries (what do they look like)?
2. We need to be able to switch gears when we are nearing the end of our recovery stage (post pandemic), in order to move business along
3. Public health to remain as proactive and upstream as possible.
4. How to utilize emergency management services in the most effective ways (liaison work)
5. Focus on multiple levels of intervention and ensure multiple strategies are implemented to address these issues - e.g. enable by telling stories, bring people into the conversation, enable community action, inform healthy public policy.
6. Community Partnerships: playing a leading role with our community partners and that we see solutions as multi sectoral
7. Continue to build strong relationships between our outreach team and clients in the communities in dealing with outbreaks
8. Continuing to build on our partnerships and offer multiple services to the community in order to deal with the recovery process (women shelters, food insecurity programs etc.)
9. Leverage our profile – to draw and attract other partners to the table
10. Ensure adequate resourcing and prioritization of public health work to take effective action and clarify what work that public health does not have the capacity to do.
11. Resource allocation for our priority programs that these initiatives fall within
12. Playing a bit of catch up because we had to suspend some of our services during Covid, getting back into the swing of things to help continue to build a healthy community, assets will be needed for this,; Massive organizational change and shift, its difficult to return to "normal" operations, reallocating staff and redistributing staff based on qualifications and abilities, intense work
13. Creating pandemic proof programing
14. Learning from other jurisdictions and learning their mistakes
15. Getting in early to congregate settings in the pandemic to prevent spreading and do damage control earlier

16. How to make better decisions, when these decisions are difficult to make (taking ethics into consideration)
17. Leverage key relationships to communicate our healthy public policy and to influence the development of these policies
18. Foundational principle of health equity and recovery will burden some who have greater pressure in health inequity (i.e., racialized communities, small businesses)

Topic 6: Mental Health of Staff

Working Definition: We recognize that our staff have been full on, and front line for a year, and this takes a significant toll. What are we doing to ensure those that took care of others are being taken care of?

Top Priorities from each small group and participant votes on most important

Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed were appropriate

1. *What do we anticipate to be the major issues related to staff's mental health?*

- Connectedness to one another
- What is the impact on continued isolation on people and their socialization levels
- Priority list of staff getting vaccinated, will the lack of this make staff more cautious to transition to normal?
- Re-socializing, reintegration of staff nearing the end of the pandemic (going back to work in person)
- Will people feel that their work is valued as much in non COVID times? Are staff going to be content going back to "normal" (post-pandemic depression)?
- Going to take some time to get back to "normal", not going to be clear necessarily
- Resiliency, vicarious trauma, recovery, fatigue and change fatigue (changing people's roles during redeployment), burnout etc.
- Pushed into roles they don't normally work in as well as with irregular intense schedules
- Workload and intensity of work
- Exhaustion and burn out
- Staff very stressed and feeling the impacts of the pandemic, demands are high
- Recognizing the impact of mental health on women vs. men (e.g.; women are bearing the brunt of the stress, and men may be hesitant to speak about mental health)
- Similar to being deployed (military service)
- Seeing shifts in staff changing sectors and attrition, more resignations could be due to health issues in their families
- Other economic or job security issues going on at home that we don't know about, someone feeling pressure at home
- What does time off (vacation, lieu, taking a rest) look like post pandemic?

2. *What are things that we need to do to proactively take care of our staff now and in the future?*

- Managers will need tools to be able to distinguish between stress, burnout and depression (post pandemic depression)…if a manager suspects any mental health concerns with their staff, they will need to have the tool to assist
- Highlighting the resources available for staff
- Proactively taking care of the mental health of our staff through programs and mandates made by MLHU (reversed the vacation ban)
- Invested in staff wellness activities ("Be Well" program), interested in who this is reaching and what else we need in order to reach others who might be falling through cracks and not getting what they need
- Promote taking breaks, taking vacations and find a way for people to take vacations so that they are not thinking that they are burning out
- Making sure staff are getting the time they need for themselves and time off, what is the flexibility like for people to take time off?
- Trade offs – example of holiday closure, taking case by case, people needing vacations
- People are fragile right now and we need to recognize that
- We are in the process of reassessing our benefits to shift to virtual counselling and the more need for counselling versus general wellness
- Training staff into different roles e.g. contact tracers and case investigators have been cross trained
- Building capacity so that there is cross coverage so people are not working at 150%

- As we move forward, build in redundancy and building capacity
- Having more resources/trained people handy in case this happens again so that we are better prepared to give people the time they need, help alleviate some of the burden
- Not shift things too much for staff
- Leave staff where they are as we continue to move through the pandemic
- Comprehensive program in place for several months to be able to help staff manage post-COVID state
- Looking to get feedback from staff to learn what will benefit them post pandemic?
- Continue to get feedback from the staff on what they need, what is working with internal programs so that we can configure our programming to suit the needs of our staff
- Is there a communications network/system where people can give their feedback ("question box") about what it is they need?
- There has been a rise for accommodations away from longer work days (11 hours days for the COVID work)
- Be intentional about not ramping up programming back to pre-COVID level and instead ease into it
- Recognition at an organizational level and a community level in regards to the pandemic response
- Making sure there is a consideration for the staff in recognizing their work "pat on the back" to say thank you, not overlooking actions and going above and beyond
- Focus on what it will take to return to normal in professional and in personal life
- More funding for EFAPs and more staff data and metrics of what is going on among staff (absenteeism)

3. *What more do we need to learn here? (at a Board level)*

- The roles of staff are going to change post pandemic, and how this is going to impact (letting staff know ahead of time)
- Negotiate additional job sharing positions
- Additional support systems in place for staff
- Coming up with specific strategies that might lead to less attrition and helping staff to feel supported within the organization
- How the BE well and other programming is effecting the staff and if it is helping alleviate some of the stress burden and improve mental health outcomes
- The Board needs to hear how compassionate our staff are to the community and how much they care and the importance of kindness – lead by example
- The Board needs to support when people say "we will stop doing this" due to capacity limit
- The usefulness of surveys that can be anonymous in assessing the needs of the staff and seeing what problems they are facing when it comes to mental health (Town Hall Meetings)

4. *The 3-5 most salient points from your discussion that you want to share with the large group*

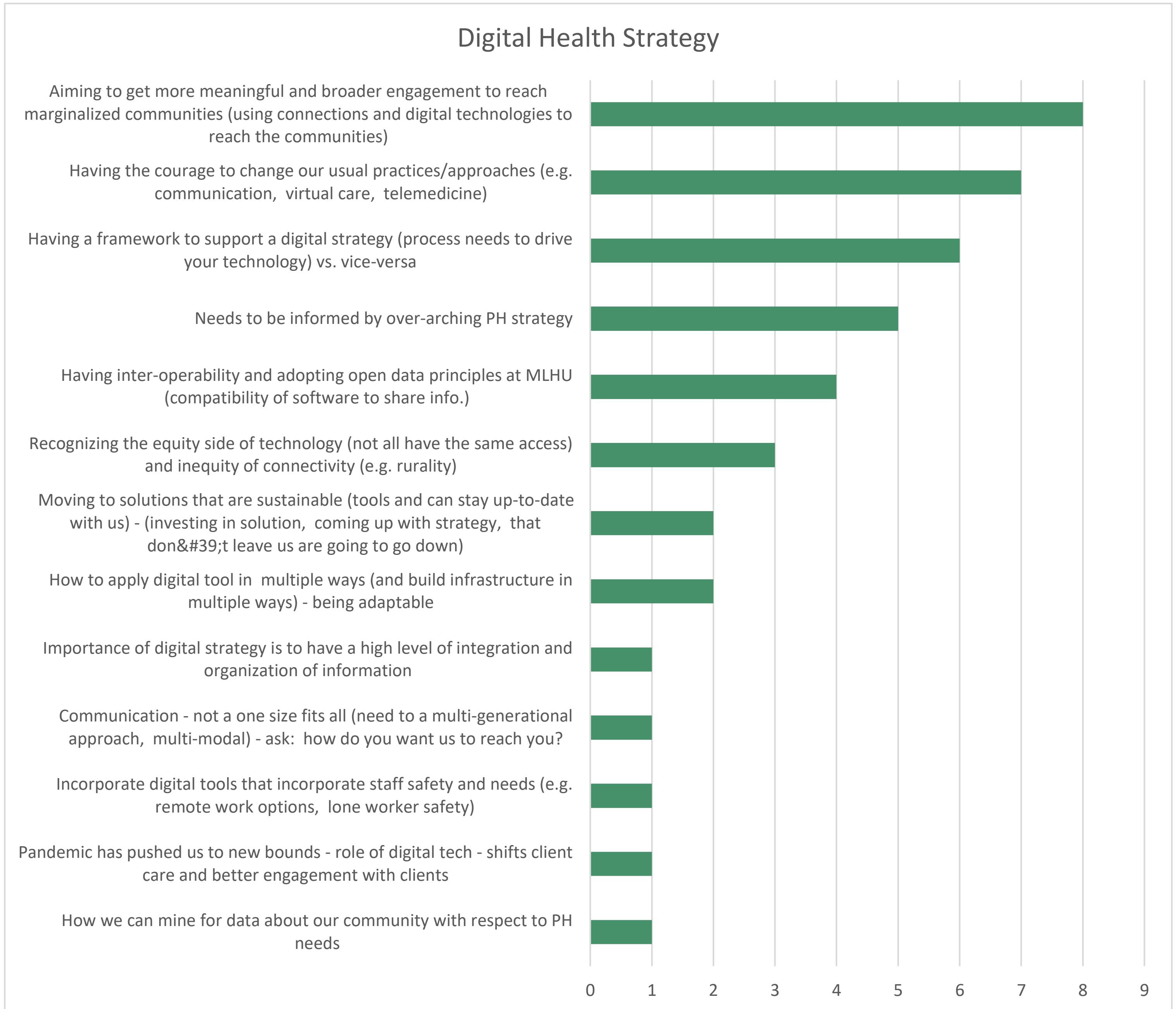
1. Managers will need tools to be able to distinguish between stress, burnout and depression (post pandemic depression)…if a manager suspects any mental health concerns with their staff, they will need to have the tool to assist
2. Board Level: Creating specific strategies that might lead to less attrition and helping staff to feel supported within the organization
3. Board Level: The usefulness of surveys that can be anonymous in assessing the needs of the staff and seeing what problems they are facing when it comes to mental health (Town Hall Meetings)
4. Recognizing the impact of mental health on women vs. men (e.g.; women are bearing the brunt of the stress, and men may be hesitant to speak about mental health and post pandemic depression)

5. What is the impact on continued isolation on people and their socialization levels?
6. Major Staff Mental Health issues: resiliency ,vicarious trauma ,recovery, fatigue and change fatigue (changing people's roles during redeployment), burnout, childcare
7. Address the concept of change fatigue that has been experienced by staff
8. During the pandemic, staff felt pushed into roles they don't normally work in as well as with irregular intense schedules
9. Highlighting the resources available for staff, and ensuring they are comfortable accessing these services
10. Invested in staff wellness activities ("Be Well" program), interested in who this is reaching and what else we need in order to reach others who might be falling through cracks and not getting what they need
11. Prioritize and pace our work
12. Willingness to take risks and hire personnel that we need to continue to have resources to get the work done
13. Creating capacity through redundancy, cross training, permission and support to stop doing things due to capacity limits
14. Be clear about what we can and cannot do well
15. Ensure recognition/celebration for staff at an organizational and community level post-COVID.
16. Recognizing our awesome staff
17. Need to continue to re-evaluate EFAP offerings to make sure that they're meeting the needs
18. Other economic or job security issues going on at home that we don't know about, someone feeling pressure at home

Topic 8: Digital Health Strategy

Working Definition: How the Board of Health responds to a Digital world - Social Media Strategy, client engagement, community delivery & engagement, working from home, cyber security, etc.

Top Priorities from each small group and participant votes on most important



Cumulative Summary Notes from Small Group Dialogue

Data is provided verbatim from notetakers, themed were appropriate

1.What is important to you about a digital strategy?

- The outcomes be seen as an enabler (not a distraction) to facilitate MLHU accomplishing its mission
- Having all the correct pieces in place in order to actually help fix the problem, instead, digital tech can sometimes complicate the process
- Having a framework to support a digital strategy and that it's outcome based – technology driving our process vs. process driving our technology. This requires investment. There is still lots to do. Setting a goal and working backwards
- Digital strategy has to follow the public health strategy as opposed to having it drive our desire for digitization of processes - strategy around the tool should follow the strategy of the purpose.
- It's critical to have a process first, then implement the technology
- Ensuring that you aren't missing opportunities
- Opportunity to seek new ways to engage wit, h different audiences and multiple communities that we serve – to do critical community engagement pieces with strong methodologies that can be used to do this
- People working across multiple systems and platforms instead of one central service, trying to string them together will be key
- How interconnected the digital system can be in terms of community engagement
- How do we recognize the tech inequity?
- Not one size fits all and taking a multi-generational approach
- Recognizing technology but at the same time focus on the equity: not everyone has access to the technology, the messaging needs to be equal
- Delivering information in an equitable/accessible way
- Helping to make information more accessible, both for the staff and clients
- Integration of tools that are utilized across the health unit
- High level of integration and organization of information
- Moving to solutions that are sustainable and are consistency updated and dynamic
- Pandemic has pushed us to new bounds and now allows us to do virtual visits with people, the role of digital tech in shifting client care and better engagement
- Invest in solutions that are sustainable and can be in place for the long term
- Sustainability will be key so that the organization can keep up with all the changes
- The capabilities of digital tech, can help reduce stress on people and increase operational time, however, need to keep training staff to make sure they still feel valuable
- Ongoing education for staff when it comes to the use of technology
- Digital tools to support staff safety

2. What is our deeper intention here?

- All of the above speak to the deeper intention
- Look at digital space out there, and look at what we can take advantage of (especially what we have never taken advantage of before)
- How to maximize efficiencies across all aspects and levels of the organization using digital tech
- To get a better understanding of our strategic objectives
- Using digital strategy to investigate pandemic movement and using the data to break the information down into useful ways, helps to formulate effective health strategies

- How to apply the digital tools in different ways and build the infrastructure platform in a stronger way (i.e., a way to redeploy staff, case software to allow staff to work remotely, using Teams etc..)
- Knowing the times and places when these digital strategies are used
- We are trying to get meaningful engagement and more broad engagement and reach our marginalized communities
- Communication is a key public health strategy, we need IT supports for this (ex. updating MLHU website hosting platform). Also needs to be meaningful to the group that it's trying to reach (ex. Tik Toks, Facebook, Instagram)
- Reliance on IT to be able to dig deeper and pull from a bigger data pool (ex. case and contact management tool) and continue to build these tools to reach our goals

3. What are the 3-5 most salient points from your discussion that you want to share with the large group

1. Interoperability: adopting open-data principles in MLHU, to allow data to flow from one system to another (compatibility with software to share information from place to place)
2. There needs to be integration of digital tools that can be utilized across the health unit
3. High level of integration and organization of information, People working across multiple systems & platforms instead of one central service, trying to string them together will be key
4. Moving to solutions that are sustainable, dynamic and consistency updated – the concept of moving towards a "path to green"
5. Having a framework to support a digital strategy and that it's outcome based – technology driving our process vs. process driving our technology. This requires investment. There is still lots to do. Setting a goal and working backwards
6. How to apply the digital tools in different ways and build the infrastructure platform in a stronger way (i.e, a way to redeploy staff, case software to allow staff to work remotely, using Teams etc..)
7. Virtual Care options for health care – virtual vs. in person: tele medicine
8. Pandemic has pushed us to new bounds and now allows us to do virtual visits with people, the role of digital tech in shifting client care and better engagement
9. Incorporate digital tools that support staff safety and address staff needs – e.g. lone worker safety, flexible work arrangements, remote work options, etc.
10. The capabilities of digital tech, can help reduce stress on people and increase operational time, however, need to keep training staff to make sure they still feel valuable
11. Focus on continuous education for staff when it comes to the use of technology
12. Public health specific IT professionals
13. Reliance on IT to be able to dig deeper and pull from a bigger data pool (ex. case and contact management tool) and continue to build these tools to reach our goals
14. Digital strategy needs to be informed by the overarching public health strategy.
15. Recognizing the divide of the tech equity (some may be left out)
16. We are trying to get meaningful engagement and more broad engagement and reach our marginalized communities
17. Not one size fits all and taking a multi-generational approach - Communication is a key public health strategy, we need IT supports for this (ex. updating MLHU website hosting platform). Also needs to be meaningful to the group that it's trying to reach (ex. Tik Toks, Facebook, Instagram)
18. Ask our stakeholders/audiences: how do we reach you and what method – translations options through technology
19. Having the courage to change our paradigm

Draft Strategic Priorities

Given the dialogue during the sessions, the following are drafted for the consideration of the Governance Committee and the Board of Health.

Provisional Strategic Plan			
Program Excellence	**Client & Community Confidence**	**Employee Engagement & Learning**	**Organizational Excellence**
Priorities			
Execute effective pandemic response and prepare for recovery	Keep our communities safe and foster community confidence	Equip staff to deliver pandemic and recovery responses while addressing staff well-being and mental health	Strengthen governance and leadership structures to deliver be equipped to lead public health
Objectives			
Develop an anti-racism public health strategy	Capture lessons learned from the pandemic and prepare for another	Continue to equip staff to conduct pandemic and recovery work	Address concerns with and prepare for modernization of public health
Prepare to address public health recovery challenges through a social determinants of health lens		Develop strategies to address well-being and mental health of staff	Ensure the right skills and competencies exist at SLT and prepare for succession
Strengthen local partnerships			Assess the need for a comprehensive digital health strategy

Provisional Strategic Planning Sessions

2021 01 27 & 28

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Draft Strategic Priorities

Given the dialogue during the sessions, the following are drafted for the consideration of the Governance Committee and the Board of Health.

Provisional Strategic Plan			
Program Excellence	Client & Community Confidence	Employee Engagement & Learning	Organizational Excellence
Priorities			
Execute effective pandemic response, prioritized public health work and prepare for recovery	Keep our communities safe and foster community confidence	Support staff to deliver public health services while addressing staff well-being and mental health	Strengthen governance and leadership structures to maximize impact on public health
Objectives			
Develop and act on an anti-racism public health strategy Engage in public health recovery challenges through a health equity lens Strengthen local partnerships Continue to deliver effective services that focus on the prevention and control of communicable diseases	Continue to capture lessons learned from the pandemic and prepare for another Seek stakeholder input through direct engagement	Continue to support staff to conduct pandemic and recovery work Expand on strategies to address well-being and mental health of staff	Address concerns with and prepare for modernization of public health Ensure the right leadership skills and competencies exist across the organization and prepare for succession Assess the need for a comprehensive digital health strategy

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