AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

MLHU Board Room – CitiPlaza
355 Wellington Street, London ON
Thursday, February 16, 2023 at 6:00 p.m.

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

2. **DISCLOSURE OF CONFLICTS OF INTEREST**

3. **APPROVAL OF AGENDA –** February 16, 2023

4. **APPROVAL OF MINUTES –** November 10, 2022

5. **NEW BUSINESS**

   5.1. 2023 Governance Committee Reporting Calendar (Report No. 01-23GC)
   5.2. Governance Policy Review (Report No. 02-23GC)
   5.3. Annual Privacy Program Update (Report No. 03-23GC)
   5.4. Quarterly Risk Register Update (Report No. 04-23GC)
   5.5. Provisional Planning Update (Report No. 05-23GC)

6. **OTHER BUSINESS**

   The next meeting of the Governance Committee will be on Thursday, April 20 at 6 p.m.

7. **ADJOURNMENT**

PUBLIC MINUTES
GOVERNANCE COMMITTEE
MLHU Board Room – Citi Plaza
Thursday, November 10, 2022 6:00 p.m.

MEMBERS PRESENT: Ms. Aina DeViet (Chair)
Mr. Matt Reid
Ms. Kelly Elliott
Mr. Michael Steele

REGRETS: Ms. Tino Kasi

OTHERS PRESENT: Ms. Carolynne Gabriel, Executive Assistant to the Board of Health (Recorder)
Dr. Alexander Summers, Medical Officer of Health
Ms. Emily Williams, Chief Executive Officer
Ms. Sarah Maaten, Acting Director, Office of the Medical Officer of Health
Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Disease
Ms. Maureen MacCormick, Director, Healthy Living
Ms. Kendra Ramer, Manager, Privacy, Risk and Governance
Mr. Michael Kadour, Consultant

At **6:02 p.m.,** Chair Aina DeViet called the meeting to order.

DISCLOSURES OF CONFLICT OF INTEREST

Chair DeViet inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **Mr. Matt Reid, seconded by Ms. Kelly Elliott,** *that the **AGENDA** for the November 10, 2022 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Mr. Michael Steele, seconded by Mr. Reid,** *that the **MINUTES** of the September 15, 2022 Governance Committee meeting be approved.*

Carried

Chair DeViet called upon Dr. Alexander Summers, Medical Officer of Health who introduced Ms. Sarah Maaten in her role as Acting Director, Officer of the Medical Officer of Health.

NEW BUSINESS

2021-22 Provisional Plan Update (Report No. 13-22GC)

This report was introduced by Ms. Emily Williams, CEO who identified that the main reasons for postponing the work on the strategic plan are:

- The Province will potentially be reviewing and revising the Ontario Public Health Standards (OPHS) in 2023.
- The Health Unit does not have clarity on the direction the Province will take with regards to COVID-19 and recovery work.
- The financial situation of the Health Unit is uncertain, pending the Provincial funding announcement anticipated in early 2023.
- Many other Ontario health units are also pausing or extending their strategic plans.

Ms. Williams introduced Ms. Kendra Ramer, Manager, Privacy, Risk, and Project Management. Ms. Ramer highlighted that the report proposes conducting a current state analysis which would include consultation with the Board of Health, the Senior Leadership Team (SLT), and MLHU staff and management to update the objectives in the current Provisional Plan. The objectives in the current Provisional Plan are framed within the context and environment of its time and some objectives will need to be reframed to remain relevant. The main activity in developing the new Strategic Plan will take place in 2023, with planning and development of the 2025-2029 strategic plan to occur in 2024. The work will be led by the Program Planning and Evaluation Team with support from the Project Management Office.

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

1) *Receive Report No. 13-22GC, re: "2021-22 Provisional Plan Update" for information; and*
2) *Approve the extension of the 2021-22 Provisional Plan to the end of 2024 following a current state analysis with a plan to develop a 2025-2029 Strategic Plan in 2024.*

Carried

MLHU Q3 2022 Risk Register (Report No. 14-22GC)

This report was introduced by Ms. Williams who introduced Ms. Ramer.

Highlights of this report included:

- The Risk Register up to the end of September (Q3) includes 16 high risks, five medium risks, and two low risks.
- Of the 16 high risks, two remain at significant residual risk: non-full-time staff joining OMERS and the return of Public Health Modernization as a result of the Provincial election.
- One technology risk was removed due to being successfully mitigated through decommissioning and removing end-of-life servers.
- Five new risks were added in Q3: two related to privacy, which have already been brought to the Board, one related to legal compliance involving a class action suit, and two categorized as financial involving non-full-time staff joining OMERS and the potential for claw back of funds from 100% funded programs.
- Two high risks transitioned from minor residual risk in Q2 to moderate residual risk in Q3: the Medical Officer of Health continuing to operate with limited back-up coverage due to the recent departing of the Acting Associate Medical Offer of Health, and the risk for turnover of municipal councilors on the Board of Health.
- The Q3 Risk Register was included in the Standard Activity Report submitted annually to the Ministry.

Chair DeViet inquired what actions can be taken to mitigate the risk of turnover on the Board of Health due to the municipal election, as significant turnover on the Board may impact its ability to move forward at the pace required to manage the COVID-19 response and financial decisions. Ms. Williams indicated that both herself and Dr. Summers are engaged in lobbying efforts to advocate for continuity on the Board of Health with the City and County.

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

1) *Receive Report No. 14-22GC, re: "MLHU Q3 2022 Risk Register" for information; and,*
2) *Approve the Q3 2022 Risk Register (Appendix A).*

Carried

OTHER BUSINESS

The next meeting of the Governance Committee is to be determined.

ADJOURNMENT

At **6:15 p.m.,** it was moved by **Mr. Reid, seconded by Ms. Elliott**, *that the meeting be adjourned.*

Carried

_____ _____

AINA DEVIET **EMILY WILLIAMS**
Chair **Secretary**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 01-23GC

TO: Chair and Members of the Governance Committee

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 February 16

2023 GOVERNANCE COMMITTEE REPORTING CALENDAR

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to:

1) ***Receive Report No. 01-23GC re: "Governance Committee Reporting Calendar"; and***
2) ***Recommend that the Board of Health approve the 2023 Governance Committee Reporting Calendar (Appendix B).***

Key Points

- The 2023 Governance Committee Reporting Calendar (Appendix B) provides a framework for activities to be undertaken in the current year.
- Policy review by the Committee has been split into areas of subject matter.
- It is recommended that the Governance Committee continue to meet five times in the calendar year to ensure all legislative accountabilities of the Board of Health are fulfilled.

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 as noted in 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.

At its meeting on January 19, 2023, the Board of Health approved the Governance Committee Terms of Reference. The Reporting Calendar (Appendix B) is reviewed and approved annually.

Amendments to the Reporting Calendar

Amendments to the 2023 Governance Reporting Calendar include:

- Removing the initiation of the MOH/CEO Performance Appraisal, as there is a standing committee for this purpose (MOH/CEO Performance Appraisal Committee).

The policy review process has been adjusted from last year, with policies grouped by subject matter area, as well as allocated over two years, to make reviewing easier for the Committee.

Next Steps

The Governance Committee has the opportunity to review the appended Reporting Calendar for 2023.

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 Chief Executive Officer.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

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 (MOH) and Chief Executive Officer (CEO) 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 MOH and 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 one provincial Board member.

The Secretary and Treasurer will be ex-officio non-voting members.

Staff support includes:

- Chief Executive Officer; and
- Executive Assistant (EA) to the Board of Health and/or EA to the MOH.

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

CHAIR

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

TERM OF OFFICE

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

DUTIES

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

1. Board member succession planning and recruitment;

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

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. Governance policy and by-law development and review;
7. Compliance with the Ontario Public Health Standards;
8. Strategic planning;
9. Privacy program;
10. Risk management;
11. Human resources strategy and workforce planning; and
12. Occupational health and safety.

FREQUENCY OF MEETINGS

The Governance Committee will meet five (5) 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 MOH and 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.
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 or when an amendment is deemed necessary by the Committee or Board of Health.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

2023 Governance Committee Reporting Calendar

Q1 (Jan 1 to Mar 31)	Q2 (Apr 1 to Jun 30)
Meeting: February	**Meetings: April & June**
• Approve Reporting Calendar • Annual Declarations – Confidentiality and Conflict of Interest • Report on Privacy Program • Report on Provisional/Strategic Plan and Performance • Board of Health Orientation • Report on Board of Health Risk Management • Review Governance By-laws and Policies	• Initiate Board of Health Self-Assessment (every 2 years) • Report on Occupational Health and Safety Program • Report on Provisional/Strategic Plan and Performance • Report on Board of Health Risk Management • Review Governance By-laws and Policies
Q3 (Jul 1 to Sep 30)	**Q4 (Oct 1 to Dec 31)**
Meeting: September	**Meeting: November**
• Report on Public Health Funding and Accountability Agreement Indicators • Report on Provisional/Strategic Plan and Performance • Report on Board of Health Self-Assessment (every 2 years) • Report on Board of Health Risk Management • Review Governance By-laws and Policies	• Report on Provisional/Strategic Plan and Performance • Report on Board of Health Risk Management • Board of Health Orientation Planning • Review Governance By-laws and Policies

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.

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.)

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.)

Strategic Planning

The organization's strategic plan is developed in consultation with the Board of Health, staff, and 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.)

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.)

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.

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.)

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

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.)

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.)

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.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 02-23GC

TO: Chair and Members of the Governance Committee

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 February 16

GOVERNANCE POLICY REVIEW

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to:
1) Receive Report No. 02-23GC re: "Governance Policy Review" for information; and
2) Approve the governance policies as amended, appended to this report (Appendix B).

Key Points

- It is the responsibility of the Board of Health to review and approve governance by-laws and policies.
- Appendix A details recommended changes to the by-laws and policies that have been reviewed by the subcommittees of the Board and outlines the status of all documents contained within the Governance Manual.
- There are three (3) policies that have been prepared for review by the Governance Committee (Appendix B).

Background

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

Policy Review

For 2023 and 2024, policies will be grouped together by subject matter area for ease in reviewing.

There are 3 (three) policies included as Appendix B that have been reviewed by the Governance Committee and prepared for approval by the Board of Health:

- G-180: Financial Planning and Performance
- G-205: Borrowing
- G-430: Informing of Financial Obligations.

Appendix A to this report details the recommended changes for the above by-laws/policies as well as the status of all documents contained within the Governance Manual.

Next Steps

It is recommended that the Board of Health approve the policies as amended as outlined in Appendix B.

This report was prepared by the Chief Executive Officer.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

2023 Governance By-law and Policy Review Schedule and Recommendations Table

February 2023

Group	Document Name	Last Review	Status	Recommended Changes	For Review on
Board of Health Operations	G-280 Board Size and Composition	10/21/2021	Current		11/16/2023
Board of Health Operations	G-300 Board of Health Self-Assessment	10/21/2021	Current		11/16/2023
Board of Health Operations	G-350 Nominations and Appointments to the Board of Health	10/21/2021	Current		11/16/2023
Board Responsibility and Transparency	G-260 Governance Principles and Board Accountability	04/15/2021	Current		4/20/2023
Board Responsibility and Transparency	G-370 Board of Health Orientation and Development	10/21/2021	Current		4/20/2023
Board Responsibility and Transparency	G-400 Political Activities	06/17/2021	Current		4/20/2023
By-laws	G-B10 By-law No. 1 Management of Property	10/21/2021	Current		6/15/2023
By-laws	G-B20 By-law No. 2 Banking and Finance	10/21/2021	Current		6/15/2023
By-laws	G-B30 By-law No. 3 Proceedings of the Board of Health	06/16/2022	Current		6/15/2023
By-laws	G-B40 By-law No. 4 Duties of the Auditor	10/21/2021	Current		6/15/2023

Group	Document Name	Last Review	Status	Recommended Changes	For Review on
Financial Activities	G-180 Financial Planning and Performance	11/18/2021	Reviewed	- Note/question that the (annual service plan) ASP would be a driver/foundation for the budget and the budget allocates resources and supports the work outlined in the ASP. - Staff response: recommend that the word 'supports' be changed to 'includes' in the policy.	2/16/2023
Financial Activities	G-430 Informing of Financial Obligations	04/15/2021	Reviewed	- Question if there was a timeline for notifying City and County of financial obligations. - Staff response: the budget timing is different for both; the County operates on the fiscal year (Apr-Mar) and the City on the calendar year. They are each updated throughout the health unit budgeting process to enable their planning processes.	2/16/2023
Financial Activities	G-205 Borrowing	04/15/2021	Reviewed	- No comments received.	2/16/2023
Risk and Privacy	G-080 Occupational Health and Safety	06/17/2021	Current		9/21/2023
Risk and Privacy	G-100 Privacy and Freedom of Information	02/17/2022	Current		9/21/2023
Risk and Privacy	G-120 Risk Management	10/21/2021	Current		9/21/2023

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

FINANCIAL PLANNING AND PERFORMANCE

PURPOSE

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

POLICY

The Treasurer or his/her designate prepares and controls the Annual Budget under the jurisdiction of the Board of Health and prepares financial and operating statements for the Board of Health in accordance with Ministry of Health policies and Public Sector Accounting Board Guidelines.

Fiscal Year

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

Annual Budget Preparation

The annual budget will be developed based on a variety of factors including strategic directions, provincial and/ or municipal guidance, previous years' base budgets, community need, new funding or legislative requirements. Budget planning and performance reporting is the responsibility of the directors, managers and other staff who manage budgets. (Refer to Appendix A for the budget planning and approval cycle.)

The planning and approval cycle has the following components:

a) Annual Service Plan – The Annual Service Plan (ASP) is a Ministry-driven requirement that provides a comprehensive summary of each MLHU program including the program's purpose, costs, key performance indicators and other relevant information. The ASP supports the annual budget that is approved by the Board of Health, as well as annual budget reporting by program to the Ministry of Health (MOH).

b) Zero-based Budgeting – Zero-based Budgeting is a process by which program and operating budgets are built 'from scratch' via the assessment of every aspect of program and service activity to determine its worth, and subsequently attributes that amount to the budget. Funds are allocated based on prioritization and necessity, not historical budget amounts.

c) Program Budgeting Marginal Analysis (PBMA) – PBMA facilitates reallocation of resources based on maximizing service. This is done through the transparent application of pre-

Formatted: Highlight

Commented [AD2]: Doesn't the ASP define the MLHU "deliverables" as required under legislation ...it would be a driver/foundation for the budget ... the budget allocates resources and supports the work outlined in the ASP?

Formatted: Highlight

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

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

e) One-time Funding Requests – One-time funding requests may be used for non-reoccurring expenditures or to temporarily enhance program objectives. (Requests should be made during the budget preparation process, by making application to the provincial government for one-time funding when filing the Annual Service Plan. Approval of the request will follow Policy G-200 Signing Authority based on the total value of the request.)

Annual Budget Approval

The Finance and Facilities Committee (FFC) of the Board of Health reviews and recommends the annual budget for Board of Health approval.

Factual Certificate

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

Audited Financial Statements

The preparation of the financial statements is the responsibility of MLHU's management. Financial statements must be prepared in compliance with legislation and in accordance with Canadian public sector accounting standards. The FFC meets with management and the external auditors to review the financial statements and discuss any significant financial reporting or internal control matters prior to their approval of the financial statements.

The Board of Health must provide audited financial reports to funding agencies for programs that are funded from April 1st – March 31st each year to provide assurance that the funds were expended for the intended purpose. These programs are also reported in the main audited financial statements of MLHU which is approved by the Board of Health. This report includes program revenues and expenditures of these programs during the period of January 1st to December 31st. These program audit reports are also included in the main audited statements for MLHU.

APPENDICES

Appendix A – Annual Budget Planning and Reporting Cycle

RELATED POLICIES

G-200 Approval & Signing Authority

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

APPENDIX A
To Policy G-180

ANNUAL BUDGET PLANNING AND REPORTING CYCLE

January	
February	- Q4 Financial Update, Financial Borrowing and Factual Certificate Update
March	- Budget submission to the Finance and Facilities Committee - Budget submission to the Board of Health for approval - Budget submission to the Ministry of Health and Long-Term Care
April	
May	- Q1 Financial Update, Financial Borrowing and Factual Certificate Update
June	- January 1 to December 31 – Audited Financial Statements to FFC - Recommend 2024 Budget Parameters and Planning Assumptions
July	
August	- Q2 Financial Update, Financial Borrowing and Factual Certificate Update - April 1 to March 31 Consolidated Financial Statements to FFC
September	- Review and Recommend Draft 2024 Board of Health Budget
October	
November	- Q3 Financial Update, Financial Borrowing and Factual Certificate Update - Review and Recommend Final 2024 Board of Health Budget
December	

Commented [SE1]: Subject to change pending Board approval of updated FFC reporting calendar

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Aina DeViet
2023-01-29 16:11:00

Reviewed - no changes...

BORROWING

PURPOSE

The purpose of this policy is to establish objectives for debt financing activities to meet infrastructure and operating requirements while meeting the objectives of the Board of Health and related statutory and contractual requirements.

POLICY

Pursuant to Section 56 (1) of the Health Promotion and Protection Act the Middlesex-London Health Unit (MLHU), may enact by-laws and policies respecting banking and finance. After consultation with municipal councils, the Board of Health, may borrow funds to meet infrastructure and operating requirements of the Health Unit.

The primary objectives of this policy are as follows:

1. **Adherence to statutory requirements**

   The Board shall secure temporary or long-term borrowing for health unit purposes as described by the Health Protection & Promotion Act, and the Municipal Act, specifically Part XIII Debt and Investment and the applicable regulations thereunder.

2. **Minimize long-term cost of financing**

   The Board shall ensure that the debt program uses a systematic approach that minimizes the impact of debt servicing costs on the operating budget.

   a. The Board shall strive to maintain a strong credit rating to assist in securing a favourable cost of borrowing.
   b. Obligated municipalities shall be consulted and considered for access to their capital markets.
   c. The term of long-term financing shall extend the shorter of the lifetime of the capital work for which the debt was incurred, or 40 years in accordance to Section 408 (3) of the Municipal Act.
   d. The Health Unit shall utilize benchmarks, measures, indicators, ratios and limits as determined relevant and appropriate by the Secretary-Treasurer or designate to monitor debt servicing costs and annual repayment limits.

In order to meet Health Unit expenditures, the Board Chair and Secretary-Treasurer of the Board of Health are, following a majority vote of the Board of Health, authorized to borrow by way of promissory note or other suitable debt instrument, from a registered chartered bank, trust company or credit union.

The Board may delegate the Secretary-Treasurer to exercise this power on the behalf of the Board in such manner as the Board may determine by Board resolution. The Secretary-Treasurer or designate shall have the authority to implement the debt program and establish procedures consistent with this policy.

While the Board of Health has the authority to borrow, approval either through lease or purchase to acquire and hold real property for the purpose of carrying out the functions of the Health Unit, approval must first be obtained by two obligated municipalities served by the Board.

APPLICABLE LEGISLATION AND STANDARDS

Health Protection and Promotion Act, R.S.O. 1990, c. H.7
Municipal Act, 2001, S.O. 2001, c. 25

RELATED POLICIES

G-B20 By-law #2 Banking and Finance

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Commented [MS2]: Is there a timeframe for notice to the City and the County?

INFORMING OF FINANCIAL OBLIGATIONS

PURPOSE

The following is a statement of financial obligations of the Board of Health. This Policy is subject to all legislation and By-laws governing the Board of Health.

POLICY

The Board of Health shall annually give written notice to the City of London and the County of Middlesex regarding:

- The estimated total annual expense that each will be required to pay to the Board of Health for delivery of the mandatory programs and services under the Ontario Public Health Standards.
- The specific proportion of the estimated amount for which each municipality is responsible, in accordance with the agreement respecting the proportion of the expenses to be paid by each municipality.
- The time at which the Board of Health requires payment to be made by each municipality and the amount of each payment required.

APPLICABLE LEGISLATION

Health Protection and Promotion Act, R.S.O. 1990, c. H.7
Municipal Act, 2001, S.O. 2001, c. 25

RELATED POLICIES

G-B20 By-Law #2 Banking and Finance

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 03-23GC

TO: Chair and Members of the Governance Committee

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 February 16

ANNUAL PRIVACY PROGRAM UPDATE

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to receive Report No. 03-23GC re: "Annual Privacy Program Update" 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.
- The MLHU's Privacy Program supports compliance with these obligations through education, policy and procedure development, assessment and management of privacy risks, facilitation of access and correction requests, and management of potential and actual breaches that may occur.
- The 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

The MLHU is a 'health information custodian (HIC)' in accordance with section 3 of the *Personal Health Information Protection Act (PHIPA)*, and an 'institution' in accordance with section 2 of the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*. Under these legislation, the 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 the MLHU's 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 have the responsibility 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 the MLHU's privacy program is operationalized by the MLHU's Privacy Officer, and includes the following components:

- Education;
- Policy development;

- Privacy impact assessment and consultation;
- Response to access and correction requests under PHIPA and MFIPPA; and
- Breach and complaint management.

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

Successes over the past year include:

- MLHU staff are compliant in completing the annual online privacy education module implemented to increase awareness and compliance with legislative requirements;
- 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; 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.

In summary, the following privacy activities occurred in 2022:

- 14 requests under the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*;
- 5 requests under the *Personal Health Information Protection Act (PHIPA)*; and
- 9 incidents that were considered a privacy breach under the *Personal Health Information Protection Act (PHIPA)*.

Corrective actions were taken following each privacy breach incident to comply with legislative requirements under MFIPPA and PHIPA

Provincial Oversight

The MLHU is required to submit annual statistical reports to the Information and Privacy Commissioner of Ontario 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).

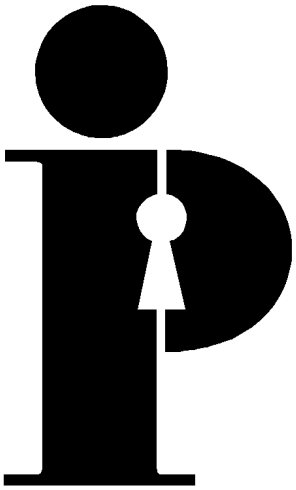
All of these reports will be submitted to the Information and Privacy Commissioner of Ontario within the required deadline (March 31, 2023).

This report was prepared by the Chief Executive Officer and Medical Officer of Health.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

PHIPA BREACH STATISTICS



Statistical Report for the Information and Privacy Commissioner of Ontario

on

Personal Health Information Privacy Breaches

WORKBOOK AND COMPLETION GUIDE

Introduction

Use this Workbook and Guide as a "how to" tool to complete the annual report for the Information and Privacy Commissioner of Ontario (IPC) about privacy breach statistics, as required by section 6.4 of Ontario Regulation 329/04 made pursuant to the *Personal Health Information Protection Act, 2004* (*PHIPA*). We encourage you to use it to help you complete and submit your questionnaire online, especially if you are unfamiliar with it.

Health privacy breach statistics will be collected through the IPC's Online Statistics Submission Website from January to March 1 each year. For your convenience this Workbook and Guide is laid out in the same manner as the online questionnaire (section by section).

If there are any questions that have not been answered by this guide, there are two ways to receive additional information from the IPC:

- e-mail statistics.ipc@ipc.on.ca;
- call our main switchboard:
  Local calls 416 326-3333
  Long distance, use our toll-free line: 1-800-387-0073

Please note: Incomplete questionnaires may result in the custodian's submission being partly or entirely excluded from the statistics generated for the IPC's annual report.

Health information custodians are required to report statistics on health privacy breaches annually to the IPC**.**

If no privacy breaches under this Act occurred, **only health information custodians that are also institutions covered by the *Freedom of Information and Protection of Privacy Act* (*FIPPA*) or the *Municipal Freedom of Information and Protection of Privacy Act* (*MFIPPA*) must still complete and submit Section 1.**

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

Note for coroners to whom Ontario Health provides personal health information that is accessible by means of the electronic health record: the requirement to submit a health privacy breach statistics report applies, with any necessary modification, to such coroners as if they were health information custodians.

Thank you for your co-operation!

SECTION 1: Identification

1.1 Please clearly indicate the name of the health information custodian, name of the contact person responsible for *PHIPA*, phone/fax numbers, mailing and e-mail addresses, name of the person to contact with any questions about the content of the report.

1.2 Are you a coroner to whom the prescribed organization provides personal health information under subsection 55.9.1 (1) of *PHIPA*?

☐ Yes. (If yes, please skip the next question)
☒ No. (If no, please continue)

1.3 Please indicate the type of health information custodian that is reporting. If the health information custodian is part of an institution under *FIPPA/MFIPPA* that has more than one type of health information custodian, please submit separate reports for each type of health information custodian.

1.4

☐	If your **health information custodian** experienced no privacy breaches**,** PLEASE STOP HERE AND SUBMIT ONLY SECTION 1 OF THE REPORT.
X	If your **health information custodian** experienced at least 1 privacy breach, PLEASE COMPLETE AND SUBMIT THE REST OF THE REPORT.

Background

Health information custodians are required to provide the Commissioner with an annual report on privacy breaches occurring during the previous calendar year.

This requirement is found in section 6.4 of Ontario Regulation 329/04 made pursuant to the *Personal Health Information Protection Act, 2004 Act,* as follows:

(1) On or before March 1 in each year starting in 2019, a health information custodian shall provide the Commissioner with a report setting out the number of times in the previous calendar year that each of the following occurred:

1. Personal health information in the custodian's custody or control was stolen.
2. Personal health information in the custodian's custody or control was lost.

3. Personal health information in the custodian's custody or control was used without authority.
4. Personal health information in the custodian's custody or control was disclosed without authority.
5. Personal health information was collected by the custodian by means of the electronic health record without authority. O. Reg. 224/17, s. 1; O. Reg. 534/20, s. 3 (1).

(2) The report shall be transmitted to the Commissioner by the electronic means and format determined by the Commissioner. O. Reg. 224/17, s. 1.

(3) A health information custodian that disclosed the information collected by means of the electronic health record without authority is not required to include this disclosure in its annual report. O. Reg. 534/20, s. 3 (2).

The remaining sections of the report ask for counts of privacy breaches that occurred in each of the above five categories. Do not count each incident more than once. If one incident includes more than one of the above categories, choose the one that best fits. For example, if an employee accessed personal health information without authority, and then disclosed the information, count that incident as either a use or a disclosure, but not both.

In completing the report, count a privacy breach in the year it was **discovered**, even if the breach occurred in a previous calendar year.

In this annual statistics report, you must include all thefts, losses, unauthorized uses or disclosures, or unauthorized collections by means of the electronic health record (EHR), even if you were not required to report them to the IPC under section 6.3 or section 18.3[1] of the Regulation.

Custodians will find it easier to provide the IPC with the information required at reporting time if they keep track of these statistics over the course of the preceding calendar year.

[1] Or, for coroners, clause 18.10(4)(b) of the Regulation.

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).	10

Enter this number into box 2.1 of the online questionnaire.

PLEASE NOTE:

Do NOT count each incident more than once. If one incident includes more than one of the following five categories (sections 3 through 7), choose the category that it best fits. For example, if an employee accessed personal health information without authority, and then disclosed the information, count that incident as either a use or a disclosure, but not both. The sum of boxes 3.1 + 4.1 + 5.1 + 6.1 + 7.1 must equal box 2.1.

SECTION 3: Stolen Personal Health Information

3.1 What was the total number of privacy breach incidents where personal health information **was stolen**? | 0 |

Enter this number into box 3.1 of the online questionnaire.

3.2 Of this total indicate the number of privacy breaches where:

Count each incident only once – the total on line 3.2.3 must equal line 3.1.

3.2.1	theft was by an **internal party** (such as an employee, affiliated health practitioner or electronic service provider).	
3.2.2	theft was by a **stranger**	
3.2.3	**Total** (should equal line 3.1)	0

3.3 Of the total on line 3.1 indicate the number of privacy breaches where:

Count each incident only once – the total on line 3.3.6 must equal line 3.1.

3.3.1	theft was the result of a ransomware attack	
3.3.2	theft was the result of another type of a cyberattack	
3.3.3	unencrypted portable electronic equipment (such as USB keys or laptops) was stolen	
3.3.4	paper records were stolen	
3.3.5	theft was a result of something else, by someone else or other items were stolen	

3.3.6	TOTAL INCIDENTS (3.3.1 to 3.3.5 = 3.3.6) Box 3.3.6 must equal Box 3.1	0

Enter the numbers in the table above into boxes 3.3.1 through 3.3.6 of the online questionnaire.

3.4 Of the total on line 3.1 indicate the number of privacy breaches where:

Count each incident only once – the total on line 3.4.6 must equal line 3.1.

3.4.1	one individual was affected	
3.4.2	2 to 10 individuals were affected	
3.4.3	11 to 50 individuals were affected	
3.4.4	51 to 100 individuals were affected	
3.4.5	over 100 individuals were affected	
3.4.6	TOTAL INCIDENTS (3.4.1 to 3.4.5 = 3.4.6) Box 3.4.6 must equal Box 3.1	0

Enter the numbers in the table above into boxes 3.4.1 through 3.4.6 of the online questionnaire.

SECTION 4: Lost Personal Health Information

4.1 What was the total number of privacy breach incidents where personal health information **was lost**? | 0 |

Enter this number into box 4.1 of the online questionnaire.

4.2 Of this total indicate the number of privacy breaches where:

Count each incident only once – the total on line 4.2.6 must equal line 4.1.

4.2.1	loss was the result of a ransomware attack	
4.2.2	loss was the result of another type of a cyberattack	
4.2.3	unencrypted portable electronic equipment (such as USB keys or laptops) was lost	
4.2.4	paper records were lost	
4.2.5	loss was a result of something else or other items were lost	
4.2.6	TOTAL INCIDENTS 4.2.1 to 4.2.4 = 4.2.5	0

Enter the numbers in the table above into boxes 4.2.1 through 4.2.6 of the online questionnaire.

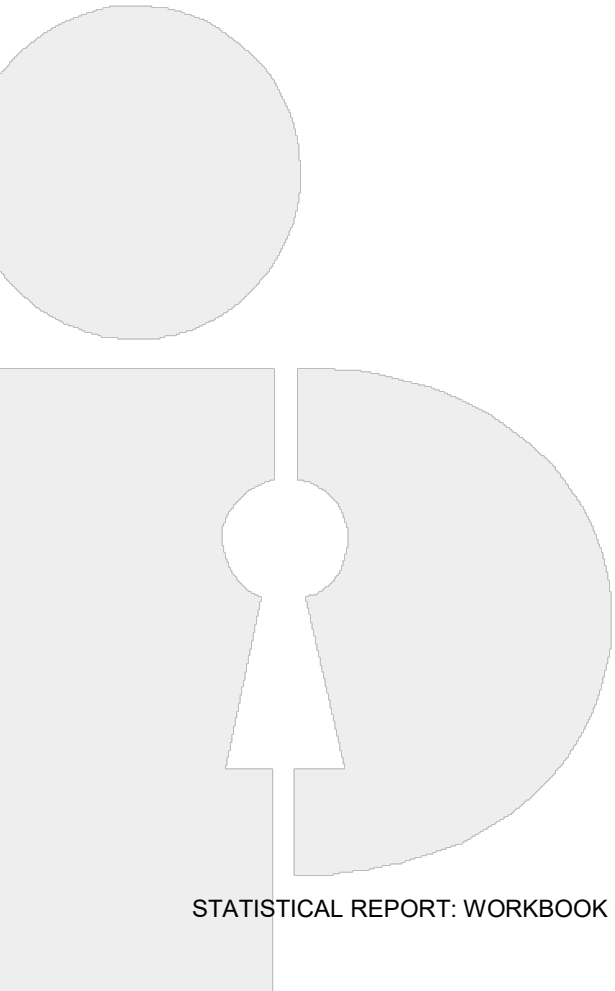
4.3 Of the total on line 4.1 indicate the number of privacy breaches where:

Count each incident only once – the total on line 4.3.6 must equal line 4.1.

4.3.1	one individual was affected	
4.3.2	2 to 10 individuals were affected	

4.3.3	11 to 50 individuals were affected	
4.3.4	51 to 100 individuals were affected	
4.3.5	over 100 individuals were affected	
4.3.6	TOTAL INCIDENTS (4.3.1 to 4.3.5 = 4.3.6) Box 4.3.6 must equal Box 4.1	0

Enter the numbers in the table above into boxes 4.3.1 through 4.3.6 of the online questionnaire.



SECTION 5: Used Without Authority

5.1 What was the total number of privacy breach incidents where personal health information **was used (e.g. viewed, handled) without authority**?

1

Enter this number into box 5.1 of the online questionnaire.

5.2 Of this total indicate the number of privacy breaches where:

Count each incident only once – the total on line 5.2.4 must equal line 5.1.

5.2.1	unauthorized use was through electronic records	
5.2.2	unauthorized use was through paper records	1
5.2.3	unauthorized use through other means	
5.2.4	TOTAL INCIDENTS (5.2.1 + 5.2.2 + 5.2.3 = 5.2.4) Box 5.2.4 must equal Box 5.1	1

Enter the numbers in the table above into boxes 5.2.1 through 5.2.4 of the online questionnaire.

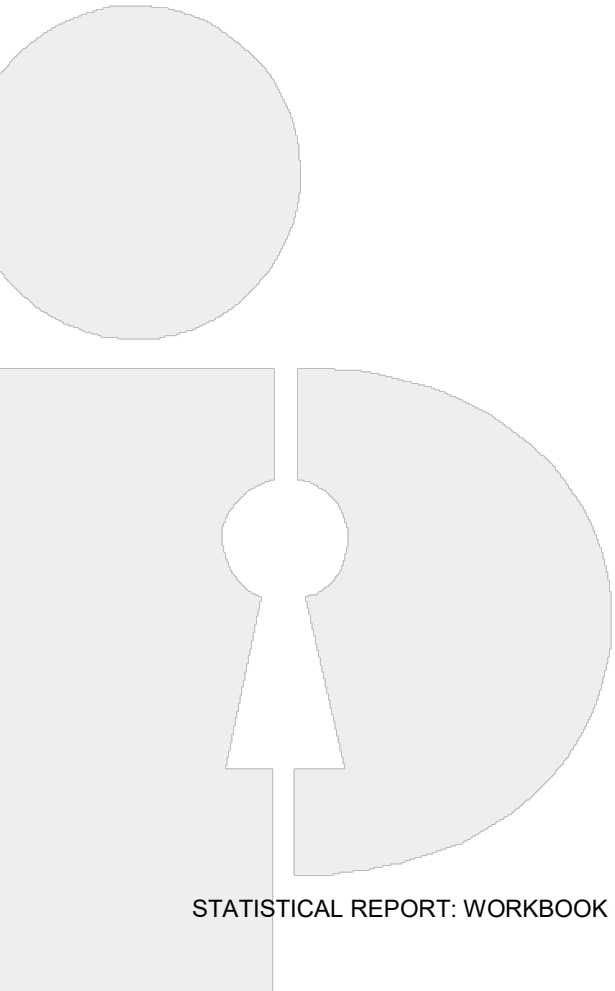
5.3 Of the total on line 5.1 indicate the number of privacy breaches where:

Count each incident only once – the total on line 5.3.6 must equal line 5.1.

5.3.1	one individual was affected	
5.3.2	2 to 10 individuals were affected	
5.3.3	11 to 50 individuals were affected	**1**
5.3.4	51 to 100 individuals were affected	

5.3.5	over 100 individuals were affected	
5.3.6	TOTAL INCIDENTS (5.3.1 to 5.3.5 = 5.3.6) Box 5.3.6 must equal Box 5.1	1

Enter the numbers in the table above into boxes 5.3.1 through 5.3.6 of the online questionnaire.



SECTION 6: Disclosed Without Authority

6.1 What was the total number of privacy breach incidents where personal health information **was disclosed without authority**?

9

Enter this number into box 6.1 of the online questionnaire.

6.2 Of this total indicate the number of privacy breaches where:

Count each incident only once – the total on line 6.2.4 must equal line 6.1.

6.2.1	unauthorized disclosure was through misdirected faxes	
6.2.2	unauthorized disclosure was through misdirected emails	4
6.2.3	unauthorized disclosure was through other means	5
6.2.4	TOTAL INCIDENTS (6.2.1 + 6.2.2 + 6.2.3 = 6.2.4) Box 6.2.4 must equal Box 6.1	9

Enter the numbers in the table above into boxes 6.2.1 through 6.2.4 of the online questionnaire.

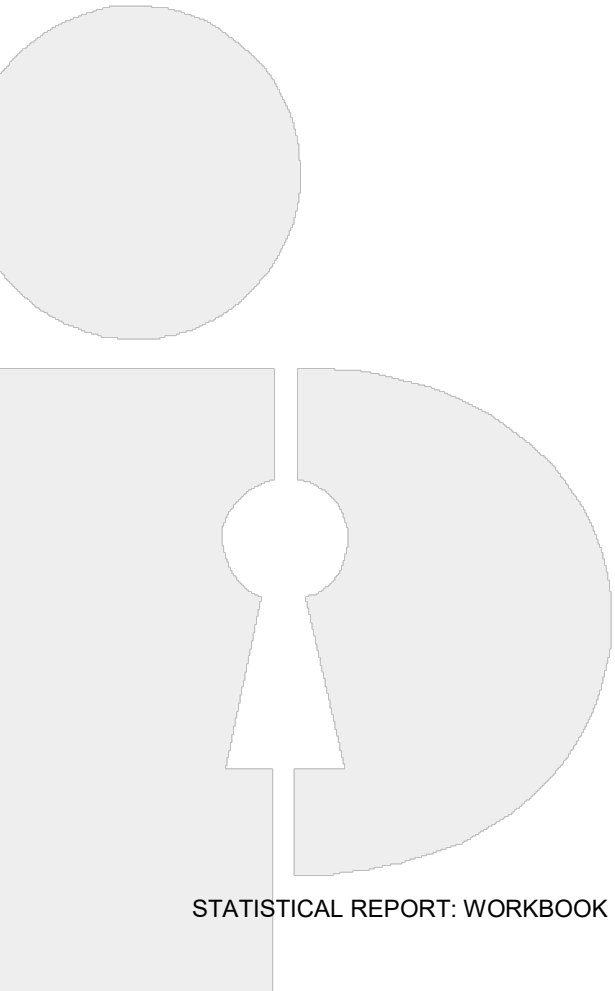
6.3 Of the total on line 6.1 indicate the number of privacy breaches where:

Count each incident only once – the total on line 6.3.6 must equal line 6.1.

6.3.1	one individual was affected	8
6.3.2	2 to 10 individuals were affected	
6.3.3	11 to 50 individuals were affected	
6.3.4	51 to 100 individuals were affected	1

6.3.5	over 100 individuals were affected	
6.3.6	TOTAL INCIDENTS (6.3.1 to 6.3.5 = 6.3.6) Box 6.3.6 must equal Box 6.1	9

Enter the numbers in the table above into boxes 6.3.1 through 6.3.6 of the online questionnaire.



SECTION 7: Collected Without Authority by means of the EHR

7.1 What was the total number of privacy breach incidents where personal health information was **collected by the custodian by means of the EHR without authority**?

Enter this number into box 7.1 of the online questionnaire.

7.2 Of this total indicate the number of privacy breaches where:

Count each incident only once – the total on line 7.2.6 must equal line 7.1.

7.2.1	One individual was affected	
7.2.2	2 to 10 individuals were affected	
7.2.3	11 to 50 individuals were affected	
7.2.4	51 to 100 individuals were affected	
7.2.5	Over 100 individuals were affected	
7.2.6	TOTAL INCIDENTS (7.2.1 to 7.2.5 = 7.2.6) Box 7.2.6 must equal Box 7.1	0

Enter the numbers in the table above into boxes 7.2.1 through 7.2.6 of the online questionnaire.

Completing and Submitting Your Questionnaire

This workbook and guide is for your use in completing your statistical report and should not be faxed or mailed to the Information and Privacy Commissioner in lieu of online submission. **Faxed or mailed copies of this workbook and guide will NOT be accepted.** Please submit your statistical report through the online questionnaire at: https://statistics.ipc.on.ca

Health Information Custodians

Health information custodians are required to submit an annual statistical report on health privacy breaches to the IPC using the Online Statistical Reporting System at https://statistics.ipc.on.ca. You will need a login id, with which you will set a password. Please request them via an email to statistics.ipc@ipc.on.ca and include the following:

- the name of your health information custodian
- the name and e-mail address of the person responsible for the content of the report (the management contact)
- the name, e-mail address, telephone and fax numbers and the mailing address of the person responsible for completing the report (the primary contact**)**
- your language preference (English or Français)

Health Information Custodians Reporting as Institutions under *FIPPA*/*MFIPPA*

As a Health Information Custodian who has also been reporting as an institution under *FIPPA/MFIPPA*, you should already have a login ID for the Online Statistical Reporting System.

If you have lost or forgotten it, you may request it via an email to statistics.ipc@ipc.on.ca indicating your institution name. If you have lost your password, you can reset it on the log-in page.

You have three different options for login and password:

- a single login id and password to submit all of your reports (for *FIPPA*/*MFIPPA* report, *PHIPA* access report and your *PHIPA* privacy breach statistics report).

  Having a single login id and password is convenient if the same person will be submitting all three reports;

- one login id and password for *FIPPA*/*MFIPPA* and a second login id and password for the two *PHIPA* reports;
- separate logins and passwords for each of the three reports.

The option you choose all depends on your organizational structure. Please indicate whether you want a single login id set or two or three separate ones.

Once you have your login id and have completed this workbook, log on to the Online Statistical Reporting System at https://statistics.ipc.on.ca and enter your questionnaire data section by section. You may log off the system at any time and it will remember where you left off when you log on the next time. This means you do not have to complete and submit your questionnaire all in one session as long as you do complete and submit it before the deadline date. **The Online Statistical Reporting System will not be available after the deadline date**.

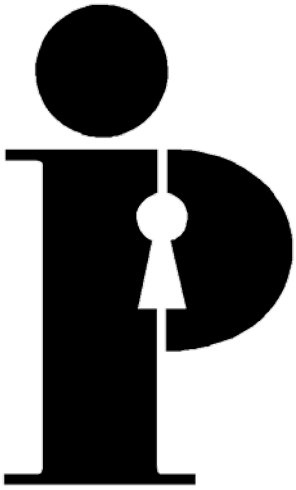
When you have completed entering your questionnaire, the system allows you to review your answers and make any necessary corrections before confirming and submitting your questionnaire. Once you have confirmed and submitted your questionnaire you are done, but should you discover that a correction is necessary after you have confirmed and submitted your questionnaire, you may log on to the Online Statistical Reporting System at any time before the deadline date and make the correction as needed. You will need to re-confirm your questionnaire and submit it again in order for the correction to be applied.

Changes to the type of questionnaire submitted may be made in the same manner. If, for example, you originally submitted a questionnaire stating that you had experienced no personal health information privacy breaches (a “zero report”), but then discovered that you indeed had experienced one or more such breaches, you may log on to the Online Statistical Reporting System at any time before the deadline date and simply change the questionnaire type selection on line 1.3 of Section 1. The system will take care of the rest and will take you to the appropriate sections of the questionnaire so you may complete them. Again, you will need to re-confirm your completed questionnaire and submit it again in order for the correction to be applied.

If you have specific questions that are not answered by this workbook and guide, please read our frequently asked questions, email **statistics.ipc@ipc.on.ca** or call the Information and Privacy Commissioner of Ontario’s main switchboard **416-326-3333**. If you are calling long distance, use our toll-free line: **1-800-387-0073**.

PHIPA

DRAFT FOR DISCUSSION PURPOSES



Statistical Report for the Information and Privacy Commissioner of Ontario on

Personal Health Information Access Requests

WORKBOOK AND COMPLETION GUIDE

Introduction

Use this workbook and guide as a "how to" tool to complete the statistical report for the Information and Privacy Commissioner of Ontario about requests made under the *Personal Health Information Protection Act, 2004* (*PHIPA*). We encourage you to use it to help you complete and submit your questionnaire online, especially if you are unfamiliar with the reporting process.

For your convenience:

- this workbook and guide is laid out in the same manner as the online questionnaire (section by section)
- some sections which will appear in *italicized text* have been expanded to contain background information which may be helpful to you
- the **bold** text is defined in the glossary at the back of this guide
- the reconciliation chart is designed to help verify the figures in the questionnaire.

If there are any questions that have not been answered by this guide, there are two ways to receive additional information from the Information and Privacy Commissioner of Ontario:

- e-mail statistics.ipc@ipc.on.ca
- call our main switchboard: Local calls 416 326-3333, long distance, use our toll-free line: 1-800-387-0073

The questionnaire only includes access or correction requests made by an individual (or by the individual's substitute decision-maker) for their own personal health information. DO NOT include disclosures of personal health information to any other party, including health information custodians, even if the individual requested the disclosures. If no requests for access to personal health information or requests for correction of personal health information were received under this act, the health information custodian must still complete and submit Section 1 and 2.

This workbook and guide is for your use in completing your questionnaire and should **not** be faxed or mailed to the Information and Privacy Commissioner in lieu of online submission. Faxed or mailed copies of this workbook and guide will NOT be accepted. Please submit your questionnaire online at: https://statistics.ipc.on.ca

SECTION 1: Identification

1.1 Please clearly indicate the name of the institution, name of the contact person responsible for *PHIPA*, phone/fax numbers, mailing and e-mail addresses, name of the person to contact with any questions about the content of the report.

1.2 Please indicate the type of municipal or provincial institution that the **health information custodian** is either an agent of or is a part of (e.g. if the health information custodian is an ambulance service and is part of a municipality, the check mark would be placed in the box for municipal corporation). If the appropriate municipal type is not listed, check "other" and specify.

1.3 Please indicate the type of health information custodian that is reporting. Submit separate reports for each type of health information custodian.

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

Enter this number into box 2.1 of the online questionnaire.

	If your institution or **health information custodian received or completed no formal written requests for access or correction of personal health information** from individuals (or from the individuals' substitute decision makers), PLEASE STOP HERE AND SUBMIT ONLY SECTIONS 1 AND 2 OF THE REPORT.
X	If your institution or **health information custodian** received or completed formal written requests for access to personal health information from an individual (or from their substitute decision maker), PLEASE CONTINUE TO SECTION 3.
	If your institution or **health information custodian** did not receive or complete any requests from individuals (or by the individuals' substitute decision makers) for access to their own **personal health information** but did receive (or carried forward from last year) or complete at least one request for correction of **personal health information**, PLEASE COMPLETE AND SUBMIT SECTION 9.

SECTION 3: Number of Requests

How Are Requests Counted?

The following will assist you to determine how and when to count a ***personal health information*** *request as being received.*

- *Any* ***personal health information*** *access request is counted as one request regardless of the number of records involved because it is about only one subject – "the person asking for the information."*

- *COUNT ONLY written requests made by individuals (or by the individuals' substitute decision makers) for their own personal health information.*

- *If you receive a request that requires clarification, DO NOT COUNT this as a request received until the requester provides you with all the information you need to complete the request.*

- *DO NOT COUNT a request to correct personal health information in this section (see section 9).*

3.1 - Enter the number of written requests made by individuals (or by the individual's substitute decision-makers) for access to their own personal health information that were received during the reporting year (January to December). | 5 |

Enter this number into box 3.1 of the online questionnaire.

-

SECTION 4: Time to Completion

4.1–4.3 Enter the number of completed **personal health information** requests in the appropriate categories.

PLEASE NOTE:

*The response time to a requester may be extended to review and locate **records** and for consultation as described in subsection 54(3).*

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

4.1	1-30 days	5
4.2	Over 30 days with an extension	
4.3	Over 30 days without an extension	
4.4	TOTAL REQUESTS COMPLETED (4.1 to 4.3 = 4.4)	5

Enter the numbers in the table above into boxes 4.1 through 4.4 of the online questionnaire.

SECTION 5: Compliance with the *PHIPA*

The *PHIPA states that requests for access to **personal health information** should be completed within 30 days. In cases where there is a need to review or search numerous **records** or to conduct consultations, a **health information custodian** can extend the 30-day time limit for no more than an additional 30 days and remain in compliance with the PHIPA. This can be achieved by issuing a **Notice of Extension** (subsection 54(4)).*

*This section has been broken down into three different sections. Sections A and B are mutually exclusive and will be used to determine the number of requests that are in compliance or not in compliance with the statutory timelines under PHIPA. Section D deals with **expedited access requests** that are already included in Sections A and B.*

A. Notice of Extension Not Issued

5.1	Enter the number of requests completed within 30 days where no **Notice of Extension** was issued.	5
5.2	Enter the number of requests completed beyond the 30 days where no **Notice of Extension** was issued.	0
5.3	Add boxes 5.1 and 5.2 to determine the total number of completed requests where no **Notice of Extension** was issued.	5

Enter the numbers in the table above into boxes 5.1 through 5.3 of the online questionnaire.

B. Notice of Extension (subsection 54(4)) Issued

5.4	Enter the number of requests completed within the time limit stipulated in the **Notice of Extension**.	0
5.5	Enter the number of requests completed that exceeded the permitted time limit stipulated in the **Notice of Extension**.	0
5.6	Add boxes 5.4 and 5.5 to determine the total number of completed requests where a **Notice of Extension** was issued.	0

Enter the numbers in the table above into boxes 5.4 through 5.6 of the online questionnaire.

C. Total Requests Completed (sections A and B)

5.7	Enter the overall total number of requests completed for the year by adding the totals from sections A and B (boxes 5.3 + 5.6 = 5.7). This total must equal the total number of requests shown in box 4.4.	5

Enter this number into box 5.7 of the online questionnaire.

D. Expedited Access requests (subsection 54(5))

5.8	Enter the 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	Enter the 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	Add boxes 5.8 and 5.9 to determine the total number of completed requests for expedited access.	0

Enter the numbers in the table above into boxes 5.8 through 5.10 of the online questionnaire.

SECTION 5(a): Contributing Factors

This section provides an opportunity for you to explain why the 30-day time line to complete requests could not be met. As well, it requests details on how to improve on the response rate in order to be compliant with the PHIPA.

Please outline any factors that may have caused you to not meet 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.

Enter the factors above into Section 5a of the online questionnaire.

SECTION 6: Disposition of Requests

*This section requests information about how each **personal health information** access request was handled.*

6.1 Enter the number of requests that resulted in full access to personal health information requested.

*6.2 Enter the number of requests where the **health information custodian** provided partial access to the requested information because **provisions** of PHIPA were used to deny access.*

*6.3 Enter the number of requests where the **health information custodian** provided partial access to the requested information because some of the records of personal health information do not exist or cannot be found.*

*6.4 Enter the number of requests where requested information was partially accessed because parts of the **record** exist outside of the PHIPA.*

*6.5 Enter the number of requests where no information was accessed and the **provisions** of PHIPA which were used to deny access.*

*6.6 Enter the number of requests where no information was accessed, because no **record** exists or none can be found.*

*6.7 Enter the number of requests where no information was accessed because the **record** is outside of the PHIPA.*

6.8 Enter the number of requests that were unfulfilled because they were withdrawn or abandoned by the requester.

6.9 Enter the number of requests from box 6.8 that were withdrawn or abandoned after a fee estimate was sent out.

6.10 Add the number of requests from boxes 6.1 to 6.8 to determine the disposition for the total number of requests. Do not include box 6.9 data in the total. This number should be greater than or equal to the total number of completed requests shown in box 4.4.

6.11 Add the number of requests in boxes 6.2 and 6.5 to determine the total number of requests where access to information was denied in whole or in part. This number should be less than or equal to box 7.12.

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

6.1	Full access provided	5
6.2	Partial access provided: provisions applied to deny access	
6.3	Partial access provided: no record exists or cannot be found	
6.4	Partial access provided: record outside of *PHIPA*	
6.5	No access provided: provisions applied to deny access	
6.6	No access provided: no record exists or cannot be found	
6.7	No access provided: record outside of *PHIPA*	
6.8	Other completed requests, e.g. withdrawn or never proceeded with	
6.9	Number of requests from box 6.8 that were not pursued following a fee estimate	
6.10	TOTAL REQUESTS (EXCLUDING 6.9) (6.1 to 6.8 = 6.10) Box 6.10 must be greater than or equal to Box 4.4	5
6.11	TOTAL REQUESTS denied access in whole or part where a provision of PHIPA was applied (6.2 + 6.5 = 6.11) Box 6.11 must be less than or equal to Box 7.12	0

Enter the numbers in the table above into boxes 6.1 through 6.11 of the online questionnaire.

SECTION 7: REASONS APPLIED TO DENY ACCESS

*Box 6.11 of the previous section (Total Requests Denied Access in Whole or in Part) shows the total number of requests for which access to part or all of the requested information was denied based on **provisions** in PHIPA. In this section, you must apply one or more **provisions** to each request. The total must be greater than or equal to Box 6.11.*

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.)

7.1	Section 51(1)(a) – Quality of Care Information	
7.2	Section 51(1)(b) – Quality Assurance Program (Regulated Health Professions Act, 1991)	
7.3	Section 51(1)(c) – Raw Data from Psychological Tests	
7.4	Section 51(d) – Prescribed Research or Laboratory Information	
7.5	Section 52(1)(a) – Legal Privilege	
7.6	Section 52(1)(b) – Other Acts or Court Order	
7.7	Section 52(1)(c) – Proceedings that have not been concluded	
7.8	Section 52(1)(d) – Inspection, Investigation or Similar Procedure	
7.9	Section 52(1)(e) – Risk of Harm to or Identification of an Individual	
7.10	Section 52(1)(f) – MFIPPA subsections 38(a) or (c) or FIPPA subsections 49 (a),(c) or (e) apply	
7.11	Section 54(6) – Frivolous or Vexatious	
7.12	TOTAL (7.1 to 7.11) (must be greater than or equal to Box 6.11)	0

Enter the numbers in the table above into boxes 7.1 through 7.12 of the online questionnaire.

SECTION 8: Fees

*This section concerns **fees** charged for access to **personal health information**.*

8.1	Number of requests for access to records of **personal health information** where **fees** were collected	0

*A **health information custodian** may waive all or part of a fee being charged if the custodian feels it is fair and equitable to do so.*

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** (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

Enter the numbers in the table above into boxes 8.1 through 8.6 of the online questionnaire.

SECTION 9: Corrections and Statement of Disagreement

*If an individual believes that his or her record of personal health information held by a **health information custodian** is inaccurate or incomplete with respect to the purposes for which the **health information custodian** uses the information, he or she has a right to:*

- *request that the **health information custodian** correct the **personal health information**;*
- *receive a written notice from the custodian to grant or refuse the request;*
- *request a written notice of the requested correction, to the extent reasonably possible, be sent to those to whom the custodian disclosed the information, except if it will have no effect on the provision of health care or other benefits to the individual; and*
- *require the **health information custodian** to attach a **statement of disagreement** to the information if the requested correction was not made and to disclose the statement of disagreement whenever the **health information custodian** discloses the information in issue.*

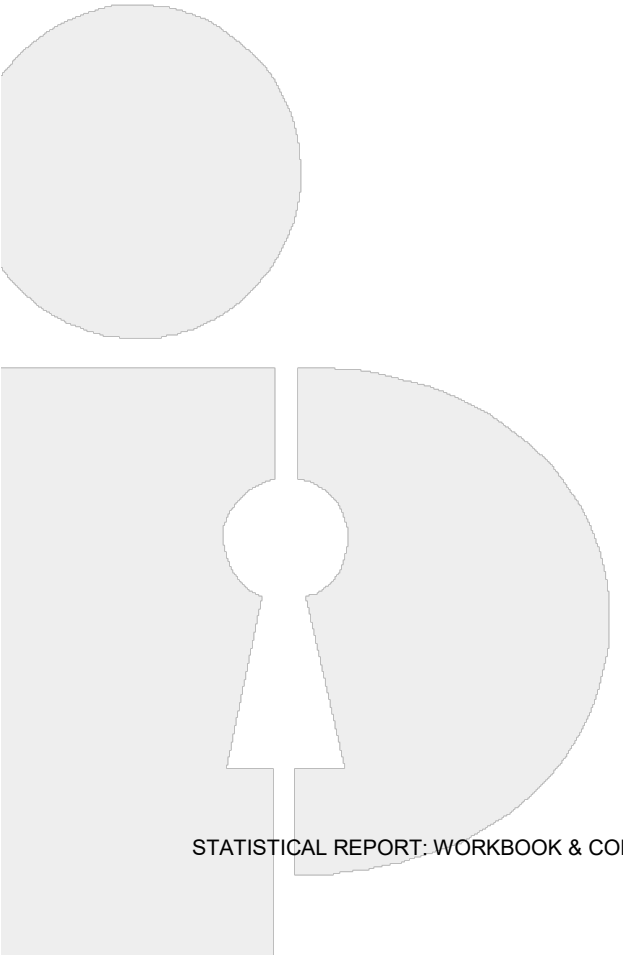
9.1	Enter the number of new correction requests received for the **reporting year**.	0

What course of action was taken when the requests for correction were received?

9.2	Enter the number of corrections that were made in their entirety.	
9.3	Enter the number of corrections partially made.	
9.4	Enter the number of correction requests that were refused.	
9.5	Enter the number of correction requests that were withdrawn by the requester before completion.	
9.6	Add boxes 9.2 to 9.5 to determine the total number of correction requests made for the **reporting year**. This total should be equal to the amount shown in box 9.1.	0

9.7	Enter the number of correction requests that were made in part (box 9.3) or denied in full (box 9.4) where **statements of disagreement** were attached to the **personal health information record**.	0
9.8	Enter the number of notices of correction or statements of disagreements that were sent to a third party	0

Enter the numbers in the table above into boxes 9.2 through 9.8 of the online questionnaire.



Completing and Submitting Your Questionnaire

This workbook and guide is for your use in completing your report and should not be faxed or mailed to the Information and Privacy Commissioner in lieu of online submission. **Faxed or mailed copies of this workbook and guide will NOT be accepted.** Please submit your report online using the IPC's Online Statistics Submission Website.

Your institution should have a login ID and password for the Online Statistics Submission Website. If you have lost or forgotten your ID or password, visit https://statistics.ipc.on.ca/ and click on the "Forgot your password or login ID?" link.

New Institutions

If your institution has recently come under the jurisdiction of the *Freedom of Information and Protection of Privacy Act* (*FIPPA*) or the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*, AND you are also a **Health Information Custodian** as defined in Section 3 of *PHIPA*, you are required to submit a statistical report annually to the IPC using the using the Online Statistics Submission Website for which you will need a login ID and a password. If this is your first time submitting an annual report to the IPC, visit our Registration for Statistical Reporting page to set up an account and get a login ID and a password. You will need to include:

- the name of your institution
- the name and e-mail address of the head of the institution (for *FIPPA/MFIPPA* only)
- the name and e-mail address of the person responsible for the content of the report (the management contact)
- the name, e-mail address, telephone and fax numbers and the mailing address of the person responsible for completing the report (the primary contact**)**
- your language preference (English or Français)

As a **Health Information Custodian**, you have the option of a single login id and password to submit both your *FIPPA*/*MFIPPA* report and your *PHIPA* report (which is convenient if the same person will be submitting both reports) or you may wish to have one login id and password for *FIPPA*/*MFIPPA* and another for *PHIPA* (which makes it easier if two different people will submit the reports) – it all depends on your organizational structure.

Once you have your login id and password and have completed this workbook, log on to the Online Statistics Submission Website at https://statistics.ipc.on.ca and enter your questionnaire data section by section. You may log off the system at any time and it will remember where you left off when you log on the next time. This means you do not have to complete and submit your questionnaire all in one session as long as you do complete and submit it before the deadline date **The Online Statistics Submission Website will not be available after the deadline date**.

When you have completed entering your questionnaire, the system allows you to review your answers and make any necessary corrections before confirming and submitting your questionnaire. Once you have confirmed and submitted your questionnaire you are done, but should you discover that a correction is necessary after you have confirmed and submitted your questionnaire, you may log on to the Online Statistics Submission Website at any time before the deadline date and make the correction as needed. You will need to re- confirm your questionnaire and submit it again in order for the correction to be applied.

Changes to the type of questionnaire submitted may be made in the same manner. If, for example, you originally submitted a questionnaire stating that you had received no requests for access to **personal health information** (a “zero report”), but then discovered that you indeed had received one or more such requests, you may log on to the Online Statistics Submission Website at any time before the deadline date and simply change the questionnaire type selection at the end of Section 2. The system will take care of the rest and will take you to the appropriate sections of the questionnaire so you may complete them. Again, you will need to re-confirm your completed questionnaire and submit it again in order for the correction to be applied.

If you have specific questions that are not answered by this workbook and guide, please email **statistics.ipc@ipc.on.ca** or call the Information and Privacy Commissioner of Ontario’s main switchboard **416-326-3333**. If you are calling long distance, use our toll free line: **1-800-387-0073**.

Glossary of Terms

Fee(s), Waived - A head may waive all or part of a fee if the custodian feels it is fair and equitable to do so.

Health Information Custodian - Any person or organization described in subsection (reporting context only) 3(1) of *PHIPA* or any group of entities that has been permitted to act as a single health information custodian pursuant to a Minister's order under subsection 3(8).

Notice of Extension - A health information custodian or head may extend the time to complete a request by a maximum of an additional 30 days. This is only permissible if meeting the initial 30 day timeline would interfere with the operations of the custodian (e.g. due to numerous pieces of information or information that requires a lengthy search to locate) or if consultations would require more time to complete. The notice must include:

- the length of the extension; and
- the reason for the extension.

Personal Health Information - Personal health information means identifying information about an individual in oral or recorded form, if the information,

- relates to the physical or mental health or provision of health care to the individual;
- is a plan of service within the meaning of the *Long-term Care Act* for the individual;
- relates to payments or eligibility for health care of the individual;
- relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part of bodily substance;
- is the individual's health number;
- identifies an individual's substitute decision-maker.

Personal health information also includes a mixed record that contains identifiable personal information that is not personal health information, but is contained in a record that contains personal health information. However, it excludes employee records held by a custodian that are not primarily used for health care.

Provision to deny access (Exclusions, Exemptions) - These are specific sections in *PHIPA* that provide the grounds on which the health information custodian or head may deny access to information.

Provision to deny access (Frivolous or Vexatious or made in bad faith) **-** A custodian may refuse to grant access or make a correction to a record if believed to be on reasonable grounds that the request was for frivolous or vexatious reasons or made in bad faith.

Record(s) - A record means a record of information in any form or in any medium, whether in written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record

Reporting Year - January to December.

Request, Access - Access requests occur only when access requests are made by individuals (or by the individuals' substitute decision-makers) for their own personal health information. DO NOT include disclosures for personal health information to any other party, including other health information custodians, even if the individual requested these disclosures.

Request, Completed - A request is considered to be complete once a decision letter has been sent to the individual in response to a personal health information access request.

Request, Correction - A request to have one's own personal health information corrected.

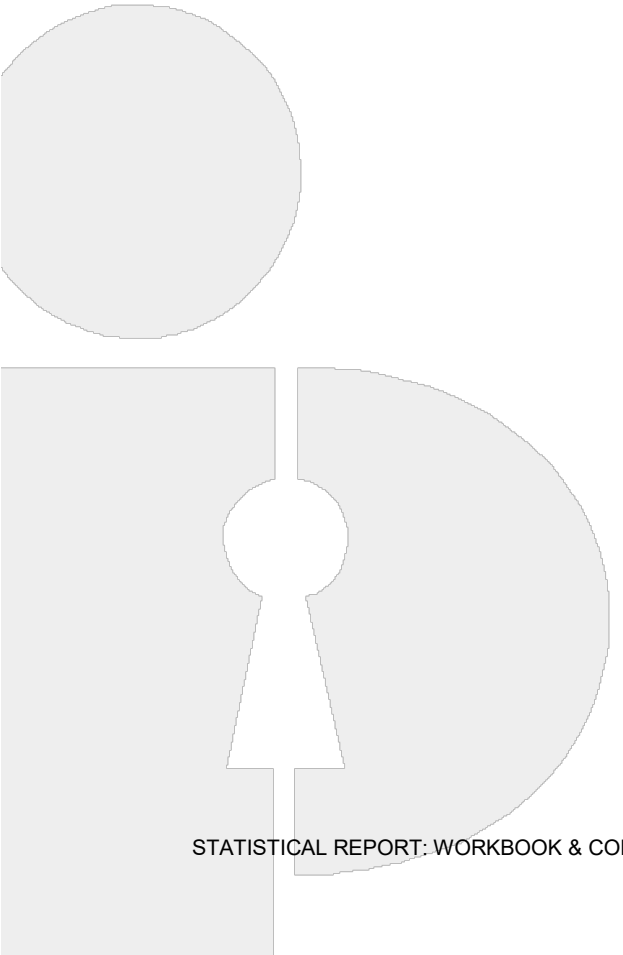
Request, Disposition - The end result of a completed access request (e.g. personal health information was disclosed, denied, or the request was withdrawn or never accessed)

Request, Expedited Access - When the individual requests that a health information custodian provide a response within a time period specified by the requester under subsection 54(5).

Statement of Disagreement - A precise statement of disagreement prepared by the individual that sets out the correction the health information custodian has refused to make

Written Public Statement - A written statement, made available to the public, that:

- provides a description of the custodian's information practices;
- describes how to contact the contact person or custodian;
- describes how an individual may access or request correction of a record of personal health information;
- describes how to make a complaint to the custodian and the IPC.



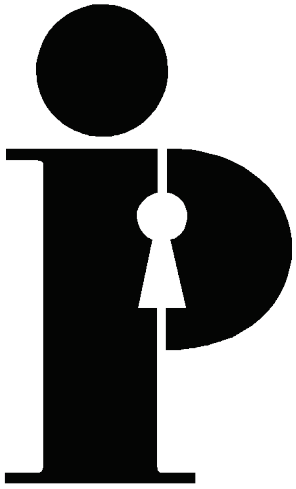
Reconciliation Chart

The chart below should be used to help verify your figures in completing this workbook and entering your questionnaire on the Online Statistics Submission Website.

Box Number	Criteria *	Box = Number(s)
4.4	=	4.1 to 4.3
5.3	=	5.1 +5.2
5.6	=	5.4 + 5.5
5.7	=	5.3 + 5.6
5.7	=	4.4
5.10	=	5.8 + 5.9
6.10	=	6.1 to 6.8
6.10	= or >	4.4
6.11	=	6.2 + 6.5
6.11	= or <	7.12
7.12	=	7.1 to 7.11
8.4	=	8.2 + 8.3
9.6	=	9.2 to 9.5
9.6	=	9.1

* = equal to
> greater than
< less than

DRAFT FOR DISCUSSION PURPOSES



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

WORKBOOK AND COMPLETION GUIDE

General Information

This workbook and guide is designed to provide step-by-step instructions for the completion of the Information and Privacy Commissioner's (IPC) Year-End Statistical Report as required by the *Municipal Freedom of Information and Protection of Privacy Act* (*MFIPPA or,* the *Act*). We encourage you to use it to help you complete and submit your questionnaire online, especially if you are unfamiliar with it.

For your convenience:

- This workbook and guide is organized into sections corresponding to those in the online questionnaire. For help with a certain section in the questionnaire, turn to the same section in this workbook.
- Certain sections which appear in *italicized text* have been expanded to contain background information that may be helpful to you.
- All terms which appear in **bold** are defined in the **Glossary** at the back of this guide.
- The Reconciliation Chart is designed to help verify the figures in the questionnaire.

If you have specific questions that are not answered by this workbook and guide, please email **statistics.ipc@ipc.on.ca** or call the Information and Privacy Commissioner of Ontario's main switchboard **416-326-3333**. If you are calling long distance, use our toll free line: **1-800-387-0073**.

Please note incomplete questionnaires may result in your institution's submission being **partly or entirely excluded** from the statistics generated for the IPC's annual report.

All institutions must complete a questionnaire and submit it online to the Information and Privacy Commission. If no requests for access to information or requests for correction of personal information were received, your institution must still complete and submit Sections 1 and 2.

This workbook and guide is for your use in completing your questionnaire and should not be faxed or mailed to the Information and Privacy Commission in lieu of online submission. **Faxed or mailed copies of this workbook and guide will NOT be accepted.** Please submit your questionnaire online to the IPC's Online Statistics Submission Website at: https://statistics.ipc.on.ca/.

Institutions that do not submit a questionnaire before the deadline will be listed as such in the Information and Privacy Commissioner's Annual Report.

Thank you for your co-operation!

Section 1: Identification

1.1 Please clearly indicate the name of the institution, the name and e-mail address of the head of the institution, the name and e-mail address of the person responsible for the content of the report (the management contact), and the name, e-mail address, telephone and fax numbers and the mailing address of the person responsible for completing the report (the primary contact) should any questions arise regarding the content of the report.

1.2 Please identify the type of institution you are reporting for by checking one of the boxes provided. If the type of institution you are reporting for does not appear on the list, check *other* and specify.

Here are some examples of common types of institutions:

Corporations

The City of Kingston
The City of Oshawa
Township of Norwich
The City of Pickering
The County of Brant
The Regional Municipality of Niagara
The Town of Ingersoll
The Restructured County of Oxford
The Village of Sundridge

Commissions

Belleville Transit Commission
London Transit Commission
Oshawa Transit Commission
Niagara Transit

Boards

Athens Public Library Board
Durham District School Board
Wabigoon Local Services Board
Killaloe and District Public Library
Perth Police Services Board

Section 2: Inconsistent Use of Personal Information

What is an Inconsistent Use?

*An **inconsistent use** occurs when **personal information** from a **personal information bank** is used or disclosed differently from the way it is used on a regular basis (see S.35 of the Act). The Act requires the institution to attach a record or notice of the **inconsistent use** or disclosure to the **personal information** involved. This record then becomes part of the **personal information** it is attached to.*

2.1 Please enter the number of times your institution made **inconsistent use** of **personal information** contained in its **personal information banks**. 0

What is Personal Information?

***Personal information** is recorded information about an identifiable individual including:*

- *the individual's address, telephone number, fingerprints or blood type;*
- *information about the individual's race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital or family status;*
- *information about the individual's educational, medical, psychological, criminal, or employment history or information concerning his or her financial transactions;*
- *any identifying number, symbol or other particular assigned to the individual;*
- *the individual's personal opinions or views except when they relate to someone else;*
- *private or confidential correspondence sent to an institution by the individual, and replies to that correspondence that would reveal the contents of the original correspondence;*
- *the views or opinions of someone else about the individual; and*
- *the individual's name when it appears with other **personal information** about that individual or when disclosure of the name would reveal other **personal information** about that individual.*

Check one:

☐	If your institution received **no requests for access** to information **or correction** of personal information please stop here and click the SAVE AND CONTINUE button at the bottom of the page to proceed to the REVIEW QUESTIONNAIRE page where you may review your questionnaire answers before you submit your report. You may make any necessary changes and/or corrections on this page then click the SAVE & CONTINUE button to update your questionnaire and proceed to the confirmation and submission page. Changes and corrections may be made any time before or after submission up to the deadline date, but must be re-confirmed and re-submitted.
☒	If your institution received (or carried forward from last year) **at least one request for access** to information, please complete the rest of the report. Click the SAVE AND CONTINUE button at the bottom of the page to proceed to the next section.
☐	If your institution only received **at least one request for correction** of personal information without any requests for access to information, please complete sections 1 ,2, and 11. Click the SAVE AND CONTINUE button at the bottom of the page to proceed to the Section 11.

Section 3: Number of Requests Completed

Please Note: *There are two types of information requests, and these need to be entered separately:*

- ***personal information*** *requests, where the requester, or authorized representative, is asking for information about himself or herself.*
- ***general records*** *requests, where the requester is asking for general information or information that includes* ***personal information*** *about someone else.*

How Are Requests Counted?

The information in this section is important to help you decide how many requests for information your institution received, since the form or letter the requester sends may actually contain a number of separate requests:

- *for* ***general records*** *requests, if the request deals entirely with one subject, it should be counted as one request. This is still the case even if the information is retrieved from different locations in your institution; or*
- *if a* ***general records*** *request deals with information about two (or more) subjects, the request should be divided into two (or more) requests; or*
- *any* ***personal information*** *request is counted as one request because it is about only one subject,* ***the person asking for the information; or***
- *if you receive a request that must be returned to the sender for clarification, do not count this as a request received until the requester returns it to you with all the information you need to* ***complete*** *the request.*

3.1 *Enter the number of new* ***personal information*** *and* ***general records*** *requests received during the* ***reporting year*** *(January – December). This includes those requests that have been received directly by your institution and those that have been transferred in from other institutions to your institution to complete, regardless of whether or not one or more of those requests is later transferred out to another institution. On the next page is a template that you may want to use to determine the number of new requests.*

	Personal Information	General Records
New requests received directly from the requester during the **reporting year**.	0	13
Indicate the number of **personal information** and **general records** requests that were transferred to you from other institutions to be **completed** by your institution.	0	0
TOTAL NEW REQUESTS (Add the above two boxes) (reflect these totals in Box 3.1 of the statistical report)	0	13

3.2 *Enter the total number of **personal information** and **general records** requests that have been completed between January 1 to December 31 of the reporting year.*

To determine the total number of requests completed:

Add the following number of requests for personal information and general records separately:

- *new requests received during reporting year (see section 3.1 of the statistical report) and requests that were carried forward from the previous year to the current year to complete*

*Subtract the following **personal information** and **general records** requests from the above:*

- *requests transferred out to other institutions to complete; and*
- *requests carried over to the next year to complete*

*The total sum of the above calculation will result in the total numbers of **personal information** and **general records** requests that were completed for the reporting year.*

*On the next page is a worksheet to be used as a tool to determine the total number of requests for the **reporting year**.*

	Personal Information	General Records
Total new requests (copy from box 3.1).	0	13
Requests carried forward from previous year. (Enter the number of **personal information** and **general records** requests that your institution could not **complete** in the previous **reporting year**, January-December, and **carried forward** to be **completed** in the current reporting year.)	0	1
TOTAL (add the above two boxes)	**A** 0	**A** 14
Requests transferred out to other institutions to complete. (Enter the number of **personal information** and **general records** requests that were **transferred** to another institution because that institution had control or custody of the information, or a greater interest in the information.)	0	0
Requests carried over to the next year to complete. (Enter the number of **personal information** and **general records** requests your institution received that were **carried over** to the next reporting year.)	0	0
TOTAL (add the above two boxes)	**B** 0	**B** 0
TOTAL REQUESTS COMPLETED (subtract B from A) (reflect these totals in Box 3.2 of the statistical report)	0	14

Section 4: Source of Requests

4.1-4.8 Enter the number of **personal information** and **general records** requests you completed from the sources listed.

PLEASE NOTE:

Use the Individual/Public *category to capture requests made by an individual themselves and use the* Individual by Agent *category to capture requests made on behalf of individuals by a third party, such as a substitute decision-maker, lawyer, insurance adjuster, etc. If the request comes from an employee of your institution, enter the request in the* Individual/Public *category if they are requesting the information themselves or the* Individual by Agent *category if the request is being made on their behalf by a third party, such as a substitute decision-maker, lawyer, insurance adjuster, etc.*

		Personal Information	General Records
4.1	Individual/Public	0	3
4.2	Individual by Agent	0	4
4.3	Business	0	0
4.4	Academic/Researcher	0	0
4.5	Association/Group	0	0
4.6	Media	0	7
4.7	Government (All Levels)	0	0
4.8	Other		
4.9	Add all the requests you have entered for both **personal information** and **general records** and write the totals in Box 4.9. These totals should be the same as those in Box 3.2 (**Total Requests Completed**).	0	14

Enter the numbers in the table above into boxes 4.1 through 4.9 of the online questionnaire.

Section 5: Time to Completion

5.1-5.4 Enter the number of **completed personal information** and **general records** requests in the appropriate categories. If your institution received a **transferred** request from another institution, the time to **completion** starts when the first institution received the request.

PLEASE NOTE:

1. *When locating and reviewing records, an institution may extend the time to provide a response to the requester under s.20(1). Time extension notices issued under s.20(1) allow you more than the standard 30 days in which to complete a request. If the request is completed (i.e. the access decision is issued) before the time extension period expires, the request is still considered to be compliant even though it took more than 30 days to complete it. This is known as* **extended compliance**. *Please refer to the glossary and Section 6 for more information.*

2. *Section 5 deals with the absolute time to completion for requests, regardless of compliance. For example, if you issued a time extension request under s.20(1) for an additional 90 days (for a total of 120 days) and completed the request in 102 days, then you should count this request in the "91 days or longer" category. It should then be entered as compliant in part B or C in Section 6 below. Refer to Section 6 for more information.*

3. *The time from when a fee estimate/interim decision letter has been issued (s.45, O.Reg 823 s.6, s.6.1 and s.7) up to the time the deposit has been paid is not included when calculating the number of days to complete a request.*

How many requests were completed in:		**Personal Information**	**General Records**
5.1	30 days or less	0	13
5.2	31 – 60 days		
5.3	61 – 90 days		
5.4	91 days or longer	0	1
5.5	Enter the totals of the previous entries (5.1–5.4) into this box. These totals should be equal to the **Total Requests Completed** in Box 3.2.	0	14

Enter the numbers in the table above into boxes 5.1 through 5.5 of the online questionnaire.

Section 6: Compliance with the *Act*

The Act *states that requests for access to information should be completed within 30 days. In cases where there is a need to search numerous records or to make consultations with a person outside the institution, the head of the institution can* ***extend*** *the 30-day time limit and still be in compliance with the* Act*. This can be achieved by issuing a Notice of Extension (s.20(1) and/or Notice to Affected Person (s.21(1)).*

This section has been broken down into four different situations that are mutually exclusive and will be used to determine the number of requests that are in compliance or not in compliance with the statutory time lines under the Act*.*

A. ***No*** *notices issued;*

B. ***Both*** *a Notice of Extension (s.20(1)) and a Notice to Affected Person (s.21(1)) issued;*

C. ***Only*** *a Notice of Extension (s.20(1)) issued; or*

D. ***Only*** *a Notice to Affected Person (s.21(1)) issued.*

PLEASE NOTE:

1. *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 = box 6.13) and (box 6.13* ***must equal*** *box 3.2)*

2. *Requests that require more than the statutory 30 days to complete are considered compliant if you issue a Notice of Extension under s.20(1) and/or a Notice to Affected Person under s.21(1) AND you complete the requests within the time limit specified in the Notice(s). This is known as* **extended compliance***.*

3. *Enter the number of requests in each category as follows:*

    a. *Requests where you issued NEITHER a Notice of Extension under s.20(1) NOR a Notice to Affected Person under s.21(1) should be entered in Part A.*

    b. *Requests where you issued BOTH notices should be entered in Part B (do NOT include the requests entered in Part C and Part D).*

    c. *Requests where you issued a Notice of Extension under s.20(1) ONLY (i.e. not including those requests where a Notice to Affection Person under s.21(1) was also issued) should be entered in Part C.*

    d. *Requests where you issued a Notice to Affected Person under s.21(1) ONLY (i.e. not including those requests where a Notice of Extension under s.20(1) was also issued) should be entered in Part D.*

    The sum of the requests entered in all four parts should equal Box 3.2

4. *The time taken to complete each request with notice(s) issued under s.20(1) and/or s.21(1) should be entered in Section 5 in the appropriate category according to the actual time it took to complete the request, regardless of compliance. See the example for more information.*

***Example** (for simplicity, let's assume we have only general records requests):*

Your institution completed 9 requests for access to information in the current reporting year.

Three (3) of those requests (requests a, b, and c) had neither a Notice of Extension under s.20(1) nor a Notice to Affected Person under s.21(1) issued. Two (requests a and c) were completed within the statutory 30 days and one (request b) was completed in 42 days.

On two (2) requests (requests d and e), you issued both a Notice of Extension under s.20(1) and a Notice to Affected Person under s.21(1):

- *On request d, the Notice of Extension specifies an additional 30 days to complete the request (for a total of 60 days from the date of receipt of the request). In addition, a Notice to Affected Person under s.21(1) was issued 34 days after the request was received (s.28(3)), specifying that the head will decide whether or not to disclose the record within 30 days of the Notice to Affected Person (s.28(4)(c)). The total time allowed for the completion of this request is 64 days. This request was completed in 66 days.*

- *On request e, the Notice of Extension specifies an additional 90 days to complete the request (for a total of 120 days from the date of receipt of the request). In addition, a Notice to Affected Person under s.21(1) was issued 42 days after the request was received (s.28(3)), specifying that the head will decide whether or not to disclose the record within 30 days of the Notice to Affected Person (s.28(4)(c)). The total time allowed for the completion of this request is 120 days. This request was completed in 112 days.*

On two more (2) requests (requests f and g), you issued only a Notice of Extension under s.20(1). You did not issue a Notice to Affected Person under s.21(1):

- *On request f, the Notice of Extension specifies an additional 45 days to complete the request (for a total of 75 days from the date of receipt of the request) and the request was completed in 42 days.*

- *On request g, the Notice of Extension specifies an additional 30 days to complete the request (for a total of 60 days from the date of receipt of the request) and the request was completed in 63 days.*

On two more (2) requests (requests h and i), you issued only a Notice to Affected Person under s.21(1). You did not issue a Notice of Extension under s.20(1)

- *On request h, the Notice to Affected Person was issued 12 days after the receipt of the request (for a total of 42 days from the date of receipt of the request) and the request was completed in 42 days.*

- *On request i, the Notice to Affected Person was issued 8 days after the receipt of the request (for a total of 38 days from the date of receipt of the request) and the request was completed in 40 days.*

***How to complete Section 6 for these requests**:*

- *Requests a, b and c had neither Notice Issued, so they are entered in Part A of Section 6.*
    - *Requests a and c were completed within the statutory 30 days, so they are entered in Box 6.1. They should also be included in the count of requests entered in Box 5.1 (30 days or less) in Section 5*
    - *Request b took 42 days, so it should be entered in Box 6.2. It should also be included in the count of requests entered in Box 5.2 (31 -60 days) in Section 5.*
- *Requests c and d had both Notices issued, so they are entered in Part B of Section 6.*
    - *Request d was allowed 64 days for completion, but took 66 days to complete, therefore it should be entered in Box 6.5. It should also be included in the count of requests entered in Box 5.3 (61-90 days) in Section 5.*
    - *Request e was allowed 120 days for completion, but took 112 days to complete, therefore it should be entered in Box 6.4. It should also be included in the count of requests entered in Box 5.4 (91 days or longer) in Section 5.*
- *Requests f and g had ONLY a Notice of Extension issued under s.20(1). The Notice to Affected Person under s.21(1) was NOT issued. Therefore, requests f and g are entered in Part C of Section 6.*
    - *Request f was allowed 75 days for completion, but took 42 days to complete, therefore it should be entered in Box 6.7. It should also be included in the count of requests entered in Box 5.2 (31-60 days) in Section 5.*
    - *Request g was allowed 60 days for completion, but took 63 days to complete, therefore it should be entered in Box 6.8. It should also be included in the count of requests entered in Box 5.3 (61-90 days) in Section 5.*
- *Requests h and i had ONLY a Notice to Affected Person issued under s.21(1). The Notice of Extension under s.20(1) was NOT issued. Therefore, requests h and i are entered in Part D of Section 6.*
    - *Request h was allowed 42 days for completion and took 42 days to complete, therefore it should be entered in Box 6.10. It should also be included in the count of requests entered in Box 5.2 (31-60 days) in Section 5.*
    - *Request i was allowed 38 days for completion, but took 40 days to complete,*

therefore it should be entered in Box 6.11. It should also be included in the count of requests entered in Box 5.2 (31-60 days) in Section 5.

Calculating Basic and Extended Compliance

Requests a, c, e, f and h are all considered compliant with the Act as each of them were completed within their specified time lines. Since requests a and c were completed within the statutory 30 day time limit, they have **basic compliance.** *Requests e, f and h have time lines extended beyond the 30 day time limit through the issuance of the Notice of Extension under s.20(1) and/or the Notice to Affected Person under s.21(1). Since each of requests e, f and h were completed within their respective stated time limits, they have* **extended compliance.**

The Basic Compliance rate as reported in the IPC's Annual Report is calculated for your institution by the following formula:

$$\frac{\text{Total Requests Completed in 30 Days or Less (Box 5.1)}}{\text{Total Requests Completed (Box 3.2)}} \times 100$$

The Extended Compliance rate as reported in the IPC's Annual Report is calculated for your institution by the following formula:

$$\frac{\text{Box 6.1 + Box 6.4 + Box 6.7 + Box 6.10}}{\text{Total Requests Completed (Box 3.2)}} \times 100$$

Using the above example and these formulas, the basic compliance rate is calculated as:

Box 5.1 / Box 3.2 x 100 = 2 / 9 x 100 = 22.2%

And the extended compliance rate is calculated as:

Box 6.1 + Box 6.4 + Box 6.7 + Box 6.10 / Box 3.2 x 100 = (2 + 1 + 1 + 1) / 9 x 100 = 55.6%

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.20(1)) nor a Notice to Affected Person (s.21(1)) were issued.	0	13
6.2	Number of requests completed in excess of the statutory time limit (30 days) where **neither** a Notice of Extension (s.20(1)) nor a Notice to Affected Person (s.21(1)) were issued.	0	0
6.3	**Total** (Add boxes 6.1 + 6.2 = box 6.3)	0	0

Personal Information	General Records
0	13

B. Both a Notice of Extension (s.20(1)) and a Notice to Affected Person (s.21(1)) Issued

		Personal Information	General Records
6.4	Number of requests completed within the time limits permitted under **both** the Notice of Extension (s.20(1)) and Notice to Affected Person (s.21(1)).	0	0
6.5	Number of requests completed in excess of the time limit permitted by the Notice of Extension (s.20(1)) and the time limit permitted by the Notice to Affected Person (s.21(1)).	0	0
6.6	**Total** (Add boxes 6.4 + 6.5 = box 6.6)	0	0

Personal Information	General Records
0	0

C. Only a Notice of Extension (s.20(1)) Issued

		Personal Information	General Records
6.7	Number of requests completed within the time limit permitted under the Notice of Extension (s.20(1)).	0	1
6.8	Number of requests completed in excess of the time limit permitted under the Notice of Extension (s.20(1)).	0	0
6.9	**Total** (Add boxes 6.7 + 6.8 = box 6.9)	0	1

Personal Information	General Records
0	1

D. Only a Notice to Affected Person (s.21(1)) Issued

		Personal Information	General Records
6.10	Number of requests completed within the time limit permitted under the Notice to Affected Person (s.21(1)).	0	0
6.11	Number of requests completed in excess of the time limit permitted under the Notice to Affected Person (s.21(1)).	0	0
6.12	**Total** (Add boxes 6.10 + 6.11 = box 6.12)	0	0

►

Personal Information	General Records
0	0

E. Total Completed Requests (sections A to D)

		Personal Information	General Records
6.13	**Overall Total** (Add boxes (6.3 + 6.6 + 6.9 + 6.12 = box 6.13) and (box 6.13 **must equal to** box 3.2)	0	14

►

Personal Information	General Records
0	14

Enter the numbers in the tables above into the corresponding boxes in Section 6 of the online questionnaire

***Calculate your own basic compliance and extended compliance rates**:*

These calculations are for your own information only. They are not entered as part of the online questionnaire, but the total compliance rates will be calculated based on your submitted questionnaire and included in the IPC's Annual Report.

Basic Compliance Rate:

	Personal Information	***General Records***	***Total***
A: Total Requests Completed in 30 Days or Less (Box 5.1)	0	13	13
B: Total Requests Completed (Box 3.2)	0	14	14
DIVIDE: A / B x 100, round to one decimal place	0	93%	93%

Extended Compliance Rate:

	Personal Information	***General Records***	***Total***
A: Box 6.1 + Box 6.4 + Box 6.7 + Box 6.10	0	14	14
B: Total Requests Completed (Box 3.2)	0	14	14
DIVIDE: A / B x 100, round to one decimal place	0	100%	100%

Section 6a: Contributing Factors

Write any reasons that made it difficult to meet the 30-day time limit. Also, include circumstances that will improve your ability to be in compliance with the *Act*.

Enter the reasons above into Section 6a of the online questionnaire

Section 7: Disposition of Requests

This section asks you to indicate how your institution dealt with each of the requests for access to information it received. The options are as follows:

7.1 ***All Information Disclosed -*** *Enter the number of* ***personal information*** *and* ***general records*** *requests that resulted in full disclosure of all information requested.*

7.2 *Disclosed in Part - Enter the number of* ***personal information*** *and* ***general records*** *requests for which the* ***head*** *of your institution disclosed only part of the information requested. Include those requests where some of the information was exempted, excluded, did not exist, was outside of the Act, i.e. Y.O.A., or frivolous or vexatious.*

7.3 *Nothing Disclosed - Enter the number of* ***personal information*** *and* ***general records*** *requests for which the* ***head*** *of your institution disclosed no information. Include those requests where all of the information was* ***exempted****, was outside of the Act, or frivolous or vexatious.*

7.4 *No Responsive Records Exist - Enter the number of personal information and general records requests for which no responsive records exist.*

7.5 *Request* ***Withdrawn -*** *or* ***Abandoned -*** *In this category enter the number of requests that were* ***withdrawn*** *or* ***abandoned*** *by the requester.*

- *A* ***withdrawn*** *request is one in which the requester notifies your institution that he or she does not wish to proceed with the request.*
- *A request is considered* ***abandoned*** *when the requester does not respond to your attempts to proceed with the request.*
    - *For* ***general records*** *the request can be considered* ***abandoned*** *if the requester does not respond to correspondence that is necessary to* ***complete*** *the request (for example, a notice of fee estimate), within 30 days of the date you sent the communication. The* ***head*** *of your institution may* ***extend*** *this time limit, and this practice is encouraged.*
    - *For* ***personal information*** *requests, the policy is to allow up to 365 days (one year) before considering the request* ***abandoned****.*
    - *If appropriate, consider including a "respond by" date in your correspondence when requesting a response from the requester indicating that you will consider the request abandoned if you do not hear from them on or before that date.*

*7.6 **Total Requests Processed***

*The sum of all the entries in **personal information** and **general records** for all questions 7.1 to 7.5 should be equal to or greater than the amounts in 3.2 (**Total Requests Completed**).*

		Personal Information	General Records
7.1	All information disclosed	0	2
7.2	Information disclosed in part	0	10
7.3	No information disclosed	0	2
7.4	No responsive records exist	0	0
7.5	Request withdrawn, abandoned or non-jurisdictional	0	0
7.6	Total Requests Processed: Add Boxes 7.1 to 7.5 = Box 7.6. Box 7.6 must be greater than or equal to Box 3.2	0	14

Enter the numbers in the table above into boxes 7.1 through 7.6 of the online questionnaire.

Section 8: Exemptions and Exclusions Applied

*To complete this section you will need to be familiar with the **exemptions** described in the* Act. *Please refer to the section on **exemptions** in:*

- *your copy of the* Act*, or*
- *the **Municipal Freedom of Information and Protection of Individual Privacy Manual** produced by the Ministry of Government Services:*

  http://www.accessandprivacy.gov.on.ca/English/manual/index.html

8.1-8.19 In this section you are asked to indicate **which exemptions** were applied to those requests where the head of your institution withheld some or all of the requested information. Every request that was exempted, (in part or in full) must have at least one **exemption** listed, but may have more than one. For example, two different **exemptions** may be used to account for why information was withheld.

8.20 *If a request made under the Act also contains personal health information as defined in s.4 of the Personal Health Information Protection Act, 2004 (PHIPA), then s.8(1) of PHIPA may be applied to that personal health information as an **exclusion*** unless *PHIPA* specifies otherwise*.*

8.21 Enter the sum of all the requests you entered in the **personal information** and **general records** columns.

Please Note:

- *S.14 **exemption**, Personal Privacy (of third party) applies only to **general records** requests.*
- *S.38 **exemption**, Personal Information (of requester) applies only to **personal information** requests.*
- *There is no correlation between the sum entered in Box 8.21 and the total number of requests completed as entered in Box 3.2. More than one **exemption** and/or **exclusion** may be applied to a given request and a given **exemption** and/or **exclusion** may be applied to more than one request.*

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	.s — Draft Bylaws, etc.		
8.2	s.7 — Advice or Recommendations		
8.3	s.8 — Law Enforcement[1]		
8.4	s.8(3) — Refusal to Confirm or Deny		
8.5	s.8.1 — *Civil Remedies Act, 2001*		
8.6	s.8.2 — *Prohibiting Profiting from Recounting Crimes Act, 2002*		
8.7	s.9 — Relations with Governments		
8.8	s.10 — Third Party Information		
8.9	s.11 — Economic/Other Interests		
8.10	s.12 — Solicitor-Client Privilege	0	2
8.11	s.13 — Danger to Safety or Health		
8.12	s.14 — Personal Privacy (Third Party)[2]	N/A	9
8.13	s.14(5) — Refusal to Confirm or Deny	0	1
8.14	s.15 — Information Soon to be Published		
8.15	s.20.1 — Frivolous or Vexatious		
8.16	s.38 — Personal Information (Requester)		N/A
8.17	s.52(2) — Act Does Not Apply[3]		
8.18	s.52(3) — Labour Relations & Employment Related Records		
8.19	s.53 — Other Acts		
8.20	*PHIPA* s.8(1) applies		
8.21	**TOTAL EXEMPTIONS** (Add boxes 8.1 to 8.20 = box 8.21)		12

Enter the numbers in the table above into boxes 8.1 through 8.24 of the online questionnaire.

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

Section 9: Fees

*This section concerns **additional fees** and **application fees**.*

		Personal Information	General Records	TOTAL
9.1	Number of requests where fees other than application fees were collected	0	0	0
9.2.1	Application fees collected	$ 0.00	$ 50.00	$ 50.00
9.2.2	Additional fees collected	$ 0.00	$ 0.00	$ 0.00
9.2.3	Total Fees (Add boxes 9.2.1 + 9.2.2 = box 9.2.3)	$ 0.00	$ 50.00	$ 50.00
	*Under certain conditions, the **head** of your institution may **waive** all or part of the additional fees being charged. These conditions include: the requesters' ability to pay, whether release of the information will benefit public health or safety, how much difference there is between the fee being charged and the actual cost of processing the request, and whether the requester is ultimately given access to the information requested.*			
9.3	Total dollar amount of fees waived	$ 0.00	$ 20.00	$ 20.00

Enter the numbers in the table above into boxes 9.1 through 9.3 of the online questionnaire.

Section 10: Reasons for Additional Fee Collection

This section concerns the reasons and the number of requests involved for the additional fee collection.

*If your institution collected **additional** fees for any requests, please enter the appropriate number of requests in the given categories to indicate why the fee was charged. A request can be entered into more than one category. For example, an institution may have charged $10 to process a request, $5 to reproduction costs and $5 to shipping costs.*

Please Note:

- ***additional fees** for **personal information** requests can only be charged for reproduction and computer costs.*

		Personal Information	General Records	TOTAL
10.1	Search time	N/A		
10.2	Reproduction			
10.3	Preparation	N/A		
10.4	Shipping	N/A		
10.5	Computer costs			
10.6	Invoice costs (and others as permitted by regulation)	N/A		
10.7	Total (Add boxes 10.1 to 10.6 = box 10.7 and Box 10.7 greater than or equal to Box 9.1)			0.00

Enter the numbers in the table above into boxes 10.1 through 10.7 of the online questionnaire.

Section 11: Corrections and Statements of Disagreement

*If a person believes that an institution has **personal information** about himself/herself that is incorrect, under the* Act*, that person has the right to:*

- *request that the institution **correct** the information,*
- *require that the institution attach a statement of disagreement to the information if the requested **corrections** were not made,*
- *require that any person or organization to whom the **personal information** has been disclosed within the last 365 days be notified of the **corrections** or statement of disagreement.*

		Personal Information
11.1	Number of new correction requests received	0
11.2	ADD: Correction requests carried forward from the previous year	
11.3	SUBTRACT: Correction requests carried over to the next year	
11.4	Total Correction Requests Completed [(Box 11.1 + Box 11.2) – Box 11.3 = Box 11.4] Box 11.4 must equal Box 11.9 If this number is zero, skip the rest of this section.	0

*If your institution received any requests for **correction** of **personal information**, what course of action was taken with each?*

		Personal Information
11.5	Correction(s) made in whole	
11.6	Correction(s) made in part	
11.7	Correction requests refused	
11.8	Correction requests withdrawn by requester	
11.9	Total (Add Boxes 11.5 to 11.8 = Box 11.9 and Box 11.9 must equal Box 11.4)	0

In cases where correction requests were denied, in part or in full, were any statements of disagreement attached to the affected 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 that information in the previous year notification of either the correction or the statement of disagreement. Enter the number of notifications sent, if applicable.

11.11	Number of notifications sent:	0

Enter the numbers in the tables above into boxes 11.1 through 11.11 of the online questionnaire.

Completing and Submitting Your Questionnaire

This workbook and guide is for your use in completing your report and should not be faxed or mailed to the Information and Privacy Commissioner in lieu of online submission. **Faxed or mailed copies of this workbook and guide will NOT be accepted.** Please submit your report online using the IPC's Online Statistics Submission Website.

Your institution should have a login ID and password for the Online Statistics Submission Website. If you have lost or forgotten your ID or password, visit https://statistics.ipc.on.ca/ and click on the "Forgot your password or login ID?" link.

New Institutions

If your institution has recently come under the jurisdiction of the *Municipal Freedom of Information and Protection of Privacy Act*, you are required to submit a statistical report annually to the IPC using the Online Statistics Submission Website for which you will need a login ID and a password. If this is your first time submitting an annual report to the IPC, visit our Registration for Statistical Reporting page to set up an account and get a login ID and a password. You will need to include:

- the name of your institution
- the name and e-mail address of the head of the institution
- the name and e-mail address of the person responsible for the content of the report (the management contact)
- the name, e-mail address, telephone and fax numbers and the mailing address of the person responsible for completing the report (the primary contact**)**
- your language preference (English or Français)
- Please indicate if your institution is also a Health Information Custodian (HIC) as defined in s.3 of the *Personal Health Information Protection Act* (*PHIPA*). Institutions under *MFIPPA* who are also HICs under *PHIPA* must submit one annual statistical report under *MFIPPA* and another report under *PHIPA*. As such, you have the option of a single login id and password to submit both reports (which is convenient if the same person will be submitting both reports) or you may wish to have one login id and password for *MFIPPA* and another for *PHIPA* (which makes it easier if two different people will submit the reports) – it all depends on your organizational structure.

Once you have your login ID and password and have completed this workbook, log on to the Online Statistics Submission Website at https://statistics.ipc.on.ca and enter your questionnaire data section by section. You may log off the system at any time and it will remember where you left off when you log on the next time. This means you do not have to

complete and submit your questionnaire all in one session as long as you do complete and submit it before the deadline date. The **Online Statistics Submission Website will not be available after the deadline date**.

When you have completed entering your questionnaire, the system allows you to review your answers and make any necessary corrections before confirming and submitting your questionnaire. Once you have confirmed and submitted your questionnaire you are done, but should you discover that a correction is necessary after you have confirmed and submitted your questionnaire, you may log on to the Online Statistics Submission Website at any time before the deadline date and make the correction as needed. You will need to re-confirm your questionnaire and submit it again in order for the correction to be applied.

Changes to the type of questionnaire submitted may be made in the same manner. If, for example, you originally submitted a questionnaire stating that you had received no requests for access or correction (a “zero report”), but then discovered that you indeed had received one or more such requests, you may log on to the Online Statistics Submission Website at any time before the deadline date and simply change the questionnaire type selection at the end of Section 2. The system will take care of the rest and will take you to the appropriate sections of the questionnaire so you may complete them. Again, you will need to re-confirm your completed questionnaire and submit it again in order for the correction to be applied.

If you have specific questions that are not answered by this workbook and guide, please email **statistics.ipc@ipc.on.ca** or call the Information and Privacy Commissioner of Ontario’s main switchboard **416-326-3333**. If you are calling long distance, use our toll free line: **1-800-387-0073**.

Glossary of Terms

Compliance Rate, Basic – This is the percentage of all requests completed within the reporting year that were completed within the statutory 30 day completion time limit

Compliance Rate, Extended – Sections 20(1) and 21(1) of the *Municipal Freedom of Information and Protection of Privacy Act* (the *Act*) allow for the statutory 30 day completion time limit to be extended to accommodate large and/or complex requests and/or allow affected persons to provide representations regarding the disclosure of the requested information by the issuance of a Notice of Extension (s.20(1)) and/or a Notice to Affected Person (s.21(1)). The Extended Compliance Rate is the percentage of all requests completed within the reporting year that were completed either within the statutory 30 day completion time limit (where no notice(s) were issued) or within the time limit specified in the notice. See also Notice of Extension and Notice to Affected Person, below.

Exclusion (Exclude, Excluded) - Something is excluded from being regulated by the *Act* because it is being regulated elsewhere by a different law.

Exemption (Exempt, Exempted) - An exemption is a specific provision in the Act that may be invoked by a head as justification for denying access to information, in whole or in part. Certain requests for access may be denied due to provisions of other Acts, and in these special cases, for purposes of the year-end statistical report, s.53(2) (Other Acts) is the relevant exemption.

Exemption, Frivolous or Vexatious - A exemption is frivolous or vexatious when the head considers the request:

- as abusing the right of access or interfering with the operation of the institution, or
- to be made in bad faith or for ulterior motives.

Fee, Additional - See *Municipal Freedom of Information and Protection of Privacy Act*, s.45 (1).

Fee, Application - See *Municipal Freedom of Information and Protection of Privacy Act*, s.17 (1)(c).

Fee, Waived - A head may waive all or part of a fee that was estimated for releasing general records information, taking into account factors including: the requester's ability to pay; whether release of the information will benefit public health or safety; how much difference there is between the fee being charged and the actual cost of processing the request; and whether the requester is ultimately given access to the information requested.

Head (of institution) - The head is the individual or body selected to be the head of the institution for the purposes of the Act by:

- the council of a municipal corporation, or by

- the members of a board, commission or other institution that is not a municipal corporation.

  The head is responsible for decisions made under the legislation on behalf of the institution and for overseeing the administration of the legislation within the institution. The head may delegate some or all of its powers and duties to an officer or officers of the institution, or another institution. In this case the head is still accountable for all decisions made and actions taken under the Act.

Inconsistent Use - (of personal information) - An inconsistent use occurs whenever an institution under the Municipal Freedom of Information and Protection of Privacy Act (the Act) uses or discloses personal information from its personal information banks differently from the way this information is used or disclosed on a regular basis.

Notice of Extension - A notice sent to a requester by the head that a time extension is needed in order to complete the request. The notice must inform the requester of:

- the length of the extension,
- the reason for the extension, and
- the fact that the requester can ask the Information and Privacy Commissioner/Ontario to review the decision to extend the time period.

The extension may be made only if numerous records must be searched or consultation with a person outside the institution is required.

Notice to Affected Person - A notice sent by the head to a third party to whom the information relates before releasing the information. The notice must inform the third party of:

- the head's intention to disclose information that has something to do with the third party,
- a description of what's in the record or the part of the record that relates to the third party, and
- the fact that the third party has twenty days after the notice is given to advise the head why part or the whole record should not be disclosed.

Personal Information - See Section 2.1 of the Guide.

Personal Information Banks - A personal information bank is any collection of personal information your institution retains that is:

- organized, and
- allows personal information about an identifiable individual to be retrieved by that individual's name or some other personal identifier.

  Personal information banks can be:

- about members of the public or employees of the reporting institution,
- recorded on computer disks, paper, fiche or other media.

Examples of Personal Information Banks

Death Register; Dog Owners Records; Employee Training Records; Family Counselling Client Records; General Welfare Assistance Client Files; Grievance Files; Hunting/Fishing Licence Application; Line Fence Viewing Files; Litigation Files (Legal Departments); Marriage Licence Applications; Municipal Seasonal Boaters Index; Tax Bill Records; Job Competition Files; Applications Workplace Safety Insurance Board Files

Reporting Year - January to December.

Request, Abandoned - A request that an institution has been unable to proceed with because the requester has not responded to communications necessary to process the request (for example, a notice of fee estimate). This does not include requests returned to the requester due to insufficient detail.

Request, Carried Forward From Previous Year (requests for access to information and correction) - A request received in, or carried over from the previous reporting year that had to be carried forward to the current year for completion.

Request, Carried Over to Next Year (requests for access to information and correction) - A request received in the current reporting year that had to be carried forward to the next year for completion.

Request, Completed (requests for access to information and correction) (Complete) - A request for which the head's decision (to grant/deny access, or to make/refuse corrections) has been communicated to the requester, or a request that has been formally withdrawn or abandoned by the requester.

Request, Correction - A request to have one's own personal information corrected following access to the information.

Request, Disposition of - The outcome of a completed request: information disclosed/denied, request abandoned/withdrawn.

Request, General Records - A request for access to general records information or to another person's personal information (where permission has been given).

Request, Personal Information - A request for access to personal information, made by the person to whom the information relates or their authorized representative.

Request, Transferred - A request for access to general records or personal information that has been sent from one institution to another; the second institution having custody, control or a greater interest in the information. If Institution A receives a request that is transferred (in whole) to Institution B, Institution A would count this as a "Request Transferred Out to Another

Institution", while Institution B would count it as a "Request Transferred In From Another Institution".

Request, Withdrawn - A request for which the head has been informed by the requester that he/she no longer wishes to continue with the request (prior to its completion).

Reconciliation Chart

The chart below should be used to help verify your figures in completing this workbook and entering your questionnaire on the Online Statistics Submission Website.

Box Number	Criteria *	Box Number(s)
4.9	=	4.1 to 4.8
4.9	=	3.2
5.5	=	5.1 to 5.4
5.5	=	3.2
6.3	=	6.1+6.2
6.6	=	6.4+6.5
6.9	=	6.7+6.8
6.12	=	6.10+6.11
6.13	=	6.3+6.6+6.9+6.12
6.13	=	3.2
7.6	=	7.1 to 7.5
7.6	=	3.2
8.21	=	8.1 to 8.20
9.1	= or <	10.7
9.2.3	=	9.2.1+9.2.2
10.7	=	10.1 to 10.6
10.7	= or >	9.1
11.4	=	(11.1+11.2)-11.3
11.4	=	11.9
11.9	=	11.5 to 11.8
11.9	=	11.4

* = equal to
> greater than
< less than

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 04-23GC

TO: Chair and Members of the Governance Committee

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 February 16

QUARTERLY RISK REGISTER UPDATE

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to receive Report No. 04-23GC re: Quarterly Risk Register Update for information.

Key Points

- Boards of Health are required to report to the Ministry of Health in a standardized manner the high risks that are currently being managed at each board of health. The Risk Management Plan remains 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 Risk Register (Appendix A) is a repository for all risks identified (high, medium and low) and includes additional information about each risk (priority rating, mitigation strategies, and residual risk).
- Actions taken to reduce risk are monitored and efforts to improve performance are reported to the Board on a quarterly basis.

Background

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

The OPHS require boards of health to have a formal risk management framework in place that identifies, assesses, and addresses risks. All boards of health are required to submit a Risk Management Report as part of their Q3 Standards Activity Report (SAR) on an annual basis. At its meeting on February 17, 2022, the Board of Health approved the 2022 Risk Management Report which summarized high risks and key mitigation strategies to be submitted to the Ministry.

Risk Management Reporting

Risk assessment and mitigation occurs at the organization, program, and project levels according to the process outlined in the approved MLHU Risk Management Policy (G-120). The Board of Health is kept informed of identified high risks and key mitigation strategies on an annual basis as detailed on the annual Risk Management Report. The Risk Register (Appendix A) that is a repository for all risks identified (high, medium and low) and includes additional information about each risk (priority rating, mitigation strategies, and residual risk).

Next Steps

The Governance Committee has the opportunity to review the Risk Register (Appendix A) included with this report.

This report was prepared by the Chief Executive Officer.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 05-23GC

TO: Chair and Members of the Governance Committee

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 February 16

2021-22 PROVISIONAL PLAN PROGRESS UPDATE

Recommendation

It is recommended that the Governance Committee recommend to the Board of Health to receive Report No. 05-23, re: 2021-22 Provisional Plan Progress Update for information.

Key Points

- In Q4 2021, the Board of Health approved extending the timelines for phase two and three of the Provisional Plan by a minimum of three months. This elongation of the phases carries the Provisional Plan into Q2 2023.
- Progress has been made on many projects on the Provisional Plan, with seven (7) projects ongoing.

Background

The Health Unit continues to ensure that the priorities and objectives identified on the Provisional Plan are prioritized and balanced with the ongoing demands of the organization. The current Provisional Plan is attached as Appendix A. On November 10, 2022, the Board of Health approved the extension of the 2021-22 Provisional Plan to the end of 2024 following a current state analysis with a plan to develop a 2025-2029 Strategic Plan in 2024.

Provisional Plan Update

The Health Unit has continued to work on the goals identified on the Provisional Plan during Q4 2022 and has executed on key deliverables associated with the seven (7) strategic projects being implemented including:

#	Project Name	Provisional Plan Goal
1	Employment Systems Review	• Implement prioritized recommendations from the Diversity and Inclusion Assessment and Anti-Black Racism Report, including piloting the use of a shared workplan to facilitate collective and collaborative organizational work across teams.
2	Implementation of the Anti-Black Racism Plan	
3	Onboarding and Enhancement of the Electronic Client Record (ECR)	• Expand the range of technology solutions to meet client, community partner and staff needs for delivering virtual programming and services and enhancing staff safety.
4	Transition to SharePoint	
5	Implementation of the Joy in Work Framework	• Assess and refine decision-making practices across the organization to ensure decisions are made at appropriate levels, efficiency is maximized, and processes are clear.
6	Return to Office	

		• Execute a plan to value and recognize staff contributions in all MLHU programs, including opportunities to enhance staff connectedness and belonging.
7	Sociodemographic and Race-based Data Collection in Electronic Systems	• Expand the systematic collection and analysis of sociodemographic and race-based data of MLHU clients, and develop a process for its use in planning and evaluation of MLHU programming and service delivery.

A Q4 Provisional Plan summary report has been included as Appendix B.

There is only one (1) deliverable, identified below, that is delayed due to the need to prioritize resources for other projects:

- Implement prioritized recommendations from the Diversity and Inclusion Assessment and Anti-Black Racism Report, including piloting the use of a shared workplan to facilitate collective and collaborative organizational work across teams.

Work will continue on a delayed schedule with specific components being prioritized.

Next Steps

The 2023/2024 Provisional Plan will be presented to the Governance Committee in Q2 2023, along with an updated method for reporting on the status of projects.

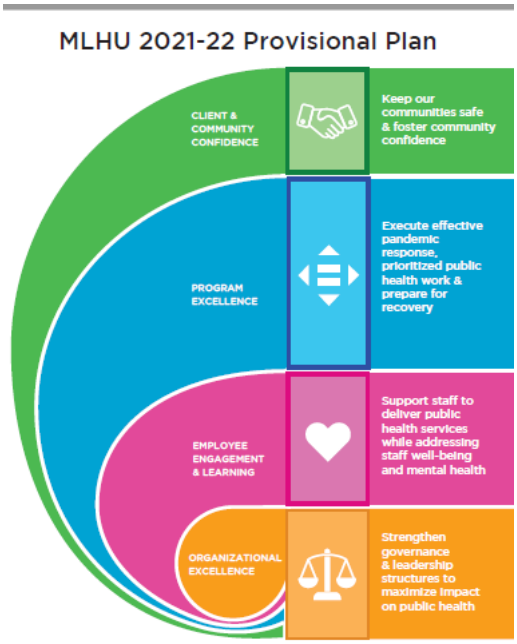
This report was prepared by the Manager, Program Planning and Evaluation.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

MLHU 2021-22 Provisional Plan

		3-6 MONTHS DO	6-12 MONTHS DESIGN	12-18 MONTHS DEFINE
CLIENT & COMMUNITY CONFIDENCE	Keep our communities safe & foster community confidence		• Expand the range of technology solutions to meet client, community partner & staff needs for delivering virtual programming and services and enhancing staff safety. • Continue to develop and implement a Client Experience tool to be utilized by teams and programs.	
PROGRAM EXCELLENCE	Execute effective pandemic response, prioritized public health work & prepare for recovery	• Quickly & equitably vaccinate as many residents of London and Middlesex as possible. • Embed information related to priority areas (i.e. mental health, food insecurity, substance use, domestic violence, racism) in COVID-19 messaging, and target priority populations as needed to ensure effective messaging. • Expand the systematic collection & analysis of sociodemographic & race-based data of MLHU clients, & develop a process for its use in planning & evaluation of MLHU programming & service delivery.	• Implement prioritized recommendations from the Diversity and Inclusion Assessment and Anti-Black Racism Report, including piloting the use of a shared workplan to facilitate collective & collaborative organizational work across teams.	• Integrate screening & risk assessment to identify mental health issues, substance misuse, domestic violence, an food insecurity into all public health programming where possible; ensuring subsequent support and/or referrals are offered as appropriate. • Inform healthy public policy related to priority areas, basic income, employment, and housing support, during & beyond COVID-19, through participation in stakeholder collaborations & partnership. • Develop surveillance indicators & gather information from the local community on the impacts of COVID-19 on various health outcomes using multiple engagement tactics. • Expand the use of sociodemographic & race-based data in population health assessment.
EMPLOYEE ENGAGEMENT & LEARNING	Support staff to deliver public health services while addressing staff well-being and mental health		• Provide regular communications to staff on health & safety topics of concern (e.g., COVID-19 exposure, psychological safety in the workplace) through email, team meetings, & virtual Town Halls. • Develop strategies to mitigate or address staff stress and/or burnout, including offering a variety of EFAP benefits including those that address mental health & well-being.	• Execute a plan to value & recognize staff contributions in all MLHU programs, including opportunities to enhance staff connectedness & belonging.
ORGANIZATIONAL EXCELLENCE	Strengthen governance & leadership structures to maximize impact on public health	• Ensure the right leadership & organizational structure is in place to support the evolving needs of the health unit, including leverage skill sets to advance the strategy of the organization.	• Develop an updated report on modernization of public health that encompasses lessons learned from the pandemic. • Assess & refine decision-making practices across the organization to ensure decisions are made at appropriate levels, efficiency is maximized, & processes are clear.	• Develop & initiate a revised performance management framework. • Initiate stakeholder engagement as an integral part of the MLHU strategic planning & incorporate the UN Sustainable Goals as a guiding framework for development of the next Strategic Plan.



GOALS	STATUS
Expand the systematic collection and analysis of sociodemographic and race-based data of MLHU clients and develop a process for its use in planning and evaluation of MLHU programming and service delivery.	
Expand the range of technology solutions to meet client, community partner and staff needs for delivering virtual programming and services enhancing staff safety.	
Implement prioritized recommendations from the Diversity and Inclusion Assessment and Anti-Black Racism Report, including piloting the use of a shared workplan to facilitate collective and collaborative organizational work across teams.	
Provide regular communications to staff on health and safety topics of concern through email, team meetings, and virtual Town Halls.	
Assess and refine decision-making practices across the organization to ensure decisions are made at appropriate levels, efficiency is maximized, and processes are clear.	

Recent Accomplishments:

- Employment Systems Review (ESR)
  - All AODA and Accommodation recommendations were implemented, including policy development and revision, and implementation of training
  - Initiated review of Recruitment policy and procedures
  - Conducted recruitment for Equity, Diversity and Inclusion (EDI) Advisory Committee
  - Received SLT approval for the Employment Equity Policy
- Anti-Black Racism Plan
  - Prepared implementation plans for recommendations related to the collection of SDOH and race-based data
  - Formed the Anti-Black Racism Plan (ABRP) Advisory Committee and held consultation session on SDOH data
- Onboarding/Enhancement of ECR
  - Finalized Profile onboarding of Young Adult Team (YAT)
- Transition to SharePoint
  - Multiple teams have been transitioned or continue to transition to SharePoint
  - Four SharePoint training sessions have been held for staff
- Return to Office
  - Created an SLT-approved criteria for assignment of workstations and lockers, while finalizing floor plans
  - Established hybrid model office processes and resources
- Implementation of Joy in Work Framework
  - Held staff consultations on improving MLHU office spaces to promote physical and psychological safety
  - Held Wellness Webinar on managing transition back to the office to facilitate stress management and resilience
  - Preference accounted for in SLT-approved criteria for workstations and lockers to promote choice/autonomy
- SDOH and Race-based Data Collection
  - Finalized the comprehensive dataset for data collection and developed implementation principles (completion of Phase 1)

Next Steps:

- Employment Systems Review (ESR)
  - Consult EDI Advisory Committee on key deliverables
  - Continue with refining recruitment processes and procedures
- Anti-Black Racism Plan
  - Continue to consult with the ABRP Advisory Committee throughout implementation of recommendations
  - Continue scoping recommendations, mapping progress, and conducting prioritization
- Onboarding/Enhancement of ECR
  - Evaluating software options for teams with which the ECR is not compatible
- Transition to SharePoint
  - Continue to transition teams and offer trainings
- Return to Office
  - Finalize the transition of activities to responsible teams (i.e., HR, Operations, etc.)
- Implementation of Joy in Work Framework
  - Continue educating on and utilizing the framework for organizational initiatives
  - Planning for next staff social event underway
- SDOH and Race-based Data Collection
  - Initiate project planning for Phase 2 of the SDOH Project (preparing for implementation)
  - Complete prioritization exercises to determine the minimum dataset for collection across all MLHU teams and programs
  - Conduct external stakeholder consultations with community partners and priority groups

Associated Projects / Activities	Status
1. Employment Systems Review (ESR)	
2. Implementation of the Anti-Black Racism Plan	
3. Onboarding/Enhancement of the Electronic Client Record (ECR)	
4. Transition to SharePoint	
5. Implementation of the Joy in Work Framework	
6. Return to Office	
7. Sociodemographic and Race-based Data Collection in Electronic Systems	

Critical Issues & Major Risks:

- Employment Systems Review (ESR)
  - Accessibility audit may produce additional recommendations, impacting project timelines and budget
  - Budget for capacity building remains unclear
- Anti-Black Racism Plan
  - Prioritized resources for other projects impact timely implementation of recommendations outside of those that are data-related
- Onboarding/Enhancement of ECR
  - Lack of funding may continue to impact progress in future
- SDOH and Race-based Data Collection
  - Implementing collection of an SDOH dataset might not be consistent with existing workflows of software system requirements across MLHU programs
  - Challenges may exist in implementing data collection and ensuring accountability of staff collecting this information