AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

Thursday, September 21, 2023 at 6 p.m.
MLHU Board Room – CitiPlaza
355 Wellington Street, London ON

1. DISCLOSURE OF CONFLICTS OF INTEREST

2. APPROVAL OF AGENDA – September 21, 2023

3. APPROVAL OF MINUTES – July 20, 2023

4. NEW BUSINESS

4.1. Board of Health Member Self-Assessment (Report No. 08-23GC)
4.2. Governance Policy Review (Report No. 09-23GC)
4.3. Quarterly Risk Register Update – Q2 2023 (Report No. 10-23GC)
4.4. 2021-2022 Provisional Plan Final Update (Report No. 11-23GC)

5. OTHER BUSINESS

The next meeting of the Governance Committee will be on Thursday, November 16, 2023 at 6 p.m.

6. ADJOURNMENT

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

Thursday, July 20, 2023 at 6:30 p.m.
Microsoft Teams (Virtual)

MEMBERS PRESENT: Matthew Newton-Reid (Chair)
Michael Steele
Tino Kasi
Emily Williams, Chief Executive Officer (ex-officio)
Dr. Alexander Summers, Medical Officer of Health (ex-officio)

REGRETS: Michelle Smibert
Aina DeViet

OTHERS PRESENT: Stephanie Egelton, Executive Assistant to the Board of Health (recorder)
Ryan Fawcett, Manager, Privacy, Risk and Client Relations
David Jansseune, Assistant Director, Finance

At **6:30 p.m.,** Board Chair Matthew Newton-Reid called the meeting to order for Committee Chair Michelle Smibert due to an unexpected conflict.

Emily Williams, Chief Executive Officer introduced Ryan Fawcett, incoming Manager, Privacy, Risk and Client Relations to the Governance Committee. R. Fawcett started at the Middlesex-London Health Unit on May 15 and has an extensive background in risk, privacy, and client relations, having held similar manager roles at the South Bruce Grey Health Centre and the St. Thomas Elgin General Hospital. R. Fawcett also holds a Green Belt in Lean Methodology and has had recent experience as a Quality Improvement Specialist at Windsor Regional Hospital.

DISCLOSURES OF CONFLICT OF INTEREST

Chair Newton-Reid inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **M. Steele, seconded by T. Kasi,** *that the **AGENDA** for the July 20, 2023 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **T. Kasi, seconded by M. Steele,** *that the **MINUTES** of the April 20, 2023 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

Governance By-Law Review (Report No. 06-23GC)

E. Williams provided an overview on the Governance Committee's review of the Board of Health's by-laws. E. Williams noted that under the *Health Protection and Promotion Act*, a Board of Health is required to have by-laws on management of property, banking, procedure and duties of the auditor.

Through a review, it was determined that the four (4) Board of Health by-laws needed review from both legal counsel and the Governance Committee before going to the Board. The by-laws have not had significant changes to them since their adoption, except for housekeeping amendments from March 2020 until June 2022 to update changes to applicable legislation impacting the Board of Health, along with updated roles and responsibilities. Legal counsel from Harrison Pensa LLP reviewed the by-laws with the Board Chair and the Executive Assistant before being presented to the Committee for their pre-meeting review.

The by-laws that were reviewed were:

- G-B10 By-law No. 1 Management of Property
- G-B20 By-law No. 2 Banking and Finance
- G-B30 By-law No. 3 Proceedings of the Board of Health
- G-B40 By-law No. 4 Duties of the Auditor

While a detailed and thorough legal review was conducted, the proposed changes to the by-laws were to modernize and clarify the by-laws for the Board through housekeeping changes. Changes included:

- General housekeeping amendments
- Reversing order of template to have readings above signing/seal
- General summarizing and condensing of provisions
- Modernizing and consistency with Robert's Rules of Order and the *Municipal Act*
- Condensing and removing information already applicable in policy
- Quorum clarifications

The Governance Committee will continue to review these by-laws bi-annually and it is anticipated that this level of review of Board of Health by-laws from legal counsel will not be needed for many years.

Upon recommendation from the Governance Committee, the by-laws will require the Board to make a motion to amend, and formalize by giving a first, second, third and final reading of by-laws for their implementation.

It was moved by **M. Steele, seconded by T. Kasi,** *that the Governance Committee:*

1) *Receive Report No. 06-23GC re: "Governance Policy Review – Board of Health By-Laws" for information; and*
2) *Approve the Board of Health Governance By-Laws as amended through a first, second, third and final reading (Appendix B).*

Carried

Quarterly Risk Register Update (Report No. 07-23GC)

E. Williams introduced Ryan Fawcett, Manager, Privacy, Risk and Client Relations to present the Q1 Risk Registry to the Committee.

R. Fawcett provided an overview of the Q1 Risk Register for the Health Unit. There were twenty-four (24) risks identified in Q4 2022, (sixteen) 16 of which have been completed or mitigated. There are eight (8) risks identified on the Q1 2023 Risk Register, with five (5) being high risk and three (3) being medium risk.

The high risks include:

- Staff burnout
- High demand for public health professionals
- Financial strain on public health
- Turnover in Board of Health Members
- Public Health Modernization

The medium risks include:

- Cyber security risks
- Class-action lawsuit against a long-term care home company and the Health Unit for COVID-19 response
- Information technology database tokens for security

It was moved by **T. Kasi, seconded by M. Steele,** *that the Governance Committee recommend to the Board of Health to:*

1) *Receive Report No. 07-23GC re: "MLHU Q1 2023 Risk Register" for information; and*
2) *Approve the Q1 2023 Risk Register (Appendix A).*

Carried

OTHER BUSINESS

The next meeting of the Governance Committee will be held on Thursday, September 21, 2023 at 6 p.m.

ADJOURNMENT

At **6:40 p.m.,** it was moved by **M. Steele, seconded by T. Kasi,** *that the meeting be adjourned.*

Carried

_____ _____

MATTHEW NEWTON-REID **EMILY WILLIAMS**
Board Chair, for Committee Chair Michelle Smibert **Secretary**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 08-23GC

TO: Chair and Members of the Governance Committee

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

DATE: 2023 September 21

BOARD OF HEALTH MEMBER SELF-ASSESSMENT - 2023

Recommendation

It is recommended that the Governance Committee make a recommendation to the Board of Health to:

1) ***Receive Report No. 08-23GC re: "Board of Health Member Self-Assessment - 2023";***
2) ***Approve the Board of Health Member Self-Assessment Tool as Appendix A; and***
3) ***Direct staff to initiate the Board of Health Member Self-Assessment for 2023.***

Key Points

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

Background

The *Ontario Public Health Standards* require that boards of health complete a self-assessment of their governance practices and outcomes at least once every two (2) years. The Board of Health last completed a self-assessment questionnaire in April 2021. The results of the 2021 Board of Health Self-Assessment were reported in June 2021 (Report No. 13-21GC). The current Board of Health Self-Assessment Tool was approved in April 2021 (Report No. 08-21GC).

Self-Assessment Process

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

Next Steps

Health Unit staff will administer the Board of Health Self-Assessment Tool and review anonymized results to identify recommendations for improvement in Board effectiveness and engagement. The assessment's findings will be submitted to the Governance Committee and recommendations will be brought forward to the Board of Health for approval in November.

This report was prepared by the Manager, Privacy, Risk and Client Relations.

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

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

2023 Board of Health Member Self-Assessment

This survey is expected to take approximately 30 minutes. Please complete by October 20, 2023.

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

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

You can complete the survey electronically or on paper. If you complete the paper version, please return it in a sealed envelope to Stephanie Egelton, Executive Assistant to the Board of Health.

If you have any questions please contact Stephanie Egelton, 519-663-5317, ext. 2448, stephanie.egelton@mlhu.on.ca.

Questions should be answered by all board members. When completed individually the results of Sections A, B and C should be compiled, shared and discussed by the whole board. This questionnaire also includes Section D, which provides feedback to the Chair of the Board.

*Circle the response that **best** reflects your opinion. The rating scale for each statement is: Strongly Disagree (1); Disagree (2); Maybe or Not Sure (3); Agree (4); Strongly Agree (5).*

A. How Well Has the Board Done Its Job?

1. Our organization operates with a strategic plan or a set of measurable goals and priorities.
1 2 3 4 5

2. The Board's regular meeting agenda items reflects our strategic plan or priorities.
1 2 3 4 5

3. The Board gives direction to staff on how to achieve the goals by setting, referring to, or revising policies.
1 2 3 4 5

4. The Board has identified and reviewed the organization's relationship with each of its key stakeholders.
1 2 3 4 5

5. The Board has ensured that the organization's accomplishments and challenges have been communicated to key stakeholders.
1 2 3 4 5

6. The Board takes all relevant information into consideration when making decisions.
1 2 3 4 5

7. The Board has ensured that stakeholders have received reports on how our organization has used its financial and human resources.
   1 2 3 4 5

8. In the past two years, the Board has adequately responded to serious complaints of wrongdoing or irregularities.
   1 2 3 4 5

9. The current relationship between the Board and senior staff results in effective and efficient management of the Health Unit.
   1 2 3 4 5

10. The standing and ad hoc committees of the Board are performing their respective accountabilities effectively and are structured appropriately.
    1 2 3 4 5

Comments: _____

My overall rating (add together the total of the numbers circled):

❒ Excellent (30-24) ❒ Satisfactory (23-19) ❒ Poor (18- 6)

B. How Well Has the Board Conducted Itself?

1. As board members, we are aware of what is expected of us.
   1 2 3 4 5

2. The agenda of board meetings are well planned so that we are able to get through all necessary business.
   1 2 3 4 5

3. It seems like most board members come to meetings prepared.
   1 2 3 4 5

4. We receive written reports to the board in advance of our meetings, with sufficient time to review them.

   1 2 3 4 5

5. All Board members are provided the opportunity to actively participate in important board discussions.

   1 2 3 4 5

6. As a Board, we encourage and incorporate different points of view for rich discussion of all board matters.
   1 2 3 4 5

7. We all support the decisions we make, even if differing points of view were shared during debate.

   1 2 3 4 5

8. Board members have some interaction with external stakeholders at board meetings (e.g. as guests) or between meetings.
   1 2 3 4 5

9. Does the Board feel they have a sound understanding of public health issues within our community?
   1 2 3 4 5

10. Does the Board understand their relationship with the Ministry of Health (e.g. funding, MOH/AMOH appointments)?
    1 2 3 4 5

Comments: _____

My overall rating:(add together the total of the numbers circled)

❒ Excellent (60- 50) ❒ Satisfactory (49-35) ❒ Poor (34-12)

C. My Performance as an Individual Board Member (*Will be de-identified for reporting purposes.*)

1. I am aware of what is expected of me as a Board member.
1 2 3 4 5

2. I have a good record of meeting attendance.
1 2 3 4 5

3. I read the minutes, reports and other materials in advance of our board meetings.
1 2 3 4 5

4. I am familiar with what is in the organization's by-laws and governing policies.
1 2 3 4 5

5. I frequently encourage other Board members to express their opinions at board meetings.
1 2 3 4 5

6. I am encouraged by other Board members to express my opinions at board meetings.
1 2 3 4 5

7. I am a good listener at board meetings.
1 2 3 4 5

8. I follow through on things I have said I would do.
1 2 3 4 5

9. I maintain the confidentiality of all board decisions.
1 2 3 4 5

10. When I have a different opinion than the majority, I raise it.
1 2 3 4 5

11. I support Board decisions once they are made even if I do not agree with them.
1 2 3 4 5

12. I promote the work of our organization in the community whenever I have a chance to do so.
1 2 3 4 5

13. I stay informed about issues relevant to our mission and bring information to the attention of the Board.
1 2 3 4 5

Comments: _____

My overall rating: (add together the total of the numbers circled)

❒ Excellent (40+) ❒ Satisfactory (28-39) ❒ Poor (11-27)

D. Feedback to the Chair of the Board ***(Optional; will be provided directly to the Chair and de-identified.)***

1. The Chair is well prepared for board meetings.
1 2 3 4 5

2. The Chair helps the Board stick to the agenda.
1 2 3 4 5

3. The Chair tries hard to ensure that every board member has an opportunity to be heard.
1 2 3 4 5

4. The Chair is skilled at managing different points of view.
1 2 3 4 5

5. The Chair has demonstrated versatility/flexibility in facilitating board discussions.
1 2 3 4 5

6. The Chair knows how to be direct with an individual Board member when their behaviour needs to change.
1 2 3 4 5

7. The Chair helps the Board work well together as a governing body.
1 2 3 4 5

8. The Chair demonstrates good listening skills.
1 2 3 4 5

9. The Chair is effective in delegating responsibility amongst Board members.
1 2 3 4 5

10. The Chair ensures the Board is aware of his/her organizational activities outside of our board meetings
1 2 3 4 5

Comments: _____

My overall rating: (add together the total of the numbers circled)

❒ Excellent (40+) ❒ Satisfactory (28-39) ❒ Poor (11-27)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 09-23GC

TO: Chair and Members of the Governance Committee

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

DATE: 2023 September 21

GOVERNANCE POLICY REVIEW

Recommendation

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

1) ***Receive Report No. 09-23GC re: "Governance Policy Review" for information; and***
2) ***Approve the governance policies as amended in 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 policies that have been reviewed by the Governance Committee and outlines the status of all documents contained within the Governance Manual.
- There are four (4) policies that have been prepared for review by the Governance Committee in (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 and by-laws will be grouped together (when possible) by subject matter area for ease in reviewing.

There are four (4) policies included as Appendix B that have been reviewed by the Governance Committee and prepared for approval by the Board of Health:

- G-080 – Occupational Health and Safety
- G-100 – Privacy and Freedom of Information
- G-120 – Risk Management
- G-500 – COVID-19 Immunization (to be renamed 'Respiratory Season Protection')

Appendix A to this report details the recommended changes for the above policies as well as the 2023 policy review status.

Next Steps

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

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

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

September 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	4/20/2023	Current		4/20/2025
Board Responsibility and Transparency	G-370 Board of Health Orientation and Development	4/20/2023	Current		4/20/2025
Board Responsibility and Transparency	G-400 Political Activities	4/20/2023	Current		4/20/2025
By-laws	G-B10 By-law No. 1 Management of Property	07/20/2023	Current		6/15/2025
By-laws	G-B20 By-law No. 2 Banking and Finance	07/20/2023	Current		6/15/2025
By-laws	G-B30 By-law No. 3 Proceedings of the Board of Health	07/20/2023	Current		6/15/2025
By-laws	G-B40 By-law No. 4 Duties of the Auditor	07/20/2023	Current		6/15/2025

Group	Document Name	Last Review	Status	Recommended Changes	For Review on
Financial Activities	G-180 Financial Planning and Performance	4/20/2023	Current		4/20/2025
Financial Activities	G-430 Informing of Financial Obligations	4/20/2023	Current		4/20/2025
Financial Activities	G-205 Borrowing	4/20/2023	Current		4/20/2025
Financial Activities	G-200 Approval and Signing Authority	4/20/2023	Current		4/20/2025
Risk and Privacy	G-080 Occupational Health and Safety	06/17/2021	Reviewed	Suggested changes from the Committee: - Consistent use of “Board of Health” vs. “BOH and Board” - Staff response: Will amend - Under the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA), it would be a suggestion that the Board delegate the MFIPPA responsibilities to the Medical Officer of Health (MOH). Again, Municipal Councils are delegated the Head and through delegation by-laws, this responsibility is given to staff (there is no delegation to the Mayor who in then delegates the responsibilities to staff. - Staff response: Will amend	9/21/2023
Risk and Privacy	G-100 Privacy and Freedom of Information	02/17/2022	Reviewed	Suggested changes from the Committee: - Consistent use of “Board of Health” vs. “BOH and Board” - Staff response: Will amend - Minor grammatical changes - Staff response: Will amend	9/21/2023
Risk and Privacy	G-120 Risk Management	10/21/2021	Reviewed	Suggested changes from the Committee: - Consistent use of “Board of Health” vs. “BOH and Board” - Staff response: Will amend	9/21/2023

Group	Document Name	Last Review	Status	Recommended Changes	For Review on
Risk and Privacy	G-500 COVID-19 Immunization	6/26/2022	Reviewed	Note: This policy is being proposed to be renamed “Respiratory Season Protection”. Suggested changes from the Committee: - Consistent use of “Board of Health” vs. “BOH and Board” - Staff response: Will amend	9/21/2023

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

OCCUPATIONAL HEALTH AND SAFETY

PURPOSE

To demonstrate the Board of Health's commitment to provide a healthy and safe work environment and prevent work-related injuries for all employees, students and volunteers.

To facilitate the Board of Health's compliance with applicable governance and accountability requirements outlined within the *Occupational Health and Safety Act* (OHSA) and the applicable regulations with respect to the duties of the employer.

POLICY

The Board of Health recognizes its ethical and legal obligations to ensure a safe and healthy work environment for Middlesex-London Health Unit (MLHU) employees and students.

All workplace parties are accountable for the prevention of work-related incidents, injuries and illness by maintaining and continually improving an Internal Responsibility System (IRS) and by taking every precaution reasonable to protect the health and safety workers.

Board members are accountable for and committed to taking all reasonable care to ensure that MLHU is in compliance with the *Occupational Health and Safety Act* and its applicable regulations.

The Board of Health designates from among its members the Board Chair to serve as the employer of the institution for the purposes of the OHSA; and further delegates the duties and responsibilities of the employer outlined in the OHSA to the Medical Officer of Health (MOH) and Chief Executive Officer (CEO). The day-to-day administration and management of MLHU's occupational health and safety program is facilitated by the Manager, Human Resources, who reports to the CEO.

The Board shall be informed of all significant health and safety risks through an annual report, summarizing the Occupational Health and Safety program, including reported workplace incidents. Additional OHS updates will be provided as needed, or upon request.

APPLICABLE LEGISLATION AND STANDARDS

Occupational Health and Safety Act

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

PRIVACY AND FREEDOM OF INFORMATION

PURPOSE

To facilitate the Board of Health's (Board) compliance with governance accountabilities and legislative requirements with respect to privacy and freedom of information.

To outline the confidentiality obligations of Board members.

POLICY

The Board recognizes its legal and ethical obligation to protect the privacy of individuals with respect to their personal information (PI) and personal health information (PHI), and is committed to ensuring the confidentiality and security of the PI and PHI under the custody and control of the Middlesex-London Health Unit (MLHU), as set out in the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA).

The Board further recognizes its obligation to provide a right of access to information under its control, as set out in MFIPPA, and is committed to openness, transparency and accountability.

Board members are further accountable for maintaining the confidentiality and security of PI, PHI and other confidential information that they gain access to for the purpose of discharging their duties and responsibilities as a member of the Board.

The Board shall be informed of all significant privacy risks and significant privacy breaches.

PROCEDURE

1. Board of Health Accountabilities Under MFIPPA

1.1. The Board designates from among its members the Board Chair to serve as the "head" of the institution for the purposes of meeting the requirements outlined in this Act (s. 3).

1.2. The Board Chair delegates the duties and responsibilities of the head to the Chief Executive Officer (CEO). Appendix A describes duties and powers of the head with respect to freedom of information and protection of individual privacy. The day-to-day administration and management of MLHU's privacy program will be operationalized by MLHU's Privacy Officer, who reports to the CEO.

1.3. The Board Chair maintains authority to delegate responsibility to external counsel to advise and/or respond to access requests filed under MFIPPA and/or PHIPA.

2. Board of Health Accountabilities Under PHIPA

2.1. The Medical Officer of Health of a Board of Health within the meaning of the Health Protection and Promotion Act serves as the health information custodian (HIC) for the purposes of PHIPA (s. 3 (1)).

2.2. In accordance with the requirements set out in the Ontario Public Health Standards, the Board shall ensure that the Medical Officer of Health, as the designated HIC, maintains information systems and implements policies/procedures for privacy and security, data collection and records management. Appendix B describes required practices to protect PHI.

3. Board of Health Member Confidentiality Attestation

3.1. Board members shall confirm understanding of their confidentiality obligations under applicable privacy legislation and governance policies, and their agreement to honour these obligations, by signing an Annual Confidentiality Attestation (Appendix C).

New Board members shall provide initial attestation upon orientation to the Board and according to the annual schedule thereafter.

DEFINITIONS

"**Agents**", in relation to a health information custodian, means a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated (PHIPA s. 2).

"**Collection**" means to gather, acquire, receive or obtain the information by any means from any source.

"**Confidentiality**" means the nondisclosure of PI or PHI except to another authorized person or where disclosure is permitted by law. Confidentiality also refers to the ethical and fiduciary duty and obligation of individual Board members to safeguard confidential information.

"**Confidential Information**" means personal information, personal health information and/or information regarding the organization which is not publicly disclosed by the organization, this information may include, but is not limited to:

- Matters including personal information and personal health information;
- Personnel matters relating to an employee of the health unit;
- The security of the property of the Board of Health;
- Proposed or pending acquisition of land, assets, or services for Board of Health purposes;
- Labour relations or employee negotiations;
- Litigation or potential litigation, including matters before administrative tribunals, affecting the Board;
- Advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- Matters related to other Acts that may be closed for discussion by the Board ;
- Matters that relate to requests under the Personal Health Information Protection Act or the Municipal Freedom of Information and Protection of Privacy Act.

"**Disclosure**" means to make the information available or to release it to another health information custodian or to another person but does not include to use the information.

"**Head**" means the individual designated, in writing, by the Board from among themselves, to act as head of the institution for the purposes of MFIPPA.

"**Health Information Custodian**" means a person or organization as defined and described in PHIPA who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties.

"**Identifying Information**" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual (PHIPA s. 4 (2)).

"**Institution**" means a Board of Health (MFIPPA, s. 2 (1)).

"**Personal Health Information**" means identifying information about an individual in oral or recorded form, if the information:

(a) Relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family;
(b) Relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual;
(c) Is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the individual;
(d) Relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual;
(e) 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 or bodily substance;
(f) Is the individual's health number; and/or
(g) Identifies an individual's substitute decision-maker. (PHIPA, s. 4 (1))

"**Personal Information**" means recorded information about an identifiable individual, including:

(a) Information relating to the race, national or ethnic origin, colour, religion, age, sex, sexual orientation or marital or family status of the individual;
(b) Information relating to the education or the medical, psychiatric, psychological, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved;
(c) Any identifying number, symbol or other particular assigned to the individual;
(d) The address, telephone number, fingerprints or blood type of the individual;
(e) The personal opinions or views of the individual except if they relate to another individual;
(f) Correspondence sent to an institution by the individual that is implicitly or explicitly of a private or confidential nature, and replies to that correspondence that would reveal the contents of the original correspondence;
(g) The views or opinions of another individual about the individual; and/or
(h) The individual's name if it appears with other personal information relating to the individual or where the disclosure of the name would reveal other personal information about the individual. (MFIPPA, s. 2(1))

"**Privacy**" means the qualified right of individuals to exercise control over the collection, use and disclosure of their personal information and personal health information, unless the collection, use and/or disclosure of the information is permitted or required by law.

"**Privacy Breach**" means the theft, loss unauthorized use or disclosure of personal information, personal health information or other confidential information.

"**Privacy Officer**" means the individual designated by the Chief Executive Officer to administer and manage MLHU's privacy program.

"**Records**" means any record of information in any form or in any medium, whether in oral, written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record (MFIPPA s. 2 and PHIPA, s. 2).

"**Security**" means a system of safeguards and precautions established to preserve confidentiality. These means may be legislative, administrative/procedural and/or technical.

"**Use**" means to view, handle or otherwise deal with the information.

APPENDICES

Appendix A – MFIPPA: Duties and Powers of the Head Related to Freedom of Information and Protection of Individual Privacy
Appendix B – PHIPA: Practices to Protect Personal Health Information
Appendix C – Annual Confidentiality Attestation

APPLICABLE LEGISLATION AND STANDARDS

Municipal Freedom of Information and Protection of Privacy Act
Personal Health Information Protection Act
Regulated Health Professions Act
Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, 2018

Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)
Duties and Powers of the Head Related to Freedom of Information and Protection of Individual Privacy

MFIPPA Section	Summary of Duties and Powers
Part I – Freedom of Information	
Right of access 4(1)	4(1) Every person has a right of access to a record or a part of a record in the custody or under the control of an institution unless, a) the record or the part of the record falls within one of the exemptions under sections 6 to 15; or b) the head is of the opinion on reasonable grounds that the request for access is frivolous or vexatious.
Severability of the record 4(2)	4(2) If an institution receives a request for access to a record that contains information that falls within one of the exemptions under sections 6 to 15 and the head of the institution is not of the opinion that the request is frivolous or vexatious, the head shall disclose as much of the record as can reasonably be severed without disclosing the information that falls under one of the exemptions. 1996, c. 1, Sched. K, s. 13.
Measures to ensure preservation of records 4.1	4.1 Every head of an institution shall ensure that reasonable measures respecting the records in the custody or under the control of the institution are developed, documented and put into place to preserve the records in accordance with any recordkeeping or records retention requirements, rules or policies, whether established under an Act or otherwise, that apply to the institution. 2014, c. 13, Sched. 6, s. 3.
Obligation to disclose 5(1)	5(1) Despite any other provision of this Act, a head shall, as soon as practicable, disclose any record to the public or persons affected if the head has reasonable and probable grounds to believe that it is in the public interest to do so and that the record reveals a grave environmental, health or safety hazard to the public.
Notice 5(2)	5(2) Before disclosing a record under subsection (1), the head shall cause notice to be given to any person to whom the information in the record relates, if it is practicable to do so.
Part II – Protection of Individual Privacy	
Notice [of collection] to individual 29(2) and (3)	29(2) If personal information is collected on behalf of an institution, the head shall inform the individual to whom the information relates of,

MFIPPA Section	Summary of Duties and Powers
	(a) the legal authority for the collection; (b) the principal purpose or purposes for which the personal information is intended to be used; and (c) the title, business address and business telephone number of an officer or employee of the institution who can answer the individual's questions about the collection. R.S.O. 1990, c. M.56, s. 29 (2). Exception (3) Subsection (2) does not apply if, a) the head may refuse to disclose the personal information under subsection 8(1) or (2) (law enforcement), section 8.1 (Civil Remedies Act, 2001) or section 8.2 (Prohibiting Profiting from Recounting Crimes Act, 2002); b) the Minister waives the notice; or c) the regulations provide that the notice is not required. R.S.O. 1990, c. M.56, s. 29 (3); 2001, c. 28, s. 23 (3); 2002, c. 2, ss. 16 (3), 19 (10); 2007, c. 13, s. 45 (3).
Right of access to personal information 36(1) and 38	36(1) Every individual has a right of access to, (a) any personal information about the individual contained in a personal information bank in the custody or under the control of an institution; and (b) any other personal information about the individual in the custody or under the control of an institution with respect to which the individual is able to provide sufficiently specific information to render it reasonably retrievable by the institution. 38 A head may refuse to disclose to the individual to whom the information relates personal information, if the record or the part of the record falls within one of the exemptions under section 38.

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

APPENDIX B
To Policy G-100

Personal Health Information Protection Act (PHIPA)
Health Information Custodian Practices to Protect Personal Health Information

PHIPA Section	Requirement
Information practices 10(1), (2) and (3)	10(1) A health information custodian that has custody or control of personal health information shall have in place information practices that comply with the requirements of this Act and its regulations. 2004, c. 3, Sched. A, s. 10 (1). (2) A health information custodian shall comply with its information practices. 2004, c. 3, Sched. A, s. 10 (2). (3) A health information custodian that uses electronic means to collect, use, modify, disclose, retain or dispose of personal health information shall comply with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 10 (3).
Collection 11.1	11.1 A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information is not collected without authority. 2016, c. 6, Sched. 1, s. 1 (3).
Security 12(1)	12(1) A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal. 2004, c. 3, Sched. A, s. 12 (1).
Notice of theft, loss, etc. 12(2) and (3)	Notice to individual 12(2) Subject to subsection (4) and to the exceptions and additional requirements, if any, that are prescribed, if personal health information about an individual that is in the custody or control of a health information custodian is stolen or lost or if it is used or disclosed without authority, the health information custodian shall, (a) notify the individual at the first reasonable opportunity of the theft or loss or of the unauthorized use or disclosure; and (b) include in the notice a statement that the individual is entitled to make a complaint to the Commissioner under Part VI. 2016, c. 6, Sched. 1, s. 1 (4). Notice to Commissioner (3) If the circumstances surrounding a theft, loss or unauthorized use or disclosure referred to in subsection (2) meet the prescribed requirements, the health information custodian shall

	notify the Commissioner of the theft or loss or of the unauthorized use or disclosure. 2016, c. 6, Sched. 1, s. 1 (4).
Handling of records 13(1)	13(1) A health information custodian shall ensure that the records of personal health information that it has in its custody or under its control are retained, transferred and disposed of in a secure manner and in accordance with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 13 (1).
Contact person 15(1) and (3)	15(1) A health information custodian that is a natural person may designate a contact person described in subsection (3). 2004, c. 3, Sched. A, s. 15 (1). (3) A contact person is an agent of the health information custodian and is authorized on behalf of the custodian to, (a) facilitate the custodian's compliance with this Act; (b) ensure that all agents of the custodian are appropriately informed of their duties under this Act; (c) respond to inquiries from the public about the custodian's information practices; (d) respond to requests of an individual for access to or correction of a record of personal health information about the individual that is in the custody or under the control of the custodian; and (e) receive complaints from the public about the custodian's alleged contravention of this Act or its regulations. 2004, c. 3, Sched. A, s. 15 (3).
Written public statement 16(1) and (2)	16(1) A health information custodian shall, in a manner that is practical in the circumstances, make available to the public a written statement that, (a) provides a general description of the custodian's information practices; (b) describes how to contact, i. the contact person described in subsection 15 (3), if the custodian has one, or ii. the custodian, if the custodian does not have that contact person; (c) describes how an individual may obtain access to or request correction of a record of personal health information about the individual that is in the custody or control of the custodian; and (d) describes how to make a complaint to the custodian and to the Commissioner under this Act. 2004, c. 3, Sched. A, s. 16 (1). (2) If a health information custodian uses or discloses personal health information about an individual, without the individual's consent, in a manner that is outside the scope of the custodian's description of its information practices under clause (1) (a), the custodian shall,

	(a) inform the individual of the uses and disclosures at the first reasonable opportunity unless, under section 52, the individual does not have a right of access to a record of the information; (b) make a note of the uses and disclosures; and (c) keep the note as part of the records of personal health information about the individual that it has in its custody or under its control or in a form that is linked to those records. 2004, c. 3, Sched. A, s. 16 (2).
Agents and information 17(1) and (3)	17(1) A health information custodian is responsible for personal health information in the custody or control of the health information custodian and may permit the custodian's agents to collect, use, disclose, retain or dispose of personal health information on the custodian's behalf only if, (a) the custodian is permitted or required to collect, use, disclose, retain or dispose of the information, as the case may be; (b) the collection, use, disclosure, retention or disposal of the information, as the case may be, is necessary in the course of the agent's duties and is not contrary to this Act or another law; and (c) the prescribed requirements, if any, are met. 2004, c. 3, Sched. A, s. 17 (1); 2016, c. 6, Sched. 1, s. 1 (5). (3) A health information custodian shall, (a) take steps that are reasonable in the circumstances to ensure that no agent of the custodian collects, uses, discloses, retains or disposes of personal health information unless it is in accordance with subsection (2); and (b) remain responsible for any personal health information that is collected, used, disclosed, retained or disposed of by the custodian's agents, regardless of whether or not the collection, use, disclosure, retention or disposal was carried out in accordance with subsection (2). 2016, c. 6, Sched. 1, s. 1 (7).
Notice to governing College 17.1(2)	17.1(2) Subject to any exceptions and additional requirements, if any, that are prescribed, if a health information custodian employs a health care practitioner who is a member of a College, the health information custodian shall give written notice of any of the following events to the College within 30 days of the event occurring: 1. The employee is terminated, suspended or subject to disciplinary action as a result of the unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee. 2. The employee resigns and the health information custodian has reasonable grounds to believe that the resignation is related to an investigation or other action by the custodian with respect to an alleged

	unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee. 2016, c. 6, Sched. 1, s. 1 (8)

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

APPENDIX C
To Policy G-100

ANNUAL CONFIDENTIALITY ATTESTATION
BOARD OF HEALTH MEMBERS

I,

_____,
Printed Name of Board Member

understand that as a member of the Board of Health for the Middlesex-London Health Unit (MLHU), I may have access to:

- Confidential information (as defined within Policy G-100)
- Personal information (PI) (as defined by MFIPPA)
- Personal health information (PHI) (as defined by PHIPA)

This information could be related to MLHU clients and their families; MLHU employees, students and volunteers; members of my own family, friends or associates; and/or MLHU business, financial and management matters.

I understand that I will only be provided access to such information for the purpose of discharging my duties and responsibilities as a member of the Board of Health. Therefore, due to the highly sensitive nature of this information, I will:

1. Safeguard all confidential information including, but not limited to, PI and PHI, from unauthorized access, use or disclosure in accordance with Policy G-100.
2. Not collect, use or disclose any confidential information including, but not limited to, PI and PHI, without authorization; nor will I discuss, divulge, or disclose such information to others, unless it is necessary to fulfill my duties and responsibilities. Specifically, I will not:
    a) Reveal to anyone the name or identity of a client, employee, student or volunteer that is disclosed through information provided to me in the course of my duties.
    b) Repeat to anyone any statements or communications made by or about confidential MLHU business, financial or management matters, or about an MLHU client, client's family or associates.
    c) Reveal to anyone any information that I learn about an MLHU client, client's family or associates as a result of discussions with others providing care to the client, client's family or associates.
    d) Write, publish, or contribute to any articles, papers, stories or other written materials, or speak with members of the media with respect to information disclosed to me in the course of my duties as a member of the Board of Health, which has been deemed confidential by the Board of Health, Medical Officer of Health or Chief Executive Officer, or would be reasonable to consider confidential or sensitive given the type of information disclosed and the context in which such disclosure is made to the Board of Health, including without limitation, the names or identities of any client, client's family or associates who can be discerned, unless such disclosure is authorized by the Board of Health.
3. Obtain authorization from the Board Chair and/or the Secretary and Treasurer prior to disclosing any confidential information including, but not limited to, PI and PHI.

I have read this statement and understand my obligation to maintain confidentiality. I agree to honour that obligation during my term as a member of the Board of Health and thereafter. I understand that any contravention of the Board of Health/MLHU privacy and confidentiality policies could result in financial penalties, legal liability and other consequences and assessments as deemed appropriate or relevant which could be initiated by the MLHU, another governing body or otherwise.

Signature	Signature of Witness
Name (Please PRINT)	Name of Witness (Please PRINT)
Date	Date

DEFINITIONS

Confidential Information" means personal information, personal health information and/or information regarding the organization which is not publicly disclosed by the organization, this information may include, but is not limited to:

- Matters including personal information and personal health information;
- Personnel matters relating to an employee of the health unit;
- The security of the property of the Board of Health
- Proposed or pending acquisition of land, assets, or services for Board of Health purposes;
- Labour relations or employee negotiations;
- Litigation or potential litigation, including matters before administrative tribunals, affecting the Board;
- Advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- Matters related to other Acts that may be closed for discussion by the Board of Health
- Matters that relate to requests under the Personal Health Information Protection Act or the Municipal Freedom of Information and Protection of Privacy Act.

"**Personal Health Information**" means identifying information about an individual in oral or recorded form, if the information:

(a) Relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family;
(b) Relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual;
(c) Is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the individual;
(d) Relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual;
(e) 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 or bodily substance;
(f) Is the individual's health number; and/or
(g) Identifies an individual's substitute decision-maker. (PHIPA, s. 4 (1))

"**Personal Information**" means recorded information about an identifiable individual, including:

(a) Information relating to the race, national or ethnic origin, colour, religion, age, sex, sexual orientation or marital or family status of the individual;
(b) Information relating to the education or the medical, psychiatric, psychological, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved;
(c) Any identifying number, symbol or other particular assigned to the individual;
(d) The address, telephone number, fingerprints or blood type of the individual;
(e) The personal opinions or views of the individual except if they relate to another individual;
(f) Correspondence sent to an institution by the individual that is implicitly or explicitly of a private or confidential nature, and replies to that correspondence that would reveal the contents of the original correspondence;
(g) The views or opinions of another individual about the individual; and/or
(h) The individual's name if it appears with other personal information relating to the individual or where the disclosure of the name would reveal other personal information about the individual. (MFIPPA, s. 2(1))

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

RISK MANAGEMENT POLICY

PURPOSE

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

POLICY

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

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

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

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

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

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

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

APPENDICES

G-120 App A – MLHU Risk Management Framework

APPLICABLE LEGISLATION AND STANDARDS

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

RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

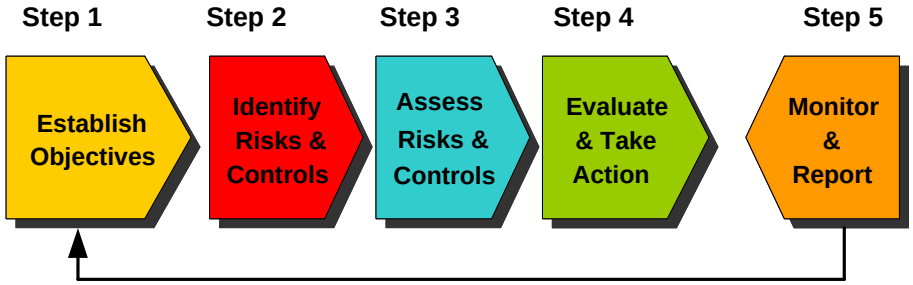
Step 1: Establish objectives

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

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

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

The risk management process



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

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

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

Step 2: Identify risks & controls

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

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

14 categories of risk

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

RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

Step 3: Assess Risks & Controls

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

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

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

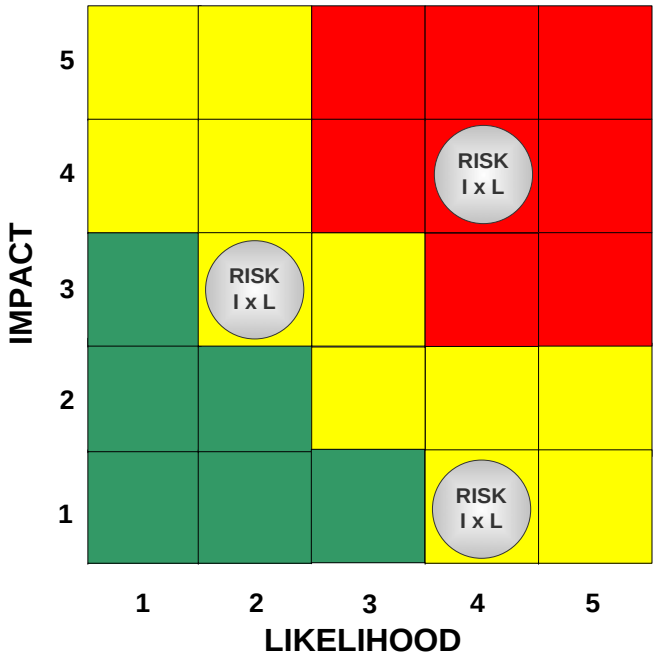
Key Risk Indicators (KRI)
- Leading Indicators - Early or leading indicators that measure sources or causes to help prevent risk occurrences
- Lagging Indicators - Detection and performance indicators that help monitor risks as they occur.

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

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

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

RISK PRIORITIZATION MATRIX



Step 4: Evaluate & Take Action

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

Step 5: Monitor & Report

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

Definitions

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

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

RESPIRATORY SEASON PROTECTION

PURPOSE

To ensure that Middlesex-London Health Unit (MLHU) Board of Health ("Board") members are up to date with the COVID-19 and influenza vaccines to minimize their risk of infection or risk of serious illness and to reduce the risk of transmission to others.

To outline the protections in place during respiratory season (November 1 – March 31) for in-person Board of Health Meetings.

POLICY

The Board of Health recognizes its ethical and legal obligations to ensure a safe and healthy environment for MLHU employees, students and the Board.

Aligning with MLHU's commitment to protecting employees and others from hazards in the workplace including infectious and vaccine preventable diseases, all Board members are required to report their COVID-19 and influenza vaccine status, including any related boosters.

Board members must submit a Self- Attestation of Vaccination Status (Appendix A-1) to MLHU's Occupational Health and Safety Department stating that they are either up to date or request an exemption and are electing to decline a highly recommended vaccine (Appendix A-1). The Self-Attestation must be submitted on an annual basis as directed by Occupational Health and Safety by existing Board members and prior to their first Board meeting by new Board members.

Any Board member refusing to comply with the reporting requirements under this policy may be removed from their Board appointment as per policy G-360 Resignation and Removal of Board Members.

During times of the year that are of higher risk for respiratory illnesses (deemed by the Medical Officer of Health to be November 1 – March 31), Board members who are not up to date with the COVID-19 or influenza vaccines, must don a medical mask, unless 2 metres from others, when onsite at MLHU offices.

Board members who are experiencing new or worsening respiratory symptoms and/or a fever shall be accommodated to attend Board of Health Meetings virtually, where applicable.

In the event of a COVID-19 or influenza outbreak amongst MLHU staff, as declared by the Medical Officer of Health, Board members who are not up to date with the relevant vaccine will participate in Board activities remotely, as determined by MLHU.

Board members' vaccination status will be maintained as confidential information to the extent feasible and will be kept in a secure and confidential location. Vaccination status information will

be collected solely for the purpose of administering this Policy, including addressing any breach of this Policy, for the purpose of addressing health and safety concerns within MLHU's workplace, and to manage any COVID-19 or influenza cases or outbreaks.

All Board members participating in Board activities in person must continue to comply with applicable policies and protocols with respect to any other measures intended to reduce the risk of transmission of infectious diseases.

DEFINITIONS

"Outbreak" means that the disease activity in the region is higher than baseline levels or above what would be expected as determined by the Medical Officer of Health (MOH).

"Up to date" means that an employee has received all COVID-19 doses recommended in Ontario's Routine Immunization Schedule or by the Government of Ontario, including any booster doses of the COVID-19 when eligible.

APPENDICES

Appendix A – Respiratory Season Protection Procedure
Appendix A-1 – Self Attestation of Vaccination Status

RELATED POLICIES

G-360 Resignation and Removal of Board Members

APPLICABLE LEGISLATION AND STANDARDS

Occupational Health and Safety Act
Health Protection and Promotion Act

KEY GUIDANCE DOCUMENTS AND RESOURCES

OHRC policy statement on COVID-19 vaccine mandates and proof of vaccine certificates

RESPIRATORY SEASON PROTECTION PROCEDURE

1. At the beginning of their term and annually thereafter, Board of Health ("Board") members must submit a signed and dated Self-Attestation of Vaccination Status (Appendix A-1) stating that they are up to date (i.e. have received relevant primary and booster doses of COVID-19 vaccine and an annual influenza immunization) or stating that they are electing to decline a recommended vaccine Appendix A-1).

2. The completed Self-Attestation of Vaccination Status must be submitted to MLHU's Occupational Health and Safety Department as directed above.

3. MLHU's Occupational Health and Safety Department may request supporting information or documentation relating to vaccination status. Board members must provide the supporting documentation requested by MLHU's Occupational Health and Safety Department.

4. During times of the year that are of higher risk for respiratory illnesses (deemed by the Medical Officer of Health to be November 1 – March 31), Board members who are not up to date with the COVID-19 and/or the influenza vaccine(s), must don a medical mask unless 2 metres from others when attending in-person events associated with the MLHU.

5. Board members are encouraged to complete symptom screening ahead of in person Board of Health Meetings to minimize the risk of infection transmission.

6. In the event of an outbreak of COVID-19 or influenza amongst MLHU staff as declared by the Medical Officer of Health, Board members who are not up to date with the COVID-19 or influenza vaccine will participate in Board activities remotely, as determined by MLHU.

7. The Chair of the Board of Health will be notified by OHS of the vaccination status (up to date or not up to date) of each Board member to ensure all safety measures listed above are followed during times of the year that are of higher risk for respiratory illness and/or in the event of a staff outbreak.

8. Board members who do not complete a Self-Attestation of Vaccination Status will be in non-compliance with the Respiratory Protection policy. Any non-compliance with this Policy may result in initiating the procedure for removal of the member as per policy G-360 Resignation and Removal of Board Members

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

APPENDIX A-1
To Policy G-500

SELF-ATTESTATION OF VACCINATION STATUS

I, _____, a member of the Board of Health,
Printed Name of Board Member

☐ am up to date with the COVID-19 vaccine, including all relevant boosters, meaning that I received a relevant primary and booster doses of COVID-19 vaccine that I am currently eligible for.

☐ have received a recent dose of the influenza vaccine.

decline receiving:

☐ the COVID-19 vaccine, any additional booster doses

☐ the influenza vaccine

and realize that by declining either or both of these recommended vaccines

the following will apply:

a) during times of the year that are of higher risk for respiratory illnesses, as deemed by the Medical Officer of Health (MOH) (typically November 1-March 31), I will be asked to wear a mask for all in person Board of Health activities where 6 feet of physical distance cannot be maintained.
b) during a COVID-19 or influenza outbreak amongst MLHU staff, I will be required to participate in Board activities remotely and not in person.

I acknowledge that the reporting my vaccine status is required in my current position as a member of the Middlesex-London Health Unit Board of Health.

I make this attestation for the purpose of complying with the requirements of Policy G-500 Respiratory Protection and for no other or improper purpose.

I acknowledge that Board of Health members, including myself, may be required to provide additional information/supporting documentation to the Occupational Health and Safety Department if required by MLHU.

Signature: _____ Date:

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 10-23GC

TO: Chair and Members of the Governance Committee

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

DATE: 2023 September 21

QUARTERLY RISK REGISTER UPDATE – Q2 2023

Recommendation

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

1) ***Receive Report No. 10-23GC re: "MLHU Q2 2023 Risk Register" for information; and***
2) ***Approve the Q2 2023 Risk Register (Appendix A).***

Key Points

- There were eight (8) risks identified in Q1 of 2023.
- In Q2 2023 one (1) NEW risk has been added to the risk register under the People/Human Resources domain – moderate residual risk.
- Residual risk in Q2:
  - Five (5) classified as minor risk.
  - Three (3) classified as moderate risk.
  - One (1) classified as significant risk – Political risk re: uncertainty of Public Health Modernization.

Background

In January 2018, the Ministry of Health and Long-Term Care (now called the Ministry of Health) 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. In response to OPHS, MLHU maintains a Risk Register (Appendix A) which is a repository for all risks identified across the organization and includes additional information about each risk (priority rating, mitigation strategies, and residual risk). It captures MLHU's response and actions taken to address risks, which are monitored on a quarterly basis and reported to the Board.

Q2 2023 Risk Register

There are nine (9) risks identified on the Q2 Risk Register. The register reflects one (1) new risk in the People/Human Resources domain pertaining to recruiting and retaining Knowledge Workers. The Public Health sector provides lower compensation than comparable roles in the market.

Of the nine (9) risks identified on the Q2 2023 Risk Register:

- Five (5) are high risk.
  - One (1) has been classified with significant residual risk due to uncertainty in public health funding mechanisms related to inflation and ongoing COVID-19 associated work. The City, County and the MLHU continue to advocate to the Ministry for adequate funding.
  - One (1) has been reduced to moderate residual risk through implementation of effective mitigation strategies. Uncertainty regarding Public Health Modernization exists; the Medical

Officer of Health (MOH) and Chief Executive Officer (CEO) continue to endorse the role of a strengthened public health sector at Association of Local Public Health Agencies (aLPHa) and Council of Medical Officers of Health (COMOH) tables.
    - Three (3) have been reduced to minor residual risk through implementation of effective mitigation strategies.
- Four (4) are medium risk.
    - Two (2) carry a moderate residual risk rating.
        - One related to the Technology risk category. Further work is underway to mitigate risk through enhanced internal asset management practices.
        - A new risk in the People/Human Resources category where Public Health sector provides lower compensation than comparable roles in the market. Work to update position descriptions began in 2022 and is ongoing.
    - Two (2) have been reduced to minor residual risk through implementation of effective mitigation strategies.

Risk management education at the MLHU is ongoing, as work to embed enhanced risk management principles and practices across the continuum of activities continues.

Next Steps

It is recommended that the Governance Committee recommend that the Board of Health review and approve the Q2 2023 Risk Register (Appendix A) included with this report.

This report was prepared by the Manager, Privacy, Risk and Client Relations.

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

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 11-23GC

TO: Chair and Members of the Governance Committee

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

DATE: 2023 September 21

2021-2022 PROVISIONAL PLAN FINAL UPDATE

Recommendation

It is recommended that the Governance Committee recommend that the Board of Health receive Report No. 11-23GC, re: "2021-2022 Provisional Plan Final 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 six (6) projects ongoing, and one (1) completed.
- The new Provisional Plan for 2023-2024 has been approved and will carry forward some key strategic initiatives.

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 October 21, 2021 the Board of Health approved extending the timelines for phase two and three of the Provisional Plan by a minimum of three (3) months. This elongation of the phases carries the Provisional Plan into Q2 2023. A new provisional plan has been approved by the Board of Health for Q3 2023- Q4 2024 with the 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 Q2 2023 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. • Execute a plan to value and recognize staff contributions in all MLHU programs, including opportunities to enhance staff connectedness and belonging.
6	Return to Office	
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 Q2 Provisional Plan summary report has been included as Appendix A.

There is only one (1) goal identified below that is associated with projects where problems have surfaced due to prioritized resources for other projects impacting timely implementation of recommendations outside of those that are data-related:

- 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.

Projects that have not been completed will either move to Operational teams to complete close outs or are included in the new 2023/2024 Provisional Plan.

Next Steps

Work is underway on initiatives within the 2023/2024 Provisional Plan. The progress for Q3 will be reported in a slightly different way. The next report will include a table showing the status of each initiative and more context will be provided if anything is off track or at risk.

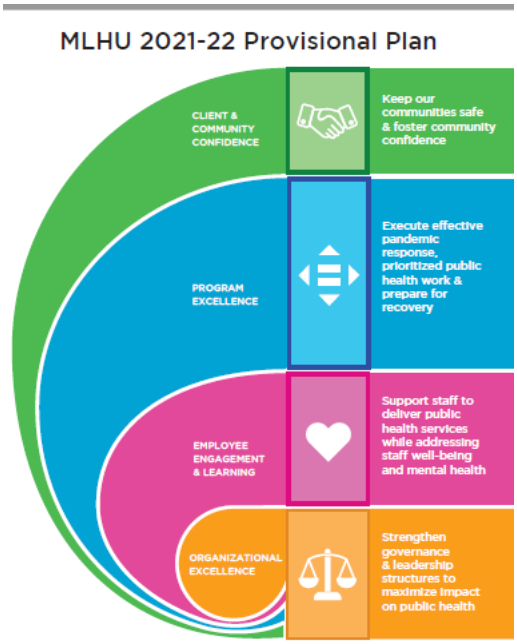
This report was prepared by the Manager, Strategy, Planning and Performance.

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

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

2021-22 Provisional Plan Status Update to BOH – Q2 2023 (Apr-Jun)

Status Legend	Complete ☑	Proceeding as planned 👍	Problems surfaced; considered manageable 🚩	Major obstacles; requires intervention ☒



GOALS	STATUS
Expand the systematic collection & analysis of sociodemographic & 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.	🚩
Execute a plan to value and recognize staff contributions in all MLHU programs, including opportunities to enhance staff connectedness and belonging.	👍
Assess & 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)

- Recruitment Policy and Procedures successfully launched with leaders, shared with union partners and released to all staff.
- Careers Page on MLHU website updated to highlight commitment to EDI, including FAQs for jobseekers.
- Retirement and Resignation Policy updated to reflect enhanced Exit Interview recommendations.
- Capacity building priorities and schedule established for leadership and employee training related to Equity Diversity and Inclusion for 2023 and 2024.
- Employment Equity diversity targets established, approved.

Anti-Black Racism Plan

- Co-created a community engagement event with key partner organizations working with the diverse Black communities of London. The event was named "**Building a Healthy Community Through Art: A Celebration of Black Joy**" and was hosted on July 15th at the W.E.A.N Community Centre (an organization lead by Black community members that provides social services to the Black community). Members of the MLHU Anti-Black Racism Plan Advisory Committee, the Nigerian Association of London and Area (NALA) and the Boys and Girls Club of London were part of the organizing committee. The event attracted over one hundred registered participants and featured art activities, dance performances from a Rwandan youth dance troupe, and DJ music and food from local Black owned businesses.
  The art event, and more importantly the co-creation process, was a mechanism to advance multiple recommendations within the ABRP. The goals of the event were to initiate trust building and strengthen MLHU presence with the African, Caribbean, and Black (ACB) communities, communicate anti-Black racism messages and information about MLHU services, strengthen partnerships with ACB and facilitate collaboration between ACB organizations towards promoting ACB health (recommendations 9, 13, 15, 17, 21, and 24).

Next Steps:

Employment Systems Review (ESR)

- Update and release of Anti-Harassment and Anti-Discrimination Policy, including new Anonymous Complaint Reporting Form and Investigation process feedback survey.
- Development of internal Anti-Harassment and Anti-Discrimination training module in collaboration with OHS team, to supplement the external Respect in the Workplace training module.
- Launch LGBTQ2+ external training module to all staff.
- Communicate Employment Equity targets to all staff in Town Hall and to Board of Health.
- Pilot Anti-Black Racism training for 2024.
- Develop guidelines for supporting staff undergoing gender transition.
- Develop guidance for smudging to promote and facilitate Indigenous traditions and ceremonies.

Anti-Black Racism Plan

- Development of Anti-Black racism key messaging to be shared on MLHU's website and social media platforms.
- Advance recommendation #22 (Use a decision-making matrix that includes an anti-racism lens when choosing to engage in new partnerships or collaborative initiatives).
- Continue to work towards respectful and trusting relationships with the ACB communities and increase cross-sector collaboration with organizations such as the Middlesex London Ontario Health Team and the City of London to disrupt racism.

Onboarding/Enhancement of ECR

- IT to maintain and take over Profile implementation

2021-22 Provisional Plan Status Update to BOH – Q2 2023 (Apr-Jun)

Status Legend	Complete ☑	Proceeding as planned 👍	Problems surfaced; considered manageable	Major obstacles; requires intervention ☒

- Developed an engagement strategy with input from ABRP Advisory Committee as specified by recommendation 10 on the ABRP.
- As part of the Social Determinants of Health Data Collection Project, prepared and trained staff and leaders from four (4) MLHU programs to pilot the collection of Race-based data (recommendation 1 on the ABRP).

Onboarding/Enhancement of ECR

- Completed workflow development, form development and training for the Infectious Disease Control Team Tuberculosis (TB) program clinic.
- Completed creation of TB forms in Profile test environment.
- Updated IHEAL program forms as needed in the Profile test environment.
- Updated 10 Healthy Start forms in the Profile production environment.
- Participated in the Profile for Public Health Working Group.
- Discussions with IDC around implementation of Profile.
- IT Team training on Profile Term Sets and Form creation completed.

Transition to SharePoint (SP)

- SharePoint training using original recorded sessions.
- Discussion with SLT on migration of MLHU Hub to SharePoint have completed with a current path of locking down as much as possible regarding the vulnerability issues, having IT continue to move as much data as possible with current capacity and then looking to 2024 for additional project management capacity to remove the MLHU HUB if still required.

Return to Office

- **Project completed** in October 2022.
- Activities were transitioned to responsible teams to operationalize processes created during Project.

Implementation of Joy in Work Framework

- Staff social held at German Canadian Club in June 2023 with over 200 staff in attendance.
- Leadership competency framework aligned to levels of leadership to inform performance appraisal process. Electronic tool previewed to determine feasibility.
- Potential leader development application process launched with over 40 applicants. Selection committee met to review leader endorsements and select 10 successful applicants for pilot group.
- Decision-authority matrix completed and introduced to MLT.

SDOH and Race-based Data Collection

- Recruited four pilot teams and trained staff and leaders.
- Created the data collection tool and various resources and supports for data collection.
- Worked with each pilot team to ensure their workflows could be adjusted to integrate the data collection.
- Established processes to monitor data and provide regular feedback to each pilot team
- Move TB to Production Environment after review
- Schedule Training for reporting with Vendor.
- Continue to update forms as needed.

Transition to SharePoint (SP)

- Continue to offer training sessions to increase staff knowledge.
- Revisit with SLT on progress of teams completing migration work and any additional assistance needed from Project Team.

Implementation of Joy in Work Framework

- Review and update leader job descriptions in alignment with competency framework and decision authority matrix. Complete electronic performance appraisal tool and pilot with MOH.
- Hold kick-off meeting with potential leader development successful applicant pool and launch development program.

SDOH and Race-based Data Collection

- Implementation and monitoring of the pilot.
- Working with pilot teams to identify areas for continuous quality improvement.
- Planning for pilot analysis and reporting (quantitative and qualitative data).

Associated Projects / Activities	Status
1. Employment Systems Review (ESR)	👍

Critical Issues & Major Risks:

Employment Systems Review (ESR)

- Recommendations arising from AODA audit require engagement with landlord for implementation;

2021-22 Provisional Plan Status Update to BOH – Q2 2023 (Apr-Jun)

Status Legend	Complete ☑	Proceeding as planned 👍	Problems surfaced; considered manageable 🚩	Major obstacles; requires intervention ☒

2. Implementation of the Anti-Black Racism Plan	🚩	continues to be time consuming and encounter some resistance. • Budget restraints on development of gender-neutral bathrooms on 2nd floor of Citi Plaza **Anti-Black Racism Plan** • Human resources and competing priorities at program level have continued to impact the speed of implementation of the ABRP recommendations. However, meaningful engagement has been prioritized as crucial foundational step. As such, the ABRP Advisory Committee, composed of diverse members of the ACB communities, is supportive of relationship building efforts which must "move at the speed of trust" (Ways of Working, p. 6 ABRP) **Onboarding/Enhancement of ECR** • Lack of funding may continue to impact progress in future. • There is a continuing need for training from other providers regarding reporting and ongoing form creation best practices. **Transition to SharePoint (SP)** • Risk still exists with the old environment but have been significantly reduced by restrictions to access. **SDOH and Race-based Data Collection** • Data governance and system issues were identified as areas to be addressed. • Challenges may exist in receiving buy-in from staff and leaders to consistently implement SDOH data collection.
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	👍	