Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, June 8, 2016 – 5:30 p.m.
Curve Lake Community Centre
20 Whetung Street East, Curve Lake First Nation

Opening Prayer
Councillor Keith Knott

1. Call to Order

Opening Statement
We respectfully acknowledge that we gather and reside on traditional Anishinaabeg land, and we offer our deep gratitude to our First Nations for their care for, and teachings about, our earth and our relations. May we honour those teachings.

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. **Presentation: Curve Lake Water Treatment**
Tammy Banks, Capital Works Coordinator, Curve Lake First Nation

5. Confirmation of the Minutes of the Previous Meeting

5.1. **May 4, 2016**

6. Business Arising From the Minutes

7. Staff Reports

7.1. **Presentation: A Day in the Life - Environmental Health Manager**
Atul Jain, Manager, Environmental Health

8. Consent Items

All matters listed under Consent Items are considered to be routine, housekeeping,

information or non-controversial in nature and to facilitate the Board's consideration can be approved by one motion.

Board Members: *For your convenience, circle the items you wish to consider separately:*
8.1a 8.1b 8.2a 8.2b 8.2c 8.2d 8.2e 8.3a

8.1. **Correspondence**

a. **Correspondence for Direction**

b. **Correspondence for Information**

8.2. **Staff Reports**

a. **Staff Report: Update on Smoke-Free Multi-Unit Housing in the Peterborough Area**
Donna Churipuy, Manager, Healthy Living

b. **Staff Report: Child Health Status Report 2015/16 – Part 3, In Summary: Parenting Practices**
Karen Chomniak, Manager, Family Health

c. **Staff Report: Vision, Mission and Values**
Dr. Rosana Salvaterra, Medical Officer of Health

d. **Staff Report: Audited Financial Statements - Preschool Speech and Language Program (2015/16)**
Bob Dubay, Manager, Financial Services

e. **Staff Report: Audited Financial Statements – Infant and Toddler Development Program (2015/16)**
Bob Dubay, Manager, Financial Services

8.3. **Committee Reports**

a. **Governance**
Gregory Connolley, Chair, Governance Committee

9. New Business

9.1. **Oral Report: Association of Local Public Health Agencies – 2016 Conference and Annual General Meeting**
Dr. Rosana Salvaterra, Medical Officer of Health

10. In Camera to Discuss Confidential Matters *(Nil)*

11. Motions for Open Session

12. Date, Time, and Place of the Next Meeting

Date: September 14, 2016
Time: 5:30 p.m.
Location: Dr. J. K. Edwards Board Room, 3rd Floor, Jackson Square, 185 King Street, Peterborough.

13. Adjournment

ACCESSIBILITY INFORMATION: Peterborough Public Health is committed to providing information in a format that meets your needs. To request this document in an alternate format, please call us at 705-743-1000.

Board of Health for the
Peterborough County-City Health Unit
DRAFT MINUTES
Board of Health Meeting
Wednesday, May 4, 2016 – 5:30 p.m.
Dr. J.K Edwards Board Room, 3rd Floor
Jackson Square, 185 King Street, Peterborough

In Attendance:

Board Members:	**Mr. Scott McDonald, Chair**
	Mayor Mary Smith, Vice Chair
	Mr. Gregory Connolley
	Ms. Kerri Davies
	Councillor Henry Clarke
	Councillor Gary Baldwin
	Mayor Rick Woodcock
	Mr. Andy Sharpe
	Chief Phyllis Williams
Staff:	**Mr. Larry Stinson, Director of Operations**
	Ms. Natalie Garnett, Recorder
	Ms. Brittany Cadence, Manager, Communication Services
	Dr. Rosana Salvaterra, Medical Officer of Health
	Ms. Alida Tanna, Executive Assistant
	Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer
Regrets:	**Councillor Lesley Parnell**
	Councillor Art Vowles
	Deputy Mayor John Fallis

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1. Call to Order

Mr. McDonald, Chair, called the meeting to order at 5:30 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Mayor Woodcock
Motion carried. (M-2016-064)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1. April 13, 2016

MOTION:

That the minutes of the Board of Health for the Peterborough County-City Health Unit meeting held on April 13, 2016, be approved as circulated.

Moved: Mr. Sharpe
Seconded: Chief Williams
Motion carried. (M-2016-065)

6. Business Arising From the Minutes

6.1. Staff Report: The Potential Health Impacts of a Casino in Peterborough – Update, April 2016

MOTION:

That the Board of Health for the Peterborough County-City Health Unit receive the following for information:

- *Staff Report "The Potential Health impacts of a Casino in Peterborough – Update, April 2016", and*
- *Technical Report "The Potential Health impacts of a Casino in Peterborough – Update, April 2016"*

Moved: Councillor Baldwin
Seconded: Mayor Smith
Motion carried. (M-2016-066)

7. Staff Reports

7.1. Staff Report and Presentation: Tobacco Use in Peterborough: Priorities for Action

Keith Beecroft, Health Promoter and Andrew Kurc, Epidemiologist provided a presentation on "Tobacco Use in Peterborough: Priorities for Action".

MOTION:

That the Board of Health for the Peterborough County-City Health Unit receive the following for information:

- *Staff Presentation "Priority Populations in Tobacco Use Prevention", and*
- *Report "Tobacco Use in Peterborough – Priorities for Action"*

Moved: Councillor Clarke
Seconded: Mayor Woodcock
Motion carried. (M-2016-067)

7.2. **Staff Report and Presentation: New Visual Identity for Peterborough Public Health**

Brittany Cadence, Manager, Communications Services, presented the proposed New Visual Identity for Peterborough Public Health.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit:
- *Receive the Staff Report "New Visual Identity for Peterborough Public Health", for information,*
- *Approve the logo/wordmark design, and*
- *That the tag line is to be used wherever possible.*

Moved: Mayor Smith
Seconded: Mr. Sharpe
Motion carried. (M-2016-068)

8. Consent Items

MOTION:
That items 8.1a, 8.1b, 8.2a, 8.2c, 8.2d, 8.2e and 8.3a be approved as part of the Consent Agenda.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2016-069)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit:
- *Receive the email dated April 18, 2016 from the Canadian Cancer Society regarding a request to endorse a requirement in Canada for plain and standardized cigarette packaging; and,*
- *Endorse the federal government's plain packaging initiative.*

Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2016-069)

MOTION:
That the following documents be received for information:

- *Letter dated March 31, 2016 from the Hon. Eric Hoskins, Minister of Health and Long-Term Care to the former Chair regarding one-time fundraising for 2014-2015, and 2015-2016.*
- *Email dated April 1, 2016 from Premier Wynne, in response to the Board Chair's letter dated March 30, 2016 regarding the Patients First Discussion Paper.*
- *Letter dated April 19, 2016 from MPP Jeff Leal, to the Hon. Eric Hoskins, Minster of Health and Long-Term Care, regarding the Patients First Discussion Paper.*
- *Letter dated April 21, 2016 from the Hon. Eric Hoskins, Minister of Health and Long-Term Care to Ontario Boards of Health regarding Ontario's publicly funded Human Papillomavirus (HPV) Immunization Program.*
- *Letter dated April 27, 2016 from the Board Chair to the Hon. Minister Jane Philpott regarding enforcement of the WHO Code.*
- *Letter dated April 28, 2016 from the Board Chair to the Hon. Eric Hoskins, Minister of Health and Long-Term Care regarding environmental health program funding.*
- *Letters/Resolutions from other local public health agencies:*

<u>Cannabis – Legalization/Public Health Approach</u>
Simcoe Muskoka District

<u>Food Insecurity/OSNPPH</u>
Northwestern

<u>Patients First</u>
Perth District

Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2016-069)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, "Q1 2016 Public Health Programs Report", for information.

Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2016-069)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive:

- *Receive the staff report, "Signing Authorities", for information; and,*
- *Approve the Assistant Director, Public Health Programs, as a cheque signing officer within the scope of Board of Health and Organizational Policies and Procedures.*

Moved: Councillor Baldwin
Seconded: Councilor Clarke
Motion carried. (M-2016-069)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, "Healthy Kids Community Challenge Project Update", for information.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2016-069)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, "Breaking Down Barriers to Breastfeeding for Women with Low Incomes in Peterborough", for information.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2016-069)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Q1 2016 Corporate Services Report, for information.
Moved: Councillor Clarke
Seconded: Mayor Smith
Motion carried. (M-2016-070)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes from the Fundraising Committee for March 7, 2016; and That the Board of Health for the Peterborough County-City Health Unit approve new Board of Health Policy 2-192, Donor Recognition.
Moved: Ms. Davies
Seconded: Mr. Sharpe
Motion carried. (M-2016-071)

9. New Business

9.1. Association of Local Public Health Agencies – 2016 Annual General Meeting Resolutions

MOTION:
That the Board of Health for the Peterborough County-City Health Unit:

- *Receive the memo dated April 19, 2016 from the Association of Local Public Health Agencies (alPHa) for information; and,*
- *Support the following resolutions scheduled to come forward to the 2016 Annual General Meeting:*
- *A16-1, alPHA Board of Directors, Change to Quorum in Constitution*
- *A16-3, Council of Ontario Medical Officers of Health, Health-Promoting Federal, Provincial and Municipal Infrastructure Funding*
- *A16-4, Haliburton, Kawartha, Pine Ridge District Health Unit, Enactment of Legislation to Enforce Infection Prevention and Control Practices Within Invasive Personal Service Settings (PSS) under the Health Protection and Promotion Act*
- *A16-5, Thunder Bay District Board of Health, Healthy Babies Healthy Children 100% Funding*

Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-072)

10. <u>In Camera to Discuss Confidential Personal and Property Matters</u>

11. <u>Motions from In Camera for Open Session</u>

12. <u>Date, Time, and Place of the Next Meeting</u>

The next meeting will be held June 8, 2016 in the Curve Lake Community Centre, 20 Whetung Street East, Curve Lake First Nation, 5:30 p.m.

MOTION:
That the That the Board of Health for the Peterborough County-City Health Unit provide the staff and technical reports on "The Potential Health impacts of a Casino in Peterborough – Update, April 2016" to the Council of the City of Peterborough.
Moved by: Councillor Baldwin
Seconded by: Ms. Davies
Motion carried. (M-2016-073)

Mr. Sharpe noted that the Peterborough County-City Health Unit should consider providing encouragement to residents to complete the census documents.

13. <u>Adjournment</u>

MOTION:
That the meeting be adjourned.
Moved by: Chief Williams
Seconded by: Mr. Connolley
Motion carried. (M-2016-074)

The meeting was adjourned at 6:37 p.m.

Chairperson

Medical Officer of Health

To: **All Members**
Board of Health

From: **Dr. Rosana Salvaterra, Medical Officer of Health**

Subject: **Correspondence for Direction**

Date: **June 8, 2016**

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1. Letter dated April 29, 2016 from the Association of Local Public Health Agencies to the Board Chair regarding 2016/17 membership fees.

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive the letter dated April 29, 2016 from the Association of Local Public Health Agencies (alPHa) regarding 2016-17 membership fees for approval; and,*
- *approve the 2016-17 fee in the amount of $10,065.46*

For your reference, fees for the last five years are included below. Fees are based on annual budgets, please note the fee increase in 2014-15 was due to the fact that Peterborough Public Health's budget passed the $7m threshold that year, which bumped fees into the next category.

		Increase
2012 – 2013 Membership Fee approved by the Board	$6,665.40	$130.70 *(+ 2.0%)*
2013 – 2014 Membership Fee approved by the Board	$6,855.36	$189.96 *(+ 2.8%)*
2014 – 2015 Membership Fee approved by the Board	$9,741.47	$2,886.11 *(+ 42%)*
2015 – 2016 Membership Fee approved by the Board	$9,868.11	$126.64 *(+ 1.3%)*
2016 – 2017 Membership Fee requested by alPHa	**$10,065.46**	**$197.35 *(+ 2.0%)***

2. Letter dated May 2, 2016 from Porcupine Health Unit to Minister Hoskins regarding Community Water Fluoridation.

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive correspondence from Porcupine Health Unit regarding their request to require community water fluoridation for all municipal water systems as well as funding and technical support to municipalities for implementation;*
- *endorse the resolution; and,*
- *communicate this support to Minister Hoskins, local MPPs, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

3. Letter dated May 13, 2016 from Middlesex London Health Unit to the Hon. Peggy Satler regarding the proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act.

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive correspondence from Middlesex-London Board of Health regarding their endorsement of a letter and background document from Toronto Public Health on supporting the Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act,*
- *endorse the letter and document put forward by Dr. David McKeown, Medical Officer of Health, Toronto Public Health, with an additional comment regarding ensuring that the language in the proposed act provides protection for workers involved with temporary agencies and other forms of precarious employment;*
- *communicate this support to MPP Peggy Sattler, with copies to Premier Wynne, MPP Andrea Horwath, MPP Patrick Brown, Hon. Kevin Flynn (Minister of Labour), Hon. Eric Hoskins (Minster of Health and Long-Term Care), Hon. Tracy MacCharles (Minister Responsible for Women's Issues), local MPPs, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Background:

The document provided by Toronto Public Health outlines the health rationale in support of the proposed amendments to the Employment Standards Act and the Occupational Health and Safety Act, specifically with regards to the provision of alternate work location and hours; paid and extended leave; prescribed sufficient evidence; and information and instruction about domestic and sexual violence in the workplace. (p. 4 of background document)

The proposed act has gone through second reading and, of as March 10, 2016, has been with the Standing Committee on Justice Policy. It is likely that, with the impending summer break, that third reading and Royal Assent will not happen until the fall.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

alPHa's members are the 36 public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

ANDSOOHA - Public Health Nursing Management

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Society of Nutrition Professionals in Public Health

April 29, 2016

Dr. Rosana Salvaterra
Medical Officer of Health
Peterborough County-City Health Unit
Jackson Square 185 King Street
Peterborough, ON K9J 2R8

Dear Dr. Salvaterra : Rosana

RE: alPHa 2016-17 Membership Fees

There has never been a more important time to be an active member of alPHa. Government initiatives with significant implications for all local public health units are underway in Ontario. These include the following:

1. A set of committees have been established to modernize:
    a. public health unit responsibilities through a review of the *Ontario Public Health Standards*, and
    b. board of health responsibilities through a review of the *Ontario Public Health Organizational Standards*.
2. The Ministry of Health and Long-Term Care has hired a governance expert to make recommendations on transitioning to skills-based boards of health beginning with Algoma Public Health and broadening to possibly include all boards of health in Ontario.
3. The Hon. Eric Hoskins, Minister of Health and Long-Term Care has released a discussion paper called, *Patients First – A Proposal to Strengthen Patient-Centred Health Care in Ontario*. In the paper, the Minister proposes to:
    a. Formalize linkages between local health integration networks (LHINs) and public health units,
    b. Empower medical officers of health to work with LHIN leadership to plan population health services,
    c. Transfer the dedicated funding for public health units to LHINs for allocation to public health units, and
    d. Transfer the responsibility for public health unit accountability agreements to LHINs.
4. The Ministry is also in the process of appointing an Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units and how to further improve public health capacity and delivery.

alPHa is involved in each of these initiatives through representatives at committee tables and mobilizing our well-established relationships with municipal and provincial elected officials and senior government bureaucrats to actively represent boards of health and public health units in these important discussions.

Enclosed is an invoice for the 2016-17 annual alPHa membership renewal. Your membership is essential to the strength of alPHa. Thank you for your ongoing support.

Sincerely,

Linda Stewart,
Executive Director

cc: Larry Stinson - Director of Operations

Association of Local Public Health Agencies

1306-2 Carlton Street
Toronto M5B 1J3

INVOICE

Invoice No.: 73309
Date: 04/01/2016
Ship Date:
Page: 1
Re: Order No.

Sold to:

Peterborough County-City Health Unit
Dr. Rosana Salvaterra
Jackson Square
185 King St.
Peterborough, Ontario K9J 2R8

Ship to:

Peterborough County-City Health Unit
Dr. Rosana Salvaterra
Jackson Square
185 King St.
Peterborough, Ontario K9J 2R8

Business No.: 127380822RT0001

Item No.	Unit	Quantity	Description	Tax	Unit Price	Amount
2016_17	Each	1	alPHa Membership - April 1, 2016 - March 31, 2017	H1	8,907.49	8,907.49
			Subtotal:			8,907.49
			H1 - HST 13% HST			1,157.97

Association of Local Public Health Agencies HST: #127380822 RT0001

Shipped By: Tracking Number:

Comment: Payable to Association of Local Public Health Agencies (alPHa)

Total Amount 10,065.46

Sold By:

Porcupine
Health Unit • Bureau de santé

May 2, 2016

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

email: info4you@porcupinehu.on.ca
Website: www.porcupinehu.on.ca

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON
M7A 2C4

Dear Minister Hoskins,

On April 22, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

WHEREAS, the relationship between poor oral health and poor physical and mental health is clear; and

WHEREAS, the relationship between poor oral health and risks associated with childhood development are known; and

WHEREAS, individuals in the community of lower socio-economic status suffer a more significant burden of poor health; and

WHEREAS, providing fluoride via community water offers the positive benefits equally for everyone in the community; and

WHEREAS, global health experts and evidence support community water fluoridation to prevent tooth decay;

THEREFORE BE IT RESOLVED THAT, the Porcupine Health Unit recommends that the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada-recommended level of 0.7 mg/L) to prevent dental caries; and

FURTHER THAT, the Province provide the funding and technical support to municipalities to implement community water fluoridation.

Thank you for your attention to this important public health issue.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

May 13, 2016

Ms. Peggy Sattler
Main Legislative Building, Room 359
Queen's Park, Toronto, ON
M7A 1A5

Dear Ms. Peggy Sattler,

At its April 21, 2016 meeting, the Middlesex-London Board of Health reviewed correspondence from Dr. David McKeown, Medical Officer of Health, Toronto Public Health regarding the *Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act*. The Middlesex-London Board of Health passed the following motion to endorse this letter:

> It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that the Board of Health endorse the letter from Toronto Public Health re Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act.*
>
> Carried

The Middlesex-London Board of Health supports advocating for workplace recognition of the physical and emotional toll that domestic or sexual violence can have on people and the impact this may have on their employment.

Yours sincerely,

Jesse Helmer
Chair, Middlesex-London Board of Health

cc: Dr. David McKeown, Medical Officer of Health, Toronto Public Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Deb Matthews, MPP London-North Centre
Jeff Yurek, MPP Elgin-Middlesex-London
Monte McNaughton, MPP Lambton-Kent-Middlesex
Theresa Armstrong, MPP London-Fanshawe
All Ontario Boards of Health

Dr. David McKeown
Medical Officer of Health

Public Health
277 Victoria Street
5th Floor
Toronto, Ontario M5B 1W2

Tel: 416-338-7820
Fax: 416-392-0713
dmckeown@toronto.ca
toronto.ca/health

March 8th, 2016

The Honourable Peggy Sattler
Main Legislative Building, Room 359
Queen's Park, Toronto, ON
M7A 1A5

Re: *Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act*

Dear Ms. Peggy Sattler,

I am writing to express my support for the proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act, which would require all employers to provide employees experiencing violence with workplace accommodations and paid and extended leave. It also would require all employers to receive information and instruction about domestic and sexual violence in the workplace.

In Canada, half of all women have experienced at least one incident of physical or sexual violence in their lifetime, and every six days, a woman is killed by her partner or ex-partner. Domestic and sexual violence have immediate and long lasting health, social and economic consequences for victims, their families, communities and society as a whole.

People experiencing domestic and sexual violence are in a position of significant physical, mental, emotional and financial hardship. Although some employers may have policies related to assisting employees experiencing violence, the proposed amendments will ensure universal access to important measures. This bill, if enacted, would promote safety in the workplace for the victim and their coworkers; reduce the burden of providing evidence when leave is necessary; prevent victims from losing their jobs when financial security is vital; help offset the costs associated with coping with or leaving an abusive partner; and afford them the time, energy and resources to focus on healing and rebuilding their lives. The attached document provides a more detailed public health rationale for key elements of this bill.

As the damaging effects of domestic and sexual violence are also seen in the workplace, a comprehensive public health approach to addressing these issues must include measures

in the workplace. I strongly support your proposed bill as an important measure that would help mitigate the negative impact of violence on the health and well-being of thousands of victims.

Sincerely,

Dr. David McKeown
Medical Officer of Health

Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act, 2016 – A Public Health Perspective

Domestic and Sexual Violence: Serious public health concerns

Domestic and sexual violence are significant public health concerns. Half of all women in Canada have experienced at least one incident of physical or sexual violence since the age of 16.[1] In Canada, women are more likely to experience violence by an intimate partner than by any other perpetrator.[2] Every six days, a woman in Canada is killed by her partner or ex-partner.[2] Men also experience domestic and sexual violence; however women are much more likely to be victims of severe forms of abuse, multiple victimizations, injuries and death.[2]

Domestic and sexual violence have immediate and long lasting health, social and economic consequences for victims, their families, communities and society as a whole. Women who have experienced violence have higher rates of stress-induced physiological changes, mental disorders, including depression, anxiety, sleep and eating disorders, homelessness, loss or separation from family and friends, loss of employment, debt and destitution.[2]

Children exposed to domestic and/or sexual violence also suffer a range of physical and mental health consequences. These consequences may put children on a negative developmental trajectory, including educational and economic under-performance, unsafe sexual practices and becoming future victims or perpetrators of abuse.[2, 3]

The impact of domestic violence in the workplace

The damaging effects of domestic violence also take place in the workplace. A recent Canadian survey found that one in three employees has experienced some form of domestic violence. Over 80% of those employees said that domestic violence had a negative effect on their work performance and over a third reported that co-workers were affected as well.[4]

Domestic violence in the workplace has substantial negative impacts not only on the victim, but also their co-workers, clients and the organization as a whole. These include:

- Reduced employee productivity;
- Potential harm to employees, co-workers and/or customers when violent abusers enter the workplace;

- Increased absenteeism;
- Decreased employee morale;
- Strained relations among co-workers;
- Replacement, recruitment and training costs when victims are injured or dismissed for poor performance;
- Higher company health expenses; and
- Liability costs if someone at the workplace is harmed.[5, 6]

Canadian employers lose an estimated $77.9 million annually due to the direct and indirect impacts of domestic violence.[2]

A comprehensive public health approach to addressing domestic and sexual violence must include measures in the workplace, such as those outlined in the proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act, 2016, that would amend the Employment Standards Act and the Occupational Health and Safety Act.

Public Health Rationale for Proposed Amendments

The following is the health rationale in support of the proposed amendments to the Employment Standards Act and the Occupational Health and Safety Act, specifically with regards to the provision of alternate work location and hours; paid and extended leave; prescribed sufficient evidence; and information and instruction about domestic and sexual violence in the workplace.

Provision of Alternate Work Hours and Location

Perpetrators of domestic abuse can interfere with a worker's employment. Providing alternate work hours and an alternate work location are important safety precautions and help an employee maintain work performance.

Perpetrators can interfere with an employee's work in a number of ways, including:

- Preventing them from getting to work through psychological or physically controlling behaviours or threats;
- Repeatedly phoning or emailing the victim;
- Coming to the workplace and asking questions of co-workers about the victim;
- Being dishonest with co-workers about the victim's whereabouts;
- Threatening co-workers;
- Verbally abusing the victim’s or organization’s property;
- Physically harming the victim and/or co-workers; and

- Stalking and/or watching the victim, which is one of the primary risk factors for attempted and actual murder of female partners in intimate relationships.[5, 6]

Studies estimate that 36 to 75% of domestic violence victims are bothered by their abusive partners while at work. In a study of employed women who recently filed domestic violence orders, 35% were stalked on the job.[6]

Providing an employee with alternate work hours is an important safety precaution with several benefits. It might prevent the perpetrator from interfering with the victim getting to work. It also allows the victim to alternate their hours and avoid routine, which may make it more difficult for the perpetrator to know the victim's work schedule. Flexible hours also allow the victim time to remove themselves from the abusive situation and or seek health or other supportive services to deal with issues arising from the violence which may be affecting their ability to attend work, or work safely and productively.

An alternate work location that is unknown to the perpetrator is also an important safety measure as it helps to prevent the victim from being abused at work and creates a secure environment where the employee, co-workers and clients can be safe and maintain work performance. Maintaining job performance helps the victim retain their job, which is an important factor in being able to leave an abusive partner.

Entitlement to Paid and Extended Leave

The health consequences of domestic and sexual violence can have a significant impact on work performance, which may put them at risk of losing their job. Victims of violence report increased levels of depression, stress, anxiety, embarrassment or shame due to stigma and fear of job loss. These lead to an inability to concentrate, more absenteeism and tardiness at work, overall lower work productivity and poor job performance. Victims of domestic violence report being fired or having to quit as a direct result of domestic abuse.[7]

The challenges involved when dealing with abuse may require taking time off work well beyond the time available through other leave entitlements currently available to employees, such as sick days and vacation. Dealing with an abusive incident or choosing to leave an abusive partner requires several actions and access to a range of services and supports, and takes substantial time, effort and financial resources. This includes accessing health services, relocating temporarily or permanently; seeking support services from a victim services organization and/or other professional counselling; finding affordable child care services and retaining a lawyer to address one or more legal issues, including family, child protection, criminal and/or immigration. Some groups, such as persons with low income, racialized women, women with disabilities, Indigenous women, and the LGBTQ community, may experience greater difficulty taking these steps due to a lack of or barriers to existing services, such as insufficient emergency, transitional and permanent housing; the cost of legal representation; lack of programs and mental health services; and the cost and time associated with transit.[8, 2]

An extended leave is an important measure that enables victims to maintain employment at a time when economic independence and financial security are vital and allows them to focus on the actions required for them and their family to heal from the abuse and rebuild their lives. Receiving pay for a portion of this leave helps offset the costs associated with dealing with domestic and/or sexual violence, which is especially critical for individuals living on low incomes.

Prescribed Sufficient Evidence

Acquiring the necessary evidence to prove that one needs accommodation or leave from work because of violence can exacerbate the employee's level of stress. Some types of evidence are easier to acquire than others (e.g., note from health provider vs. police record). Providing flexibility in the type of evidence that is acceptable lessens the burden of proof and enables employees to exercise a level of control over their personal information, which may minimize barriers to seeking access to accommodation or a leave.[9]

Adding Information and Instruction about Domestic Violence in the Workplace to the Occupational Health and Safety Act

Domestic and sexual violence are sensitive and complex issues. In order for management and staff to protect themselves, co-workers and their organization, they must be trained to recognize the signs of violence; the importance of being sensitive; and to fully understand their roles and responsibilities, as outlined in workplace domestic and sexual violence policies and procedures. For example, there is still a lot of stigma around domestic violence. Victims of domestic violence might choose not to disclose to their employer because they fear losing their job, are ashamed and believe that the employer will be apathetic. Employers who are educated about domestic and sexual violence are more likely to create a supportive work environment, implement protective measures and ensure available resources are utilized.[6, 10, 5]

Despite the importance of education on domestic and sexual violence, studies show that few employers currently provide training to managers, supervisors and employees on what to do if they themselves experience domestic violence or if they suspect a colleague of being a victim of domestic violence.[4] A survey of Canadian employers found that while the majority had a domestic violence policy in place, less than one third trained their managers and employees on this subject.[4] When employers were asked why they had created domestic violence policy and associated procedures, 70% said it was to comply with legislation.[4] Similarly, mandating information and instruction in the workplace will help ensure employers and their employees are prepared to respond to employees experiencing domestic and sexual violence and administer their policies and procedures in an effective, sensitive, and consistent manner.

Conclusion

This bill acknowledges that people experiencing domestic and sexual violence are in a position of significant physical, mental, emotional and financial hardship. Although some employers may have policies to support employees experiencing violence, the proposed amendments will ensure universal access to important safety measures. It will promote safety in the workplace for victims and their co-workers; reduce the burden of providing evidence when leave is necessary; help prevent victims from losing their jobs when financial security is vital; help offset the costs associated with coping with or leaving an abusive partner, which is critical for vulnerable populations; and afford them the time, energy and resources to focus on rebuilding their lives. Mandating information and instruction on domestic and sexual violence in the workplace will also ensure employers and their employees will be prepared to effectively assist employees in crisis.

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To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Correspondence for Information**

Date: June 8, 2016

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:

1. E-newsletter dated May 2, 2016 from the Association of Local Public Health Agencies (alPHa).

2. Email dated May 6, 2016 from Premier Wynne to Board of Health Chairs regarding community hubs.

3. E-newsletter dated June 1, 2016 from alPHa.

4. Letter dated June 2, 2016 from the Board Chair and Medical Officer of Health to the Hon. Eric Hoskins, Minister of Health and Long-Term Care regarding Patients First.

5. Letter dated June 3, 2016 from alPHa providing a summary of Bill 210, The Patients First Act.

6. Letters/Resolutions from other local public health agencies:

   Cannabis – Legalization/Public Health Approach*
   Elgin St. Thomas

   Herpes Zoster Vaccine*
   Algoma

   Nutritious Food Basket*
   Lambton

   Patients First*
   Middlesex London

   Smoking and Vaping Laws**
   Middlesex London *(appendices available upon request)*

*NOTE: *The Board has taken previously taken a position on these items.*
***NOTE: Board advocacy is not required at this time; staff are engaged in consultations regarding the new regulations.*

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: Monday, May 02, 2016 12:22 PM
To: Alida Tanna
Subject: alPHa Information Break - May 2, 2016

alPHa
Association of Local PUBLIC HEALTH Agencies
30 YEARS 1986-2016

Information Break

May 2, 2016

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Register Now for 2016 alPHa Annual Conference

Registration is now open for *Building a Healthier Ontario*, alPHa's annual conference that will be held June 5-7 at the downtown-located Novotel Toronto Centre. Marking our 30th anniversary as an association, the conference will explore building public health relationships in a transformed Ontario health system; a main focus will be partnering with Local Health Integration Networks. New this year are breakout sessions on understanding LHINs, scenario planning for Patients First, and population health planning. All this plus more! We hope you can attend.
Get more information on the 2016 Annual Conference here

TIP: Book your hotel guestroom today to avoid disappointment (click here or call 416-367-8900 and quote Association of Local Public Health Agencies).

Patients First Activities

At its April 21 meeting the alPHa Board of Directors held a Patients First scenario planning exercise led by public health consultant Dr. Brent Moloughney. The Board discussed public health-related policy items and potential actions to take as an association on these policy items. A follow up report on the exercise will be shared with the membership when it becomes available. At the same meeting, the Board spoke with Roselle Martino, Assistant Deputy Minister, on Patients First issues. Also recently, the alPHa Board reiterated its concerns to the province over unintended consequences that may result from Patients First proposals, including a weakened public health system and a loss of local board of

health independence. The letter was in response to an April 20 memo from Minister Hoskins to boards of health acknowledging public health contributions at the health system level. alPHa will continue to engage with the province on Patients First and keep members posted in the coming months.
Read alPHa's latest letter on Patients First
Read Minister Hoskin's letter to Boards of Health on Patients First
Read alPHa's response to the Patients First discussion paper

Ontario Expands HPV Vaccination Program

The province announced plans to expand its publicly funded Human Papillomavirus (HPV) vaccine to include male students beginning September 2016. The school-based immunization program will now see all Grade 7 students offered this cancer-fighting vaccine in the fall.
Read the ministry news release here

Correspondences

alPHa has recently written a number of letters to government, including concerns over the licensing zoning for MMT clinics and the proposed changes to regulations under the *Smoke Free Ontario* and *Electronics Cigarettes Acts*. alPHa has also written a letter of congratulations regarding the province's expansion of the HPV vaccination program, and in another correspondence, urged the government to immediately coordinate a response to opioid overdoses with a prevention and intervention approach.
Read alPHa's latest correspondences here

Reminder: alPHa Fitness Challenge, May 5

Don't forget this **Thursday, May 5** is the annual alPHa Health Unit Employee Fitness Challenge. Ontario's public health units are being put to the test in this friendly competition to see which one can involve the most number of staff in physical activity for 30 minutes on May 5th. So spread the word and gear up! *Note to Physical Activity Coordinators:* Completed forms must be submitted by **May 9, 12:00 noon** to karen@alphaweb.org
Learn more about the 2016 Fitness Challenge here

Upcoming Events

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference, Building A Healthier Ontario*- 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.

From: Premier of Ontario | Première ministre de l'Ontario <Premier@ontario.ca>
Sent: Friday, May 6, 2016 12:28 PM
Subject: FW: An email from Premier Kathleen Wynne / Un courriel de la première ministre Kathleen Wynne

Please see below an email from Premier Kathleen Wynne to the chair of the local Board of Health.

Vous trouverez ci-dessous un courriel de la première ministre Kathleen Wynne à la présidence du conseil local de santé.

[Version française après le texte anglais.]

Today, the Honourable Liz Sandals, Minister of Education, announced investments and regulatory changes to support the use of schools as community hubs.

In August 2015, the Community Hubs Framework Advisory Group, chaired by Special Advisor, Karen Pitre, released *Community Hubs in Ontario: A Strategic Framework and Action Plan* ("Action Plan"), a report with 27 recommendations on how our government can support community hub development. Today's announcement represents the latest in a series of many steps our government has taken towards implementing all of the recommendations.

In response to the Action Plan's recommended short-term strategy for school property and extensive stakeholder consultation, the Ministry of Education has made the following amendments to Ontario Regulation 444/98 – *Disposition of Surplus Real Property*:

- Extend the current surplus school circulation period from 90 days to 180 days, providing listed public entities with 90 days to express interest in the property and an additional 90 days to submit an offer
- Expand the list of public entities to receive notification of surplus school property disposition.

This means that school boards will begin circulating surplus school properties that they are seeking to sell or lease to an expanded list of public entities, including public health units as of September 2016.

These amendments will provide more opportunities for community organizations to purchase or lease surplus school properties in order to allow for continued community use.

The Ministry of Education is also supporting the use of schools as community hubs by investing $90 million through new capital funding programs that will help schools better serve students, families and communities.

Information regarding the changes to Ontario Regulation 444/98 and the school board disposition process can be found on the following website: http://www.edu.gov.on.ca/eng/parents/properties.html.

For guidance on how your organization can connect with community partners and explore community hub development, I encourage you to contact the Community Hubs Secretariat at Community.Hubs@Ontario.ca.

I believe this initiative represents an important step in supporting the government's objectives of removing barriers to community hub development, coordinating planning opportunities for public assets to serve as hubs, providing integrated service delivery to communities, and respecting the importance of local planning decisions.

I want to express my sincere appreciation to the many community organizations and other public sector entities for the feedback received to inform these changes and for their ongoing efforts to better serve Ontarians.

We are committed to continuing to engage collectively with our partners to build on the strengths of our partnerships. This will further improve community access to schools to support the communities they serve, as well as supporting our vision for Ontario as the best place to live, work and raise a family.

I look forward to continuing to work together.

Kathleen Wynne
Premier

c: The Honourable Liz Sandals
Karen Pitre, Special Advisor on Community Hubs

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: Wednesday, June 01, 2016 11:34 AM
To: Alida Tanna
Subject: alPHa Information Break - June 1, 2016

alPHa
Association of Local PUBLIC HEALTH Agencies
30 YEARS 1986-2016

Information Break

June 1, 2016

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

2016 ANNUAL CONFERENCE EDITION

Minister Hoskins at alPHa Conference

alPHa is pleased to announce that the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, will be bringing greetings and remarks to the alPHa membership on **Monday, June 6, from 12:50 to 1:00 PM**. This marks the first time Minister Hoskins will address an alPHa convention. Be sure to attend!
View the latest Program-at-a-Glance here

2016 Conference Sponsors

alPHa's annual conference is generously supported by its sponsors and contributors. We wish to acknowledge the following organizations and their support of alPHa and this event:

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Public Health Ontario
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Smart Serve Ontario

Gold Sponsor
GSK

Silver Sponsors
Mosey & Mosey Insurance
Public Health en français - Community of Practice

Bronze Sponsor
Sanofi Pasteur

2016 Conference Exhibits

Come visit our conference exhibits -- we have a total of 9 this year! Located in the main foyer (hallway) on the second floor of the Novotel Toronto Centre hotel, these exhibits can enhance your conference experience. Learn about a host of public health-related initiatives and products, from the latest public health vaccines, responsible alcohol services, group health benefits, French language support for health units, and more.

Visit our exhibitors and speak to a representative from:

BORN Ontario
Dairy Farmers of Canada
GSK
Mosey & Mosey Insurance
OnCore - EnCours
Public Health en français - Community of Practice
Public Health Ontario
Sanofi Pasteur
Smart Serve Ontario / DrinkSmart Inc.

Upcoming Event (in case you skipped the items above)

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference, Building A Healthier Ontario*- 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.

HIGHLIGHTS: Special guest speaker - **Hon. Eric Hoskins**, Ontario Minister of Health and Long-Term Care. Plenary sessions on working with **Local Health Integration Networks** and **Patients-First** related breakout sessions. **Award ceremony** honouring distinguished public health professionals. **Networking** opportunities, and much more.

Peterborough
Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

June 2, 2016

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
ehoskins.mpp@liberal.ola.org

Dear Minister Hoskins:

Thank you for your letter, dated April 20, 2016, directed to Boards of Health and Medical Officers of Health highlighting the role of public health in healthy system transformation. We are pleased to see your comments about the importance of public health units and integration of population health and health equity into health system planning.

At its meeting on May 4, 2016, the Board of Health for Peterborough Public Health (formerly the Peterborough County-City Health Unit) received your letter for information, and requested that we share with you the status of support in Peterborough for the proposed transformation.

Following a review of the Patients First Document at the March 9, 2016 meeting, our Board of Health called upon the Province of Ontario to ensure a continued strong role for public health in keeping people healthy by:

- maintaining independent governance of the public health sector by local boards of health;
- maintain its direct and transparent funding of local boards of health;
- continue to directly negotiate Provincial Public Health Funding and Accountability Agreements (PHFAA) with local boards of health.

In addition, the Board of Health requested that staff seek support for this resolution (attached) from each of the municipal and First Nation Councils in the Peterborough County-City Health Unit, and that this information be shared with each of our local Members of Provincial Parliament (Minister Jeff Leal and MPP Laurie Scott) and the Minister of Health and Long-Term Care. Presentations have been provided to all municipal councils and both of our First Nation councils, to date the following have endorsed the resolution to maintain public health funding and accountability with the Province and not the LHIN:

- Curve Lake First Nation
- Hiawatha First Nation
- Township of Cavan Monaghan
- Township of Douro-Dummer

- Township of Havelock-Belmont-Methuen
- Township of North Kawartha
- Township of Selwyn
- City of Peterborough
- County of Peterborough

Meetings have also been held with our local MPPs Leal and Scott, both have expressed support for our position.

Although from a public health perspective we appreciate the proposed direction for an expanded scope for public health to contribute to LHIN planning, we believe the transfer of responsibility for funding and accountability for public health to LHINs has no clear demonstrated value and has significant potential for negative unintended consequences. The direct relationship with the Province ensures that the same principles and standards are upheld and implemented for all boards of health, further ensuring that all Ontarians benefit equitably from the public health system. We encourage you, therefore, to await direction form the Expert Panel on Public Health and consider the value of a continued direct relationship between the Province and local boards of health.

Thank you for your consideration.

Yours in health,

Original signed by

Scott MacDonald
Chair, Board of Health

Original signed by

Rosana (Pellizzari) Salvaterra, MD, MSc, CCFP, FRCPC
Medical Officer of Health

/at
Encl.

cc: M.P.P. Jeff Leal, Peterborough
M.P.P. Laurie Scott, Haliburton-Kawartha Lakes-Brock

Patients First and Public Health

A request from the Board of Health for Peterborough County-City Health Unit (March 9, 2016)

WHEREAS the discussion paper *Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario* conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care, by establishing links between LHINs and public health which can occur through identifying new roles and responsibilities that do not require changes in the funding or governance of public health in Ontario; and

WHEREAS the wider problem of improving and supporting the health and health equity of Ontarians is mandated to the public health system, through the Health Protection and Promotion Act that has created local boards of health and has made them accountable for the delivery of public health programs and services as required by the Ontario Public Health Standards and the Ontario Public Health Organizational Standards, and

WHEREAS the direct relationship with the province ensures that the same principles and standards are upheld and implemented for all boards of health, further ensuring that all Ontarians benefit equitably from the public health system; and

WHEREAS municipal and First Nation representation on boards of health ensure valuable connections with decision makers and staff to support local healthy public policy; and

WHEREAS evidence from other jurisdictions where public health funding has been integrated regionally with funding for the rest of the health care system shows that opportunities for system improvement is often not realized and unintended risks to public health have arisen:

BE IT THEREFORE RESOLVED that the board of health for the Peterborough County-City Health Unit calls upon the province of Ontario to ensure a continued strong role for public health in keeping people healthy by

- maintaining independent governance of the public health sector by local boards of health; and
- maintain its direct and transparent funding of local boards of health; and
- continue to directly negotiate Provincial Public Health Funding and Accountability Agreements (PHFAA) with local boards of health.

Local municipal and First Nation Councils are called upon to endorse this motion and advise Premier Kathleen Wynne, Minister of Health and Long Term Care, the Honourable Eric Hoskins, and local MPPs, Minister of Agriculture and Rural Affairs Jeff Leal, and Laurie Scott, in writing.

Moved by: Mr. Sharpe
Seconded: Chief Williams
Motion carried (M-2016-032).

alPHa Summary
Bill 210 – The Patients First Act
An Act to amend various Acts in the interest of patient-centred care

Bill 210, the long-anticipated legislation related to the proposals for health system reform that were laid out in the Patients First Discussion Paper was introduced for first reading in the Ontario Legislature on June 2 2016.

In his introduction of Bill 210, The Minister of Health and Long-Term Care stated that "this bill would make amendments to the Local Health System Integration Act, 2006, and various other acts to expand the mandate of local health integration networks to make LHINs accountable for primary care planning, responsible for the management and delivery of home care, and formalize linkages between LHINs and public health units". The related Ontario News Release includes a reference to "ensuring that public health has a voice in health system planning" as part of those formalized linkages.

Most of the legislative changes would be made to the Local Health System Integration Act, with a view to authorizing the expanded service roles of the LHINs (mainly those that currently reside with Community Care Access Centres) and the enhanced planning and coordination functions that were described in the Patients First discussion paper.

There are amendments to both the Health Protection and Promotion Act and the LHIN Act that formalize relationships between LHINs and Medical Officers of Health as well as Boards of Health. These changes do not include a transfer of public health funding and accountability agreements to the LHINs from the MOHLTC, as originally proposed in the discussion paper.

alPHa is pleased to provide its members with this overview of the changes most relevant to their interests.

EXCERPTS FROM THE BILL 210 EXPLANATORY NOTE OF INTEREST TO PUBLIC HEALTH (*alPHa editorial notes in italics*)

- The Bill amends the Local Health System Integration Act, 2006 and makes related amendments to several other Acts. (*Most of the amendments to other Acts are simply the removal of references to CCACs. Two changes to the HPPA are described below*).

- The Lieutenant Governor in Council is given the power to change the geographic area of local health integration networks by regulation. (*It is alPHa's understanding that the Ministry appreciates the difficulties with the current misalignment between LHIN and PHU boundaries and intends to address them*).

- Local health integration networks are required to establish geographic sub-regions in their local health system for the purposes of planning, funding and service integration. They must develop strategic directions and plans for these sub-regions in their integrated health service plan. (*This is included simply with reference to their potential bearing on the intended relationships with medical officers and boards of health*)

- Local health integration networks are given the ability to provide funding to health service providers in respect of services provided in or for the geographic area of another network. (*see note below*)

- New procedures and requirements are provided for service accountability agreements. The provision about local health integration networks not being allowed to enter into agreements or other arrangements that restrict or prevent an individual from receiving services based on the geographic area in which the individual resides is re-enacted in a new section. (*This and the point above are included here to highlight the fact that the Patients First discussion paper suggested that public health funding and accountability agreements would be transferred to LHINs from the MOHLTC. This was a major concern for alPHa's members and we are pleased that the Patients First Act does not follow through on this change. Boards of health are not identified as "health service providers", the entities to which these and other changes to LHIN authority will apply*).

- Health Protection and Promotion Act: Medical officers of health are required to engage with their local health integration networks. The Chief Medical Officer of Health is given the power to issue directives to local health integration networks, rather than CCACs. (*Details of the changes are presented in a table in the next section*).

EXCERPTS FROM THE TEXT OF BILL 210 OF INTEREST TO PUBLIC HEALTH

1. (1) Subsection 2 (1) of the *Local Health System Integration Act, 2006* is amended by adding the following definition:

"medical officer of health" has the same meaning as in the *Health Protection and Promotion Act*; ("médecin-hygiéniste")

4. (2) Section 5 (*"The objects of a local health integration network are to plan, fund and integrate the local health system to achieve the purpose of this Act, including"***), of the Act is amended by adding the following clause:**

(e.1) to promote health equity, reduce health disparities and inequities, and respect the diversity of communities in the planning, design, delivery and evaluation of services;

9. Section 10 of the Act is amended by adding the following subsection:

Medical officer of health engagement

(3.1) A local health integration network shall ensure that its chief executive officer engages with each medical officer of health for any health unit located in whole or in part within the geographic area of the network, or with the medical officer of health's delegate, on an ongoing basis on issues related to local health system planning, funding and service delivery.

13. (2) Section 15 of the Act is amended by adding the following subsection:

Consultations

(4) A local health integration network shall engage and seek advice from each board of health for any health unit located in whole or in part within the geographic area of the network in developing its integrated health service plan.

39. *Health Protection and Promotion Act* is amended *(the current sections of the HPPA are provided for your reference).*

HPPA Section 67 Current	***HPPA Section 67 Amended with the addition of the following subsections***
67. (1) The medical officer of health of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. 1997, c. 30, Sched. D, s. 7 (1). **Direction of staff** (2) The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programs or services under this or any other Act. R.S.O. 1990, c. H.7, s. 67 (2); 1997, c. 30, Sched. D, s. 7 (2). **Management** (3) The medical officer of health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. 1997, c. 30, Sched. D, s. 7 (3). **Area of authority** (4) The authority of the medical officer of health of a board of health under this Act and the regulations is limited to the health unit served by the board of health. R.S.O. 1990, c. H.7, s. 67 (4).	**Engagement with LHIN** (5) The medical officer of health of a board of health shall engage on issues relating to local health system planning, funding and service delivery with the chief executive officer or chief executive officers of the local health integration network or networks whose geographic area or areas cover the health unit served by the board of health. **Delegation** (6) A medical officer of health may only delegate his or her responsibilities under subsection (5) to another medical officer of health for a health unit within the relevant local health integration network, with the agreement of that other medical officer of health.
HPPA Section 77.7 (6) Current	HPPA Section 77.7 (6) Amended
"health care provider or health care entity" means: 2. A service provider within the meaning of	"health care provider or health care entity" means: 2. A service provider within the meaning of

the *Long-Term Care Act, 1994* who provides a community service to which that Act applies. 3. A community care access corporation within the meaning of the *Community Care Access Corporations Act, 2001*. 5. A pharmacy within the meaning of Part VI of the *Drug and Pharmacies Regulation Act*.	the *Home Care and Community Services Act, 1994* who provides a community service to which that Act applies. **Paragraph 3 of the definition of "health care provider or health care entity" in subsection 77.7 (6) of the Act is repealed.** **(4) Paragraph 5 of the definition of "health care provider or health care entity" in subsection 77.7 (6) of the Act is repealed and the following substituted:** 5. A pharmacy within the meaning of the *Drug and Pharmacies Regulation Act.* **(5) The definition of "health care provider or health care entity" in subsection 77.7 (6) of the Act is amended by adding the following paragraph:** 9.1 A local health integration network within the meaning of the *Local Health System Integration Act, 2006*.

OTHER INFORMATION

Ontario News Release: http://bit.ly/1UxCciA
Full text of Bill 210: http://bit.ly/1TSTUAg
alPHa News Release: Attached
Summary of Related alPHa Correspondence: Attached

Members should be aware that alPHa has been very active on this since the Patients First discussion paper was released in December of 2015. It has been the major point of discussion for the alPHa Board and its Committees (including the Boards of Health and COMOH Sections), with internal meetings dedicated to responses and scenario planning as well as external ones with partners at all levels of the Ministry of Health and Long-Term Care. alPHa will remain active on behalf of its members as the specifics of the formalized relationship between LHINs and Local Public Health are developed.

We hope that you find this information useful.

alPHa
Association of Local
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Agencies

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Providing Leadership in Public Health Management

NEWS RELEASE

June 2, 2016 **For Immediate Release**

Minister Affirms the Importance of Public Health to the Health of Ontarians and the Sustainability of the Health Care System

TORONTO – Today, the Ontario government introduced the *Patients First Act*. The proposed legislation calls on the Local Health Integration Networks (LHINs) to work more closely with local public health units. The expected outcome would be a health care system that better meets patients' needs. More importantly, the outcome would be a health care system that better prevents people from becoming patients in the first place.

"The Association of Local Public Health Agencies (alPHa) applauds this initiative to reorient the health care system toward disease prevention and health promotion," says alPHa President, Dr. Valerie Jaeger. "Along with our health care colleagues, we are strong advocates for health and we know that an effective health care system contributes to the health of individuals and communities. We are pleased at the opportunity and the health dividends that the *Patients First Act* represents."

However, alPHa also recognizes that these proposals only encompass one of the five pillars in the Ottawa Charter for Health Promotion. Introduced by the World Health Organization (WHO) 30 years ago, the Charter maps out five strategies or pillars to keep individuals and communities healthy: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and finally, reorienting health care services so that opportunities for disease prevention are acted on. This last pillar is a focus of the public health-related proposals in the *Patients First Act*.

The landmark, internationally acclaimed Charter has guided public health practice around the world. It also put Canada on the map as a global leader, not only for its illness care system, but also for its public health system—tackling the underlying conditions that keep people healthy.

alPHa's Past President, Dr. Penny Sutcliffe emphasized that, "Health, of course, is about much more than access to health care. An accessible, quality health care system is an essential but insufficient ingredient in creating opportunities for health for all. Working on the other four Charter pillars is critical if Ontarians are to be the healthiest they can be and if the health care system is to be sustainable." Dr. Sutcliffe added, "This is what local public health units do every day in collaboration with many community partners. The health opportunities presented by the *Patients First Act* will not be realized if its implementation means an erosion of the capacity of Ontario's local public health system to work on all pillars of the Ottawa Charter."

alPHa wholeheartedly supports measures that will improve the health care system. We are also committed to comprehensive public health action – action which a recent report by the Institute for

Clinical Evaluative Sciences (ICES) estimates has saved the Ontario health care system almost $5 billion in the last 10 years.

These are the health dividends of an effective public health system – dividends that can then be reinvested in all the things that really matter to health – education, transportation, child care, municipal infrastructure, drinking water, reconciliation with Indigenous communities, housing, food security, jobs, family supports, and more – so that all Ontarians can live healthier and be ill less frequently, while knowing that a more accessible and patient-centred quality health care system is there for us when we need it.

About alPHa

The Association of Local Public Health Agencies (alPHa) is a non-profit organization that provides leadership to Ontario's boards of health and local public health units. The Association works with governments and other health organizations, to advocate for a strong and effective local public health system in the province, as well as public health policies, programs and services that benefit all Ontarians.

- 30 -

For more information regarding this news release, please contact:

Linda Stewart
Executive Director
(416) 595-0006 ext. 22
linda@alphaweb.org

SUMMARY OF alPHa CORRESPONDENCE RELATED TO PATIENTS FIRST (most to least recent)

alPHa News Release - Patients First Act

June 2 2016 alPHa News Release following the introduction of Bill 210, the Patients First Act.

alPHa Brief - Patients First Response

April 29 2016 - single-page summary of alPHa's response to the Patients First discussion paper, distributed to members for use during meetings with MPPs and other local advocacy activities.

alPHa Letter - Patients First

April 28 2016 alPHa letter to the Minister of Health and Long-Term Care that responds to his April 20 memo to Boards and MOHs regarding health system transformation, noting its omission of any specific reference or response to alPHa's February 28 recommendations on the Patients First discussion paper.

MOHLTC Memo - Patients First

April 20 2016 memo from the Minister of Health and Long-Term Care to alPHa's members regarding his vision for public health's role in the Patients First health care system transformation plan.

alPHa Letter - Patients First Expert Panel

March 4 2016 alPHa letter responding to the Patients First Discussion Paper proposal to establish an Expert Panel to advise on deepening and formalizing linkages between LHINs and Public Health Units. Includes a recommendation to include the current alPHa President as a member.

alPHa Letter - Thanks to Deputy Minister

March 2 2016 letter from the alPHa President thanking Deputy Minister Bob Bell for joining the February 25th Section meetings for dialogue with our members.

alPHa Letter - Thanks to Deputy Minister

March 2 2016 letter from the alPHa President thanking Deputy Minister Bob Bell for joining the February 25th Section meetings for dialogue with our members.

alPHa Letter - Patients First Response

February 29 2016 alPHa response to the Ministry of Health and Long-Term Care discussion paper, "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario".

MOHLTC Letter - Health System Discussion Paper

December 17 letter to the alPHa President from the Minister of Health and Long-Term Care inviting input to the engagement processes related to the just-released Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario discussion paper.

alPHa News Release - MOHLTC Discussion Paper

December 17 alPHa News Release congratulating the Minister of Health on the release of his proposed vision for the health system in Ontario (Patients First - A Proposal to Strengthen Patient Centred Health Care in Ontario).

March 23, 2016

The Right Honourable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Prime Minister Trudeau:

Re: Public Health Approach to Cannabis Legalization and Regulation

The Board of Health for Elgin St.Thomas Public Health brings forth the following resolution for government to carefully consider as it explores policy options around the legalization of cannabis.

WHEREAS Canada's recently elected federal government has indicated a clear intention to move forward on activities to legalize and increase public access to marijuana, and

WHEREAS within the current legal context, cannabis is widely used in the Elgin St.Thomas catchment area: 46.8 % of adults (aged 19 years and older) reported ever using marijuana, cannabis, or hashish, and 26.6 % of adults reported use of marijuana, cannabis, or hashish in the previous 12 months.

WHEREAS residents in our community are not only using marijuana at regular intervals but are doing so in conjunction with the operation of motor vehicles which can lead to an increased risk of crashes, and

WHEREAS the Canadian Centre for Substance Abuse (CCSA) has identified that consuming cannabis regularly during adolescence interferes with the function and development of and individual's brain system and that delaying the age of use onset is recommended to reduce the harms associated with youth, and

WHEREAS the Centre for Addiction and Mental Health (CAMH), Canada's leading hospital for mental illness, has concluded that legalization, combined with strong health-focused regulation, could provide and opportunity to reduce the harms associated with cannabis use, and

WHEREAS there is an existing framework of lower-risk cannabis guidelines (LRCUG) endorsed by a number of organizations including CAMH and the Canadian Public Health Association (CPHA), that can serve as a meaningful base for public education to reduce high-risk cannabis use and harms and

NOW THEREFORE BE IT RESOLVED that Elgin St.Thomas Public Health Board of Health supports a public health approach to any cannabis legalization framework introduced into Ontario, including a strong health-centred and age-restricted regulations to reduce the health and societal harms associated with cannabis use, and

FURTHER THAT this resolution be shared with the Honorable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

Members of Elgin St.Thomas Public Health Board of Health respectfully request that the Right Honourable Prime Minister use a public health approach to the regulation and legalization of cannabis in Canada.

Sincerely,

Cynthia St. John
Executive Director

Dr. Joyce Lock
Medical Officer of Health

cc: The Honourable Jane Philpott, Minister of Health, Government of Canada
The Honourable Eric Hoskins, Minister of Health and Long-Term Care, Government of Ontario
The Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
The Honourable Madeleine Meilleur, Attorney General of Ontario
Karen Vecchio MPP Elgin- Middlesex- London
Jeff Yurek MP Elgin- Middlesex- London
The Honourable Kathleen Wynne, Premier of Ontario
Dr. Gregory Taylor, Chief Public Health Officer, Public Health Agency of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Linda Stewart, Executive Director, Association of Local Public Health Agencies (alPHA)
Dr. Catherine Zahn, President and Chief Executive Officer, Centre for Addiction and Mental Health Ontario Boards of Health
Linda Sibley, Executive Director, Addiction Services of Thames Valley
Heather Debruyn, Executive Director, Canadian Mental Health Association

Algoma
PUBLIC HEALTH
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www.algomapublichealth.com

May 3, 2016

The Honourable Dr. Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins,

The Board of Health for the District of Algoma recently received a staff report regarding the Herpes Zoster Vaccine. We note the February 25th letter from The Board of Health for Peterborough County-City Health Unit to you requesting the addition of the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults. We also note the statement in the Ontario 2016 Budget that "The government is making the shingles vaccine free for eligible Ontario seniors between the ages of 65 and 70 — saving them about $170 and reducing emergency room visits and hospitalizations."

We commend your government on adding the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults and look forward to the speedy implementation of this new cost-effective initiative which will benefit thousands of Ontario senior citizens.

Sincerely,

Lee Mason

Mr. Lee Mason,
Chair, Algoma Public Health

cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Hon. David Orazietti, M.P.P.
Ontario Boards of Health
Linda Stewart, Association of Local Public Health Agencies

Office of the County Warden
789 Broadway Street, Box 3000
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Fax: 519-845-3160

May 9, 2016

The Honourable Deb Matthews
Deputy Premier
President of the Treasury Board
Minister Responsible for the Poverty Reduction Strategy
Room 4320, 4th Floor, Whitney Block
99 Wellesley Street West
Toronto, ON M7A 1W3

The Honourable Helena Jaczek
Minister of Community and Social Services
6th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1E9

Attention: The Honourable Ministers Matthews and Jaczek

Dear Minister Matthews and Minister Jaczek:

Re: Rising Cost of Healthy Food as Determined by the 2015 Nutritious Food Basket Cost Data

During its meeting on February 3, 2016, the County of Lambton Board of Health accepted a report from Lambton Public Health, reflecting results of the 2015 Nutritious Food Basket (NFB) cost data. As Ministers responsible for both the Poverty Reduction Strategy and Community and Social Services, we request that social assistance rates be increased to reflect the rising cost of healthy food as determined by the Nutritious Food Basket, and to index rates to inflation to keep up with the rising cost of living.

In 2013 and 2014, 8% of Lambton residents reported moderate or severe food insecurity. Local data indicates that it costs $869.46 per month to feed a family of four in Lambton County, and that a single person receiving Ontario Works has a shortfall of $160.55 every month after paying for rent and food.

Since 2009, prices for the NFB have increased by 17.5%, well above the consumer price index for the same period of time. When money is tight, many Lambton residents struggle to make ends meet by cutting their food budget.

We acknowledge your ongoing commitment to moving the needle on poverty in Ontario through the *Poverty Reduction Strategy*. On February 25, 2016 we learned that the Province's budget included pursuing a Basic Income Pilot under section E, "Towards a Fair Society". Certainly this could serve to address the concerns of household food security for individuals and families that have access to this pilot program. We recognize however, that not all communities will see the immediate impacts of the pilot and Lambton's Board of Health continues to have concerns about access to healthy food for its residents based on 2015 Nutritious Food Basket cost data.

Thank you for hearing our concerns, which are echoed across Ontario's Boards of Health. We look forward to hearing how these planned changes will impact residents of the County of Lambton who are struggling to meet their basic needs as costs continue to rise.

We encourage you to partner with Boards of Health to evaluate the Basic Income Pilot(s) in order to achieve a comprehensive understanding of the impacts of this program on population health.

Sincerely,

Warden Bev MacDougall
Chair, County of Lambton Board of Health

cc: The Honourable Kathleen Wynne, Premier of Ontario
M.P.P. Bob Bailey, Sarnia-Lambton
M.P.P. Monte McNaughton, Lambton-Kent-Middlesex
Ontario Boards of Health
County of Lambton Lower-Tier Municipalities
Linda Stewart, Association of Local Public Health Agencies
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division
Margaret Roushorne, General Manager, Social Services Division

May 13, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins,

At its April 21, 2016 meeting, the Middlesex-London Board of Health reviewed correspondence from Dr. Valerie Jaeger, President, Association of Local Public Health Agencies (alPHa) regarding alPHa's preliminary comments on your Ministry's discussion paper *Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario*.

The Middlesex-London Board of Health passed the following motion to endorse this letter:

> It was moved by Mr. Peer, seconded by Ms. Fulton, *that the Board of Health endorse the letter from the Association of Local Public Health Agencies re Patients First discussion paper*.
>
> Carried

The Middlesex-London Board of Health supports the recommendations outlined in the attached letter to your Ministry.

Yours sincerely,

Jesse Helmer
Chair, Middlesex-London Board of Health

cc: Dr. Valerie Jaeger, President, Association of Local Public Health Agencies
Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies
All Ontario Boards of Health

alPHa
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alPHa's members are the 36 public health units in Ontario.

alPHa Sections:

- Boards of Health Section
- Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

- ANDSOOHA - Public Health Nursing Management
- Association of Ontario Public Health Business Administrators
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Society of Nutrition Professionals in Public Health

February 29, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations, the Association of Local Public Health Agencies (alPHa) is pleased to provide comment on the Ministry of Health and Long-Term Care discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. We received and reviewed the paper with much interest and anticipation. There is much to consider from a local public health perspective. We offer our preliminary comments herein and will be very pleased to engage further as the government's work progresses to strengthen patient-centred health care in Ontario.

We note the fact that how a "problem" is defined will greatly inform the solutions that are considered.

Patients First conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care. One solution to this problem is to better integrate population health within the health system, specifically through establishing closer linkages between LHINs and public health units. We are aware of recent work exploring the use of the population health approach in health system planning (CIHI 2014) and appreciate the merits of this work in contributing to health system sustainability. Further, we believe that local public health has valuable expertise to offer in this area. Indeed this approach is one of the five actions for health promotion as set out in the 1986 Ottawa Charter for Health Promotion.

A wider problem is improving and supporting the health and health equity of Ontarians which is effectively the mandate of the Ontario public health system. A solution to this problem would be to support and strengthen the public health system which works on all five Ottawa Charter actions for health promotion. The public health system understands that although access to a quality health care system is a determinant of individual and population health, it is a relatively minor determinant as compared with social and economic circumstances that create opportunities for health, mediated by factors such as education, food security, physical activity opportunities, social networks, effective coping strategies, etc. The public health system is that part of the overall health system that is specifically mandated to work with both health and non-health sector partners to act on these determinants and create opportunities for health for all.

We are concerned that some of the *Patients First* proposals regarding public health may have the unintended consequence of eroding the capacity of the public health system to improve the health of Ontarians through our intersectoral work on the determinants of health.

At the same time, we firmly hold that public health can assist in reorienting the health care system and see this as a valuable contribution of public health to the problems of health care system sustainability as set out in *Patients First*. We also hold that health care system sustainability is achieved by ensuring a strong public health system that can stem the tide of need; focusing on healthy people first.

In the recommendations that follow, we list and briefly describe what we present are the conditions necessary to achieve both. That is, to ensure that public health is able to contribute to the reorientation of the health care system so that population and public health priorities inform health care planning, funding and delivery, while at the same time protecting public health's ability to work upstream to promote and protect the health of all Ontarians.

Recommendations

1. **Funding and Accountability** – Provincial Public Health Funding and Accountability Agreements (PHFAA) must continue to be directly negotiated between local boards of health and the MOHLTC.
   a. A direct relationship mitigates against the threat of resource reallocation (financial and functional) to the acute care system as has been evidenced in the experience of other regions with integrated health systems.
   b. The direct relationship ensures that common Ministry principles and standards are upheld and implemented for all boards, further ensuring that all Ontarians benefit equitably from the public health system.
   c. The direct relationship with the Ministry is needed to maintain the independent voice of public health at LHIN tables; otherwise public health would be advising on health resource allocation and also be a resource recipient.

2. **Independent Voice of Boards of Health –** Boards of health must be maintained as defined in the Health Protection and Promotion Act, directly accountable to the Minister of Health.
   a. Boards of health must continue as entities with an independent voice with roles and responsibilities as set out in statute, standards and accountability agreements.
   b. Municipal representation on boards of health ensures invaluable connections with decision makers and staff in non-health sectors where there is scope of authority over key determinants of health (e.g. bylaws, built environment, social services, child care, planning, long term care, drinking water, recreational facilities, first responders, etc.).
   c. For certain boards of health (e.g. single tier and regional boards), local government is the de facto board of health, creating governance issues if required to report to an appointed LHIN board.
   d. Ways to strengthen boards of health should be explored; this should form part of the work of the Expert Panel following the report of the Institute on Governance (IOG).

3. **Integration of Local Population and Public Health Planning with Other Health Services –** The Ontario Public Health Standards and Ontario Organizational Standards, as required, should be modified to require boards of health to align their work and ensure that population and public health priorities inform LHIN health planning, funding and delivery. Reciprocal amendments should be made to the LHIN legislation (or other mandate documents as appropriate) to require LHIN boards to ensure that population and public health priorities inform LHIN health planning, funding and delivery. alPHa looks forward to participating in the following activities.
   a. Identification of the enabling policies and structures to ensure an effective relationship between the medical officer of health and LHIN leadership.
   b. The identification of the resources and funding required for public health to effectively engage in this work.

4. **Process for Determining Respective Roles –** The respective roles of local public health and LHINs (and other system players involved with population and public health including the Population and Public Health Division, MOHLTC, the Capacity Planning and LHIN Support, Health Analytics Branch, MOHLTC and Public Health Ontario) must be determined through a transparent, inclusive and deliberative process that is informed by evidence. We maintain that this is a key role of the proposed Expert Panel.
   a. It must be recognized that the work for public health as described in *Patients First* is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.
   b. There is an important distinction between providing population health information and translating this information into planning, funding and delivery decisions for acute care and other downstream services. It should not be assumed that the latter is a public health competency.

5. **Geographic Boundaries –** LHIN boundaries should be re-configured to align with municipal, local public health, education and social service boundaries to support their relationships with local public health and population health and health care system planning.

Local public health appreciates that a population health approach to health system planning is an emerging paradigm that may contribute to the sustainability of the health care system. Local public health also agrees with the *Patients First* discussion document that the public health system has expertise that may support such a reorientation of the health care system. Simply put, however, we must ensure that this "fix" to the health care system does not "break" the public health system.

We are committed to engaging in a thoughtful change management process with you that minimizes system disruption, mitigates risks associated with system instability and fosters balance between the systems intended to treat illness and the systems intended to prevent disease and promote health. To this end, we look forward to ongoing dialogue with government on the issues addressed in this letter. We trust that this will take place in many ways, including our participation in the proposed Expert Panel. We remain available for further consultation and are eager to pursue next steps.

In closing, I would reiterate that we are committed to finding win-wins so that Ontarians can continue to benefit from a strong and effective public health system while knowing that a quality health care system is there for them when they need it.

Sincerely,

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister of Health and Long-Term Care
Nancy Naylor, Associate Deputy Minister of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Board of Health Chairs
Medical Officers of Health

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

May 13, 2016

Attention: Association of Local Public Health Agencies, all Boards of Health

Please find attached the Middlesex-London Board of Health Report No. 024-16 titled "*Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws*".

At their April 21st 2016 meeting, the Middlesex-London Board of Health passed the following motion to endorse this report:

It was moved by Ms. Fulton, seconded by Mr. Hunter, *that the Board of Health*:

1. *Endorse Report No. 024-16 re: "Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws" and*
2. *Direct Health Unit staff to submit Appendix B and corresponding references to the Regulatory Registry for Ministry of Health and Long-Term Care consideration.*

Carried

Following the Board's endorsement, a copy of this report, Appendix B and corresponding references were submitted to the Regulatory Registry for consideration by the Ministry of Health and Long-Term Care.

Yours sincerely,

Jesse Helmer
Chair, Middlesex-London Board of Health

cc: Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies
All Ontario Boards of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 024-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016, April 21

COMMENTS ON THE MINISTRY OF HEALTH AND LONG-TERM CARE'S PROPOSAL TO STRENGTHEN ONTARIO'S SMOKING AND VAPING LAWS

Recommendation

It is recommended that the Board of Health

1. ***Endorse Report No. 024-16 re: "Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws" and***
2. ***Direct Health Unit staff to submit Appendix B and corresponding references to the Regulatory Registry for Ministry of Health and Long-Term Care consideration.***

Key Points

- In May 2015, the *Making Healthier Choices Act, 2015 (MHCA)* received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, increasing the maximum fines for youth-related sales offences, and increasing smoking restrictions on hospital property.
- The *MHCA* also created new legislation, the *Electronic Cigarettes Act, 2015* (*ECA*), to regulate the sale, use, display, and promotion of e-cigarettes. On January 1, 2016, provisions in the *ECA* came into effect, prohibiting the sale or supply of e-cigarettes to people less than 19 years of age.
- The Ministry is proposing further legislative and regulatory amendments to strengthen smoking and e-cigarettes laws in Ontario, outlined in Appendix A.
- The Middlesex-London Health Unit is in support of the proposed amendments with some suggested revisions, attached as Appendix B, to enhance public protection. Ongoing, dedicated funding with inflationary increases is required from the Ministry to support this work.

Background

The Ministry of Health and Long-Term Care is committed to improving the health and wellness of Ontarians. In May 2015, the *Making Healthier Choices Act, 2015* received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, increasing the maximum fines for youth-related sales offences, and increasing smoking restrictions on hospital property. These provisions came into effect January 1st, 2016. The *Act* also created new legislation - the *Electronic Cigarettes Act, 2015 (ECA)* – to regulate the sale, use, display, and promotion of e-cigarettes. On January 1, 2016, particular sections of the *ECA* came into force, prohibiting the sale or supply of e-cigarettes to people less than 19 years of age.

The ministry is proposing further legislative and regulatory amendments that would strengthen smoking and e-cigarettes (vaping) laws in Ontario. In summary, the Ministry's proposed amendments, if approved would:

1. Expand the *Smoke-Free Ontario Act's* "no smoking rules" to apply to medical marijuana;
2. Prohibit the use of e-cigarettes – including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of "e-cigarette" to include "e-substance";
5. Expand the list of places where e-cigarettes are prohibited for sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

The Ministry proposal is outlined in greater detail in their public consultation paper, attached as Appendix A.

Opportunity for Public and Stakeholder Input

The Health Unit has a vested interest in ensuring that the proposal will meet local public health needs, will contribute to a strengthened provincial tobacco control strategy, and is enforceable by the Health Unit's Tobacco Enforcement Officers. The Health Unit's comments on the Ministry's proposal and suggested revisions Ministry's approach are attached as Appendix B, and summarized as follows:

- The prohibition on the smoking or holding of lit tobacco should be expanded to include ***the smoking or holding of lit marijuana***, and not limit the prohibition to medical marijuana only
- The prohibition on the smoking or holding of lit tobacco should be expanded to include smoking hookah or water pipe devices, regardless of whether or not the substance smoked contains tobacco
- The proposed approach to prohibit the use of e-cigarettes in places where smoking is prohibited, including the e-cigarette retail environment is applauded. The exemption for the use of e-cigarettes in theatrical stage productions should not be permitted, and the definition of "electronic cigarette" should be amended to remove the requirement that the device contain a power or heating source.
- Parents, guardians or caregivers that supply an e-cigarette to a minor to consume medical marijuana can only do so if the device is purchased from a pharmacy or directly from the authorized licensed producers of medical marijuana under the Marihuana for Medical Purposes Regulations.
- Tobacco products should not permitted to be sold at retailers that choose to operate under the display, promotion and handling exemption outlined in the Ministry's proposal. The promotion and marketing of e-cigarettes and e-substances should also be strictly prohibited at places of entertainment, including bars, restaurants, special events, casinos, concerts and racetracks.

Health Unit staff shared the Ministry's announcement, the consultation paper and information on how to submit comments on the legislation with community and municipal partners to solicit community input.

This report was prepared by Ms. Linda Stobo, Program Manager, Chronic Disease Prevention & Tobacco Control.

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

This report addresses the Chronic Disease and Injuries Program Standards of the Ontario Public Health Standards #1, 3, 4, 6, 11, 12 and 13"

Peterborough
Public Health

Staff Report

Update on Smoke-Free Multi-Unit Housing in the Peterborough Area

Date:	June 8, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Donna Churipuy, Manager, Healthy Living

Recommendations

That the Board of Health for Peterborough Public Health receive the staff report, *Update on Smoke-Free Multi-Unit Housing in the Peterborough Area,* for information.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

On October 13, 2010, the Board of Health received a staff report for information on "*Mitigating the health risks associated with secondhand smoke in multi-unit dwellings".*

On April 11, 2012, Dr. Salvaterra shared a video to demonstrate the progress made in support of the Region of Waterloo community housing smoke-free initiative. It is estimated that within 10 years all community housing will be smoke-free in Waterloo region. A copy of the video was sent to Ken Doherty, Director of Community Services, City of Peterborough at the request of Councillor Parnell.

Subsequently, on May 9, 2012, the Board of Health requested that staff proceed to contact Peterborough Housing to present the Waterloo Region community housing smoke-free initiative.

On June 12, 2013, the Board of Health received the staff report, *Smoke-Free Multi-Unit Dwellings: Update to the Board of Health*, for information, and letters were sent to the Peterborough Housing Corporation referencing other municipalities that have enforced smoke-free multi-unit dwellings, and to the provincial government , with copies to our local municipalities, requesting provincial action, such as making smoke-free policies a condition for provincial funding for housing initiatives in order to facilitate the development of more smoke-free multi-unit dwellings.

Councillor Beamer noted on December 11, 2013 that the Board of the Peterborough Housing Corporation (PHC) at its September meeting reviewed correspondence sent by the Board of Health. The letter, sent in late July, advocated for the implementation of a smoke-free policy at PHC units and dwellings. Councillor Beamer commented that the correspondence generated fruitful discussion at the meeting, and that the Board is investigating the matter further.

On April 9, 2014, the Board of Health for the Peterborough Public Health approved a resolution for submission to the Association of Local Public Health Agencies (alPHa) for their Annual General Meeting (AGM) in June 2014: Designating provincially and municipally funded multi-unit dwellings smoke-free. The resolution was carried at the June 2014 AGM.

Last year, on November 11, 2015, the Board of Health received a letter confirming receipt of correspondence dated October 8, 2015 from Dr. Salvaterra to Lorraine Fry, Executive Director Non-Smokers' Rights Association and Donna Kosmack, Manager, South West Tobacco Control Area Network, regarding the Board's endorsement of action for smoke-free multi-unit housing.

Background

Multi-Unit Houses (MUHs) refer to residences like duplexes, triplexes, row houses, condominiums and apartment buildings where multiple people reside under one roof in separate units. In many instances MUHs share heating, cooling and ventilation systems, and are often connected by shared hallways or entrance ways.

The *Smoke-Free Ontario Act* (SFOA) protects people from second hand smoke in the public areas of MUHs (hallways, elevators, laundry rooms, etc.) by prohibiting smoking in those spaces; however, under provincial legislation smoking is permitted within the private units of these buildings.[1]

In 2014, nine out of ten adults in Ontario (89%) believed that smoking should not be allowed inside MUHs including apartment buildings, rooming houses and retirement homes with shared ventilation**.** The level of support has increased significantly since 2005 (89% vs.73%, respectively).

As of December 2015, 205 MUHs or non-profit housing corporations across 89 municipalities in Ontario had adopted or were in the process of adopting 100% smoke-free housing policies.[2]

Local data from the Canadian Community Health Survey suggest that 87% of residents who live in MUHs in Peterborough do not smoke in their home and 80% have smoking restrictions in their home.[3]

However, smoking in non-regulated private living areas in MUHs continues to be one of the most common complaints staff in the Tobacco Use Prevention program receive from tenants and landlords in private and publicly funded housing. Implementing strategies to increase availability of smoke-free multi-unit housing has become a public health priority across many jurisdictions including the Peterborough area.[4]

Recent Activities in the Peterborough Area

In 2015, staff from Peterborough Public Health met with staff of the City of Peterborough, Housing Division and the Service Manager Advisory and Resource Team (SMART) committee to promote the development of smoke-free housing policies and to debunk myths associated with smoke- free housing policy development. As a result, the Housing Division is working with local housing service providers to gather data from tenants on their perceptions of smoke-free housing policies. The housing division for the City of Peterborough is actively promoting the development of smoke- free housing policies among area housing service providers.

On December 8, 2015, staff from the Region of Waterloo presented to local housing service providers on the Region of Waterloo's experience with the development and implementation of smoke-free leases. Housing service providers were provided with access to sample policies. The presentation was well received by many of the participants. Staff from Peterborough Public Health continue to support the City of Peterborough Housing Division in its efforts to promote and support implementation of smoke- free housing policies among area housing service providers.

In 2015, in Peterborough, one additional seniors' housing service provider implemented a smoke-free housing policy and the recently renovated Knox Church boasts 42 units of affordable and smoke-free living. Also, both of the new Ashburnham Realty buildings on Hunter St. are 100% smoke-free and the rest of their buildings are transitioning towards smoke-free leases. Staff also approached a local developer of new seniors' housing in Lakefield encouraging development of a 100% smoke-free housing policy.

Provincial Activities

The Ministry of Municipal Affairs and Housing (MAH) is holding a consultation on a number of issues associated with the Residential Tenancy Act (RTA), including making it easier to create and enforce smoke-free policies. Currently, smoke-free policies (i.e., in the lease) are enforceable under the RTA's 'Reasonable Enjoyment' and 'Damage' provisions. Although no-smoking policies are legal and enforceable, the fact that the RTA does not consider smoking a 'material breach' of a lease makes it harder to implement and enforce this measure. If the

Residential Tenancies Act (RTA) had stronger wording specifically mentioning the issue of smoking, the path to enforcement would be clearer.

With a clearer legal status, more landlords would be willing to adopt smoke-free policies which would be a major step forward for public health. It would be especially helpful for vulnerable people who often cannot afford or are otherwise unable to move when faced with involuntary exposure to second-hand smoke.

Peterborough Public Health is preparing comments to send to the MAH in support of the proposed changes to the RTA.

Rationale

There is no safe level of exposure to secondhand smoke. Infants and children are particularly susceptible to the harmful effects of second hand smoke exposure, since they often cannot physically remove themselves from the exposure, and they breathe at a faster rate than adults.[5] As such, it is imperative to implement protective strategies for infants, children and youth in multi-unit housing.

As well as safeguarding child health and development, smoke-free MUHs are associated with lower rates of adolescent smoking and an increased rate of smoking cessation in youth.[6] Young persons living in a household where someone smoked regularly were more than three times more likely to smoke, 22.4% versus 7.0%. Smoke-free MUHs discourage parental smoking in the home, thereby modeling, normalizing and encouraging smoke-free living for adolescents.[7]

Many low income residents reside in publically funded multi-unit housing. Residents of publically subsidized housing may be exposed to higher levels of secondhand smoke due to higher smoking rates, building design, limited mobility, and poorer health status.[8] In addition to the positive health outcomes attributed to not smoking in the home, smoke-free homes are also safer homes, as cigarette smoking is the leading cause of preventable fires in Ontario.[9]

Strategic Direction

This report applies to the following strategic direction:

- Determinants of Health and Health Equity

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References:

[1] http://otru.org/wp-content/uploads/2014/10/update_aug2014_v2.pdf
[2] https://drive.google.com/file/d/0B3a1sVKJ3YZzMWJodzI5cHdrbTA/view?pref=2&pli=1
[3] Canadian Community Health Survey 2007/2008, Statistics Canada, Share File, MOHLTC
[4] http://www.smokefreehousingon.ca/hsfo/file/files/S-F_Housing_Review_of_Evidence-2014.pdf
[5] http://www.smokefreehousingon.ca/hsfo/file/files/S-F_Housing_Review_of_Evidence-2014.pdf
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Peterborough
Public Health

Staff Report

Child Health Series 2015/2016
3. In Summary: Parenting Practices

Date:	June 8, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Gail Chislett, Health Promoter

Recommendations

That the Board of Health for Peterborough Public Health receive the *Child Health Series 2015/2016: 3. In Summary: Parenting Practices,* for information.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

The Board of Health received presentations with Infographics for:

- *1. In Summary: Family Demographics* on December 9, 2015; and
- *2. In Summary: Family Dynamics* on March 9, 2016.

Background

Optimum child health, growth, and development are more likely to occur in families with sufficient resources, healthy family dynamics, and positive parenting practices. Positive parenting practices include fostering secure attachment, breastfeeding, and using positive parenting methods.

Secure attachment promotes cognitive and socio-emotional development. Living in poverty is a risk factor for insecure attachment. Breastfeeding promotes child health, development, and attachment, with a larger positive effect seen in children born into families with low socio-economic status. Positive parenting increases the likelihood of children having better health, growth, and development outcomes and is protective against negative early influences such as poverty and parental psychological distress.

There is little, if any, local surveillance data on attachment, parenting styles, and positive parenting. In contrast, information on breastfeeding is collected in Peterborough and Ontario.

Rationale

The rise in breastfeeding rates in Peterborough County and City over the past ten years is very positive. However, maintaining breastfeeding exclusivity remains a challenge, both locally and provincially. In order to improve child outcomes, breastfeeding promotion and support must remain a priority, with ongoing attention to initiation, maintenance, and six month exclusivity.

It is clear that local data is needed to assess attachment, parenting styles, and positive parenting. However, research supports the recommendation for community provision of easily-accessible, high-quality parenting programs to improve child health, growth, and development.

Strategic Direction

Parenting practices are central to child health and developmental outcomes, and lend themselves to public health interventions, both universal and targeted. Since parenting practices are influenced by the parents' socio-economic status, level of stress, and psychological well-being, they are also related to Peterborough Public Health's strategic direction of Determinants of Health and Health Equity.

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Attachments:

Attachment A - 3. In Summary: Parenting Practices

CHILD HEALTH SUMMARY SERIES

2015/2016

Companion Documents to
REPORT ON CHILD HEALTH
Peterborough County-City Health Unit
2015

3. In Summary: Parenting Practices

Executive Summary

This third report, *In Summary: Parenting Practices*, is condensed from the Peterborough County-City Health Unit's REPORT ON CHILD HEALTH (2015) and addresses parenting in the City and County of Peterborough ("Peterborough[1]"). Emphasis is placed on attachment, breastfeeding, parenting styles, and positive parenting, and most information relates to families with children from birth to five years of age, since this is the critical period for health, growth, and development. Positive parenting increases the likelihood of children having better health, growth, and development outcomes.

There is little, if any, local surveillance data on attachment, parenting styles, and positive parenting. It is clear that more local data is needed. In contrast, information on breastfeeding has been diligently collected in Peterborough and Ontario for years. Two key findings emerged:

1. Breastfeeding rates in Peterborough are trending upward.

2. Although exclusive breastfeeding is recommended, supplementation rates (with infant formula) are high in the early post-partum period in Peterborough and across the province.

These findings indicate that over the past ten years, Peterborough breastfeeding rates have been rising. This is very positive since children who are not breastfed are more vulnerable to poor health, growth, and development outcomes. However, maintaining breastfeeding exclusivity, the standard infant feeding recommendation, is still a challenge. Findings indicate that in Peterborough (as in the province) exclusive breastfeeding rates drop dramatically in the first two weeks after birth.

In order to improve child outcomes in Peterborough, breastfeeding promotion and support must remain a priority. Breastfeeding initiation, maintenance, and six month exclusivity can be supported through:

- advocacy and support for implementation of the Baby-Friendly Initiative (BFI) in health care facilities;
- implementation of a breastfeeding education strategy for maternal-child health care professionals;
- advocacy for home-based delivery of breastfeeding supports;
- community breastfeeding promotion and education;
- ensuring that support is available for breastfeeding mothers; and
- a coordinated community approach to delivery of breastfeeding services.

Although no data is available on parenting practices locally, it is known that they can have a substantial impact on child health, growth, and development. All parents, and their children, can benefit from the community provision of easily-accessible, high-quality parenting programs addressing attachment and positive parenting practices.

[1] The term "**Peterborough**" as used in this report refers to the geographical area of Peterborough County, and this report presents findings on the residents within this area. Statistics Canada provided two data subsets for Peterborough County ("Peterborough"): City, and County (Peterborough County excluding City). The geography of Peterborough County includes the following areas of governance: City of Peterborough, Township of Asphodel-Norwood, Township of Cavan Monaghan, Township of Douro-Dummer, Township of Havelock-Belmont-Methuen, Township of North Kawartha, Township of Otonabee-South Monaghan, Township of Selwyn, and Municipality of Trent Lakes), Curve Lake First Nation, and Hiawatha First Nation.

Table of Contents

Executive Summary 2

List of Figures 3

3. In Summary: Parenting Practices 4

- Attachment 5
- Breastfeeding 6
- Parenting Styles 8
- Positive Parenting 9

Peterborough Families – How are They Doing? 10

List of Figures

Figure 1. Prevalence of breastfeeding at discharge, and any / exclusive breastfeeding at 48 hours and two weeks by year; 2008-2014 7

3. In Summary: Parenting Practices

Healthy child development lays the foundation for adult health and creates the blueprint for the next generation. Poor child health and developmental outcomes represent a burden to society and a cost to health, education, justice, and social systems over the lifespan. Assessing the status of our children's health and investing in appropriate early interventions can modify their trajectory and positively contribute to the overall health of our community.

This series of summary reports condensed from the *REPORT ON CHILD HEALTH (2015)*[2] is intended to describe child health in the City and County of Peterborough ("Peterborough[3]"); provide information and perspective for the community; and influence planning and policy directions.

This third summary report *PARENTING PRACTICES* addresses attachment, breastfeeding, parenting styles, and positive parenting. Healthy parenting practices are crucial to good child health, growth, and development. This is especially true during the early years, since the quality and quantity of a child's early experiences and relationships affect how well the brain develops and performs. This in turn has an impact on achievement, behaviour, and health throughout life. Positive parenting promotes positive child outcomes and can actually confer protection against adversity.

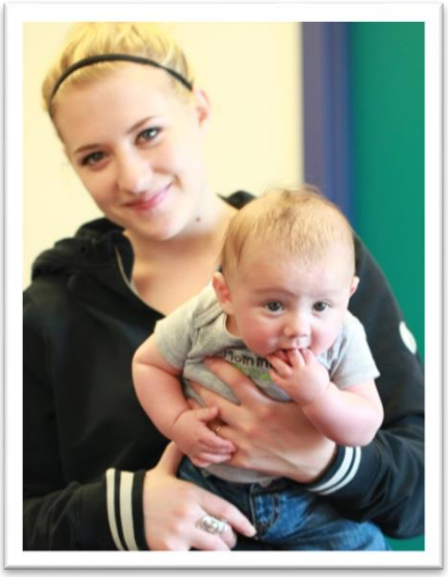
Talking about parenting can be complicated. The broad term *parenting* refers to an array of parental roles, duties, responsibilities, thoughts, emotions, expectations, and behaviors related to caring for, nurturing, protecting, socializing, guiding, disciplining, educating, and, in general, raising a child. *Parenting style* refers to the parent's overall approach, including responsiveness to the child, and is usually stable over time. *Parenting practices* are the more modifiable behaviours and concrete things that parents do on a regular basis to raise their children.

A large body of research shows that many factors influence parenting practices, such as the parents': socio-economic status (SES), level of stress, resiliency, education, cognitive capacity, temperament, gender, health, psychological make-up, past and current mental illness, experience with intimate partner violence, experience of being parented, motivation to parent, and history of childhood abuse. As well, the broader context of culture, community, and society influences parenting. Within a family, parenting practices may vary from one parent to another and from one child to another, depending on individual characteristics such as temperament and personality, and their interplay between parent and child.

[2] For more information on references, data sources, and methodology, please contact the Peterborough County-City Health Unit.

[3] The term "**Peterborough**" as used in this report refers to the geographical area of Peterborough County, and this report presents findings on the residents within this area. Statistics Canada data collection for Peterborough County ("**Peterborough")** has two data subsets: **City** and **County** (Peterborough County excluding City), and this report follows their protocol. However, it should be noted that the geography of Peterborough County includes the following areas of governance: the City of Peterborough, the County of Peterborough (which is composed of eight townships: Asphodel-Norwood, Cavan Monaghan, Douro-Dummer, Havelock-Belmont-Methuen, Municipality of Trent Lakes, North Kawartha, Otonabee-South Monaghan, and Selwyn Township), Curve Lake First Nation, and Hiawatha First Nation.

Attachment



In general, the word *attachment* refers to refers to a binding tie of affection between two people that endures over time. As used in a child development context, *attachment* refers to a particular aspect of the parent-child relationship emerging during the first year of life. The parent is the *attachment figure* who has a natural inclination to provide a safe and secure base for the child seeking protection and comfort. The infant uses *cues* or *signals* to engage the parent; these include clinging to, following, smiling at, crying, and calling. The way in which the parent responds is related to his or her *parental sensitivity* (i.e., the extent to which the parent is alert, available, appropriate, warm, and responsive).

The term *attachment* is not interchangeable with the term *bonding*. *Bonding* refers to the development of a warm, close emotional relationship between parent and child which may start during pregnancy or when the baby is born.

The formation of attachment is driven by parent-child interactions including infant signalling and parental response, touch, and *engagement*. *Engagement* involves non-verbal, face-to-face communication between parent and infant, initiated by one or the other, and features direct gaze, vocalization, and facial expressions. Engagement may influence brain development and emotion and stress regulation, as well as infant attachment. However, the parent's ability to notice, interpret, and respond appropriately to an infant's signals has the most influence on the developing attachment relationship.

After approximately six months of age, babies have developed a style of attachment which is dependent on face-to-face communication, daily interactions, and the type of response they receive when they are signalling for attention, in discomfort, ill, hurt, frightened, or distressed.

Attachment interactions influence early neurological organization and development, language development, and stress regulation. Secure attachment is vital for infant well-being and necessary for brain development. It is associated with more imaginative play, social and cognitive competence, compliance, persistence, positivity, self-esteem, and self-confidence. Attachment plays a role in acquiring a conscience. In the long-term, secure attachment promotes good developmental outcomes, self-regulation, and successful relationships. Insecure attachment predicts low self-esteem and poor social and cognitive competence, and may lead to problem and aggressive behaviours in children and adolescents.

Positive parenting practices foster secure attachment. Parental risk factors for insecure attachment include poverty, significant life stressors, intimate partner violence, mental illness, depression during pregnancy, post-partum depression, and history of childhood adversity.

Attachment style: When the caregiver is consistently available and responsive, providing a trusted and secure base in times of stress or need, the infant develops a **secure attachment** style (confident in the company of the caregiver, and secure enough to explore the environment). In contrast, when the caregiver is unresponsive or inconsistently responsive, especially in times of stress, the infant develops an **insecure attachment** (either excessively clinging to or avoiding the caregiver, and infrequently exploring the environment).

Attachment data is not available at the Peterborough level.

Infant attachment style is difficult to measure on a large scale, since the process can involve, e.g., parent questionnaires, observations of parent-child interactions, and interviews.

Breastfeeding

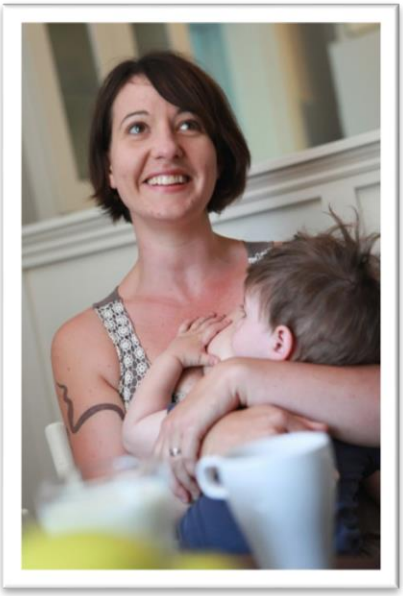
Breastfeeding represents the biologically "normal way" to feed a baby and growing child. In its simplest form, breastmilk is food that meets all the nutritional needs of an infant for the first six months of life and continues to be an important source of nutrition into early childhood. Breastmilk is available at no cost to almost all children, regardless of socioeconomic status, since almost every new mother is capable of breastfeeding. In contrast, infant formula is costly and requires proper preparation and storage, making it an insecure food source for infants from families with limited finances.

The standard infant feeding recommendation by all major health organizations is for exclusive breastfeeding for the first six months of an infant's life.

Beyond basic nutrition, breastfed babies receive immune properties from their mother's milk which protect them from a range of illnesses, including ear infections, gastrointestinal infections, respiratory infections, and the risk of Sudden Infant Death Syndrome (SIDS). Longer term outcomes for breastfed babies include a lower risk of childhood leukemia, improved dental health, lower risk of Type 1 and 2 diabetes, a lower likelihood of being overweight or obese later in life, enhanced cognitive function, and better mental health.

The physical act of breastfeeding promotes child cognitive and socio-emotional development. Breastfeeding provides a natural setting for prolonged, frequent, face-to-face, back-and-forth interactions. These stimulate early brain development, and likely contribute to the optimal brain structure and function seen in breastfed babies. A longer duration of breastfeeding is associated with more healthy attachment. As well, the socio-emotional adjustment of breastfed children is somewhat protected from the negative effects of poor maternal mental health, possibly related to the decrease in maternal stress associated with breastfeeding hormones, and the increase in affection shown by depressed mothers who breastfeed.

In addition, breastfeeding seems to have a larger positive effect on children who are vulnerable at birth or due to a low SES. For example, breastfeeding is positively associated with enhanced readiness for kindergarten, and higher math and reading skills in nine year old children. However, these associations are more pronounced in children who have experienced challenges at birth, e.g., low birth weight, low Apgar[4] scores at birth, or a stay in a Neonatal Intensive Care Unit, and in children from low SES families facing challenges, for instance low maternal education.



Babies who are not breastfed are at risk of a variety of acute and chronic illnesses, less robust brain growth and cognitive function, lower maternal sensitivity, and less secure attachment styles.

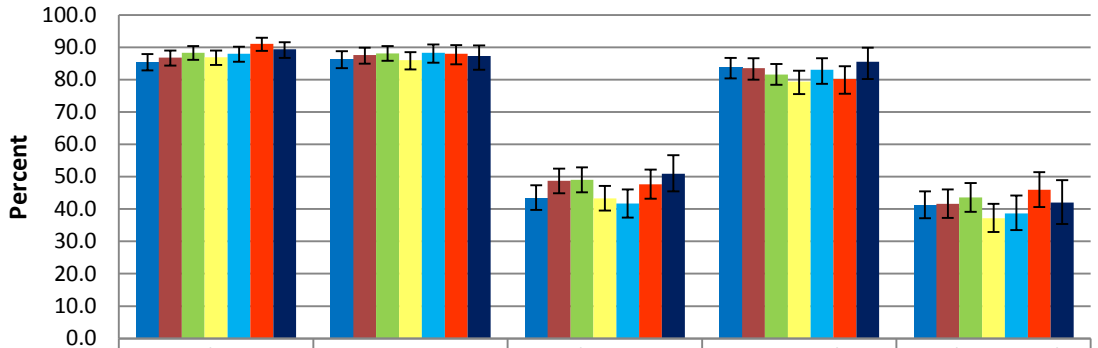
Breastfeeding rates are monitored both locally and provincially. The proportion of women residing in Peterborough who gave birth to a full term infant and were exclusively breastfeeding on hospital discharge was 67.4% % in the 2013/2014 fiscal year. By comparison,

[4] The Apgar score (measured out of 10) is an assessment of a newborn's heart rate, breathing effort, muscle tone, reflexes, and skin colour following delivery. High scores are a sign that the baby is doing well.

the proportion of women residing in Ontario who gave birth to a full term infant and were exclusively breastfeeding on hospital discharge was 62.1% in 2013/2014.

Peterborough County-City Health Unit (PCCHU) collected breastfeeding data for 5,781 local women who gave birth between January 1, 2008 and December 31, 2014. The proportion of women reporting breastfeeding at discharge from the hospital increased between 2008 and 2014 by 3.8% (Figure 1). In addition, the proportion of women reporting any breastfeeding at 48 hours increased slightly during this time frame. Exclusive breastfeeding at 48 hours increased from 43.5% in 2008 to 50.9% in 2014. In 2014 the proportion of women who were breastfeeding at two weeks was 85.5%, an increase from the previous years. Finally, the proportion of women reporting exclusive breastfeeding at two weeks decreased slightly between 2013 and 2014 by 4.0%.

Figure 1. Prevalence of breastfeeding at discharge, and any / exclusive breastfeeding at 48 hours and two weeks by year; 2008-2014



	Discharge	Any 48	Exclusive 48	Any 2 Wk	Exclusive 2 Wk
2008	85.6	86.4	43.5	83.8	41.3
2009	86.8	87.6	48.7	83.6	41.7
2010	88.3	88.1	49.0	81.6	43.6
2011	86.9	86.0	43.3	79.4	37.1
2012	88.0	88.3	41.7	83.0	38.6
2013	91.1	88.0	47.6	80.2	46.0
2014	89.4	87.3	50.9	85.5	42.0

If women are not exclusively breastfeeding at the two week follow-up call they are asked to indicate reasons for feeding their infant something other than breastmilk. Not having enough milk was the most frequently reported reason for supplementation at 35.4%. The baby having difficulty latching (9.2%), infant illness or allergies (5.4%), having sore nipples (5.2%), and feeling overwhelmed (5.2%) were also reported.

Between September 2012 and February 2013, PCCHU conducted a comprehensive telephone survey of local women at the time that their infants were six months old. Nine out of ten (90.6%) respondents initiated breastfeeding. Eight in ten women (81.5%) who initiated breastfeeding did so within the first two hours after giving birth. The proportion of women surveyed who reported breastfeeding at two, four, and six months, was 71.9%, 64.5%, and 58.6%, respectively. In contrast, in 2006, PCCHU found that 40.0% of new mothers surveyed continued to breastfeed at six months. The proportion of women who were exclusively breastfeeding at six months in 2012/2013 was six percent. While the exclusive breastfeeding rate at six months is low, it may be a reflection of the strict definition that was used for 'exclusive' breastfeeding. Many women reported that they had started to introduce solid foods to their babies prior to six months, and as such, these babies could not be included in 'exclusive breastfeeding' counts. The most common reason for stopping breastfeeding was 'not enough milk/milk didn't come

in/baby was hungry', which accounted for just over half of the responses. The second most common reason (approximately one in five) for stopping breastfeeding was 'latching difficulties/baby not latching'.

Parenting Styles

Parenting style refers to how the parent responds to the child, and the overall approach the parent uses to control the child and exercise parental authority. This determines the "emotional climate" for parenting. Parenting styles tend to be stable, since they are determined by the parent's attitudes and beliefs about parenting.

Four parenting styles are identified based on levels of parental warmth/responsiveness (being attuned to, and accepting and responsive to the child's needs and interests) and parental demandingness/control (involving child supervision, control, discipline, and expectations for obedience and self-control). **Authoritative parents** are the most balanced and most committed. **Authoritarian parents** assert power and psychological control to keep children subordinate and discourage independence. **Permissive parents** are overly lenient, failing to provide authority, order, and routine; while **neglectful parents** are rejecting, uninvolved, and non-supportive. The neglectful style is infrequent, especially in parents of young children.

Parenting styles:

1. **Authoritative** (balanced) parents demonstrate high levels of control and responsiveness;
2. **Authoritarian** (strict) parents demonstrate a high level of control and a low level of responsiveness;
3. **Permissive** (indulgent) parents demonstrate a low level of control and a high level of responsiveness; and
4. **Neglectful** (disengaged) parents demonstrate low levels of control and responsiveness.

Research has shown that parenting style is linked to child outcomes, including school performance, delinquency, and psychosocial functioning. Children of authoritative parents are more likely to be resilient, with better psychological competence. In addition, they are more likely to exhibit secure attachment, demonstrate socio-emotional competency, make friends in their early years, have good self-esteem, be successful academically, avoid substance use, and be emotionally stable as young adults.

Children of authoritarian, permissive, and disengaged parents do not show the same positive outcomes. For example, children and adolescents in authoritarian families develop a gamut of problems, including anxiety, depression, and behaviour problems. Authoritarian maternal parenting is linked to children's mood disorders and poor development. As well, adolescents in authoritarian families are more likely to be incompetent and maladjusted, with mood problems and low self-esteem, compared to adolescents from authoritative families who are more likely to be pro-social, competent, and well-adjusted. Permissive parenting style, similar to authoritative parenting, may promote children's self-esteem and autonomy; however it has been linked to adolescent drug use and abuse, deviant behavior, and school misbehaviour. Negligent parenting is associated with avoidant attachment. When parents in a family have different parenting styles, they influence each other's behaviour for the better or worse, and the interaction of styles can moderate or worsen child outcomes.

Data on the incidence of various parenting styles is not available at the Peterborough level.

Positive Parenting

Positive parenting refers to the parent or caregiver's consistent use of effective, responsive, supportive, warm, and nurturing parent-child interactions while protecting, fostering, teaching, and guiding the child. Positive parenting helps children to develop, learn, and flourish in a safe, secure, and loving environment, in home conditions which support their best development.

While a positive parent displays warm, supportive, helpful, and involved behaviours with the child, a negative parent may behave in a critical, aggressive, unkind, irritable, and demanding way. Negative parenting may involve inconsistent discipline, punitive or coercive discipline (yelling, nagging, threatening), lack of warmth, physical aggression (hitting, beating), and insufficient monitoring and supervision. Negative parenting may also be referred to as poor, harsh, punitive, or hostile parenting. Parents may exhibit a mix of positive and negative parenting behaviours, with the overall approach falling somewhere on a scale from very negative to very positive.

Association of Public Health Epidemiologists in Ontario:
"*Positive parenting* is defined as positive/warm and consistent parenting interactions with the child (e.g., parents frequently talk, play, praise, laugh and do special things together with

Parents are more likely to use positive parenting practices if they have high levels of parenting self-efficacy (the belief that one can do a good job as a parent and promote good child development and behaviour) and have experienced positive parenting and healthy family relationships as a child. Parents with a better SES are more likely to have better parenting practices; however not all high SES parents have positive parenting practices and many low-SES parents do have positive parenting practices.

Parents are more likely to engage in negative parenting practices if they come from a background of adversity or neglect, and/or have experienced unhealthy family relationships and negative parenting as a child. Those dealing with mental illness, substance misuse, a lack of personal or material resources, or stressful conditions are also more likely to engage in negative parenting practices, as are impoverished adolescent single mothers and mothers experiencing multiple partner transitions.

Positive parenting is associated with positive child health, growth, and development outcomes such as an increase in socio-emotional functioning, social competence, and pro-social behavior, and a reduction in child conduct disorders. In addition, positive parenting is protective against early hardship and risk factors which contribute to negative outcomes. For example, children growing up in poverty are more likely to develop stress-related illnesses later in life, such as cardio-vascular disease; however the presence of a warm, sensitive, and supportive mother in early life reduces this likelihood. As well, positive parenting lessens the poor outcomes associated with lone parenting and parental psychological distress, even for families living in poverty.

Negative parenting increases the risk for adverse child outcomes, especially emotional and behavioural problems**.** Parental practices such as yelling, nagging, threatening, hitting, beating, inconsistent discipline, lack of warmth and support, and insufficient monitoring are associated with disruptive child behaviour. Some researchers have linked the use of corporal punishment with decreased child mental health, more difficulty learning right and wrong, poor parent-child relationship, increased child

aggression, and delinquent and antisocial behaviour. Harsh parenting has been linked to youth conduct disorders, delinquency, school drop-out, and substance use.

Data on the incidence of positive parenting is not available at the local or provincial level.

Peterborough Families – How are They Doing?

There is little, if any, local surveillance data on attachment, parenting styles, and positive parenting. It is clear that more local data is needed. In contrast, information on breastfeeding has been diligently collected in Peterborough and in Ontario for years. Two key findings emerged:

1. **Breastfeeding rates in Peterborough are trending upward.**
   - Exclusive breastfeeding at 48 hours increased from 43.5% in 2008 to 50.9% in 2014.
   - PCCHU found that six months breastfeeding duration rates have increased from 40.0% of mothers in 2006 to 58.6% in 2012/2013.

2. **Although exclusive breastfeeding is recommended, supplementation rates (with infant formula) are high in the early post-partum period in Peterborough and across the province.**
   - In 2013/2014, approximately one third (32.6%) of Peterborough women giving birth to full term infants were *not* exclusively breastfeeding on hospital discharge.
   - In 2014, 49.1% of mothers contacted by the Healthy Babies, Healthy Children (HBHC) program were not exclusively breastfeeding at 48 hours following hospital discharge, indicating that their infants had received at least one non-breastmilk supplement by this time.

These findings indicate that over the past ten years, Peterborough breastfeeding rates have been rising. This is very positive, since children who are not breastfed are more vulnerable to poor health, growth, and development outcomes. However, maintaining breastfeeding exclusivity, the standard infant feeding recommendation, is still a challenge. Findings indicate that in Peterborough (as in the province) exclusive breastfeeding rates drop dramatically in the first two weeks after birth.

In order to improve child outcomes in Peterborough, **breastfeeding promotion and support must remain a priority.** Breastfeeding initiation, maintenance, and six month exclusivity can be supported through:

- advocacy and support for implementation of the Baby-Friendly Initiative (BFI) in family-serving health care facilities;
- implementation of a breastfeeding education strategy for maternal-child health care professionals;
- advocacy for home-based delivery of breastfeeding supports through the HBHC program;
- community breastfeeding promotion and education campaigns;
- ensuring that support options are available for mothers initiating and/or experiencing difficulty breastfeeding; and
- a coordinated community approach to delivery of breastfeeding services.

And, although no data is available on parenting practices locally, it is known that they can have a substantial positive, protective, or negative impact on child health, growth, and development. High quality parenting programs are instrumental in fostering attachment, providing information, building skills, and encouraging the use of positive parenting practices. All parents can benefit from the community provision of easily-accessible parenting programs (including targeted home visiting) addressing attachment (including parent-child sensitivity, attention to infant cues, timely and

appropriate response, and positive regard) and positive parenting practices (including positive behavioural support and positive parent-child interactions).

Culturally appropriate parenting programs may better serve groups with a shared culture or ethnicity, such as LGBT (e.g., lesbian, gay, bisexual, transsexual, transgender, two-spirit, intersex, queer, and questioning) parents, new immigrants, Deaf parents, or Aboriginal families as is recommended in the Truth and Reconciliation Commission of Canada's *Calls to Action* (2015).

Evaluation of such initiatives will speak to their success, and ongoing population surveillance will track change, monitor trends, and inform future directions and strategies.

The life trajectories of young Peterborough children can and must be improved.

Peterborough
Public Health

Staff Report

Vision, Mission and Values

Date:	June 8, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Larry Stinson, Director of Operations

Recommendations

That the Board of Health for Peterborough Public Health:

- receive the staff report, *Vision, Mission and Values,* for information; and
- approve the framework for action proposed by staff.

Financial Implications and Impact

There are no direct financial implications from the recommendations. There will be costs related to staff time and Board participation in completing the work.

Decision History

The Board of Health Strategic Plan, 2013 - 2017 was approved in June 2013. During the process for development of this plan, it was decided to retain the previous vision, mission and values and focus on the strategic directions. During the Board/Management Planning session in February 2016, direction was given to staff to develop plans for reviewing and revising the Vision, Mission and Values for Peterborough Public Health (PPH) and to bring these recommendations to the Board.

Background

The vision, mission and values of any organization should reflect the fundamental reason for existence and articulate its unique approach to achieving this purpose. These elements should form the foundation of decision making and actions made throughout the organization. Of these three elements, it can be argued that the most critical to defining the organization is its core values. Since the mandate of public health is well defined through the Ontario Public Health Standards, it is not surprising that there is little variance among vision and mission statements across the 36 health units. Core values, however, reflect the unique nature of each organization and of the people who work within it. The review process should, reflect the importance of these components.

At PPH the review process needs to begin with what exists. The mission and vision statements are part of the existing Strategic Plan. The Strategic Plan also contains core values, but there are two other sources to consider for identifying values. The first are values that emerged from the development of a PPH Management Framework by the Management team. The second is a value proposition and value statements that emerged from the branding process completed in 2015. Although there is some alignment between these three sources, each offers some unique perspectives. Questions have also been raised about whether core values lose their impact when they are too broad in scope or number. The review process should, therefore, take us from this starting point to a more impactful set of values.

It is proposed that the review and revision process be led internally by staff and be primarily an internal (Board and staff) exercise. This is based on the premise that the outcome should define how we see ourselves and how we want to be, not how others want to see us. The process will be conscious of capacity, but value the importance of true engagement.

Proposed Plan:

What is Done	How it will be Done	Who is Involved	When will it Happen
Review of the Vision and Mission statements	Facilitated discussion at special Board Meeting	Board of Health	September
Narrow the Field of potential core values	Online Delphi-type process	All Staff/Board Members	October
Clarify the meaning of potential values	Team Meetings (including Board Meeting) facilitated session	Teams Board of Health	November
Proposed values circulated for feedback	Online	All Staff/Board Members	November

What is Done	How it will be Done	Who is Involved	When will it Happen
Final version of Vision, Mission and Values approved	Board approval	Board of Health	December

Rationale

The Organizational Standards, as part of the Ontario Public Health Standards 2008, requires that the board of health shall have a strategic plan and shall ensure that it: Expresses the philosophy/mission, a values statement, and the goals and objectives of the board of health (among other things). The proposed process will allow the ability to fulfill this responsibility and to establish a framework for operations that is aligned with our desired future as an organization. The intent is to use technology to identify ideas and build some consensus and to use smaller group dialogue to build a common understanding of the identified values and how they should be applied in our program and service delivery.

Strategic Direction

This report applies to the following strategic direction:

- Quality and Performance

Contact:

Larry Stinson
Director of Operations
(705) 743-1000, ext. 255
lstinson@peterboroughpublichealth.ca

Peterborough
Public Health

Staff Report

2015/2016 Preschool Speech and Language Program Audited Financial Statements

Date:	June 8, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Bob Dubay, Manager, Financial Services

Proposed Recommendations:

That the Board of Health for Peterborough Public Health approve the 2015/2016 Preschool Speech and Language Program Audited Financial Statements.

Financial Implications and Impact

To submit the 2015/2016 Preschool Speech and Language Audited Financial Statements to the Board for approval in accordance with the agreement between the Five Counties Children's Centre (5CCC) and Peterborough Public Health (PPH).

Decision History

The Board of Health is required by the agreement with the 5CCC to approve the Audited Financial Statements.

Background

The Preschool Speech and Language Program (PSLP) fiscal period began April 1, 2015 and ended March 31, 2016 and is funded 100% through the MCYS by a grant from the 5CCC.

The PSLP is a regional partnership with the 5CCC, the Haliburton, Kawartha, Pine Ridge District

Health Unit (HKPR) and PPH. Funds from the MCYS are provided to 5CCC which in turn provides funds to help support the PPH Family HEALTHline and other activities. Parents may phone in to receive information on speech and language screening and referrals to community agencies. Health promotion activities (media events, posters and pamphlets, displays, etc.) are jointly developed with HKPR.

Rationale

The funding flowed from the 5CCC provides funding to support PPH's Family HEALTHline. The total revenue and expenditures for the fiscal period ending March 31, 2016 were $12,670.

A copy of the draft Auditors Report and Financial Statements are attached. The Audited Financial Statements are drafted in accordance with Generally Accepted Accounting Principles.

Strategic Direction

Continued participation in the regional PSLP will enable the Board of Health to work strategically with the 5CCC and other partnerships throughout the regional PSLP Network to ensure that local health needs for parents of young children are identified and assessed.

Contact:

Bob Dubay,
Manager, Financial Services
(705) 743-1000, ext. 286
bdubay@peterboroughpublichealth.ca

Attachments:

Attachment A – Draft Auditors Report and Financial Statements, Preschool Speech and Language Program

PETERBOROUGH COUNTY-CITY HEALTH UNIT

PRESCHOOL SPEECH AND LANGUAGE PROGRAM

STATEMENT OF REVENUE AND EXPENSES

FOR THE YEAR ENDED MARCH 31, 2016

INDEPENDENT AUDITORS' REPORT

To The Members Of The Board Of Health Of The Peterborough County-City Health Unit

Report on the Financial Statement
We have audited the accompanying statement of revenue and expenses of the Peterborough County-City Health Unit – Preschool Speech and Language Program for the year ended March 31, 2016, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statement
Management is responsible for the preparation and fair presentation of this financial statement in accordance with Canadian Public Sector Accounting Standards, and for such internal controls as management determines are necessary to enable the preparation of this financial statement that is free from material misstatement, whether due to fraud or error.

Auditors' Responsibility
Our responsibility is to express an opinion on the financial statement based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether this financial statement is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in this financial statement. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of this financial statement, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of this financial statement in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of this financial statement.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, this financial statement presents fairly, in all material respects, the revenue and expenses of the Peterborough County-City Health Unit – Preschool Speech and Language Program as at March 31, 2016 in accordance with Canadian Public Sector Accounting Standards.

Basis of Accounting and Restriction on Use
Without modifying our opinion, we draw attention to Note 1 to the financial statement, which describes the basis of accounting. The financial statement is prepared to assist the Peterborough County-City Health Unit – Preschool Speech and Language Program to meet the requirements of the Health Unit. As a result, the financial statement may not be suitable for another purpose. Our report is intended solely for the Health Unit and Five Counties Children's Centre and should not be distributed to parties other than the Board of Health of the Peterborough County-City Health Unit and Five Counties Children's Centre.

Chartered Professional Accountants
Licensed Public Accountants

Peterborough, Ontario
June 8, 2016

PETERBOROUGH COUNTY-CITY HEALTH UNIT
PRESCHOOL SPEECH AND LANGUAGE PROGRAM

STATEMENT OF REVENUE AND EXPENSES
For The Year Ended March 31, 2016

	Budget 2016 $ (Unaudited)	Actual 2016 $	Actual 2015 $
Revenue			
Five Counties Children's Centre grant	12,670	12,670	12,670
	12,670	12,670	12,670
Expenses			
Personal Services Expenses			
Salaries and wages	8,955	8,955	8,396
Employee benefits	2,405	2,405	2,074
Phone line support	360	360	1,250
	11,720	11,720	11,720
Other Operating Expenses			
Rent	420	420	420
Audit	530	530	530
	950	950	950
	12,670	12,670	12,670
Excess Of Revenue Over Expenses For The Year	-	-	-

The accompanying note is an integral part of this financial statement.

PETERBOROUGH COUNTY-CITY HEALTH UNIT
PRESCHOOL SPEECH AND LANGUAGE PROGRAM

NOTE TO THE FINANCIAL STATEMENT
For The Year Ended March 31, 2016

NOTE 1: SIGNIFICANT ACCOUNTING POLICIES

The statement of revenue and expenses of the Preschool Speech and Language Program of the Peterborough County-City Health Unit has been prepared in accordance with the standards in the Chartered Professional Accountants Canada Public Sector Accounting (PSA) handbook. The more significant accounting policies are summarized below:

Accounting Entity

This financial statement comprises all of the activities for which the Preschool Speech and Language Program of the Peterborough County-City Health Unit is legally accountable. The funding and financial reporting requirements of this program are separate and apart from the other functions of the Health Unit.

Tangible Capital Assets

Tangible capital assets are recorded at cost which includes all amounts that are directly attributable to acquisition, construction developments or betterment of the asset. The Preschool Speech and Language Program has no significant capital assets.

Operating Grants

The Preschool Speech and Language Program claims each year from the Five Counties Children's Centre grants equivalent to its net allowable operating costs. While these claims for allowable operating costs are recorded as revenue in the current year, the reimbursement for these costs is dependent ultimately upon their acceptance by the Five Counties Children's Centre.

Budget Data

Budget data is compiled from the budget approved by the Board of Health, with subsequent adjustments. Budget data is not subject to audit.

Recognition of Revenue and Expenses

Revenue and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenue as they become available and measurable, expenses are recognized as they are incurred and measurable as a result of receipt of goods and services and the creation of a legal obligation to pay.

Use of Estimates

The preparation of financial statements in compliance with Canadian Public Sector Accounting Standards requires management to make estimates and assumptions for operating grants that affect the reported amounts of revenue and expenses during the year. Actual results could differ from the estimates, the impact of which would be recorded in future periods.

Peterborough
Public Health

Staff Report

2015/2016 Infant & Toddler and Development Program Audited Financial Statements and Transfer Payment Annual Reconciliation

Date:	June 8, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Bob Dubay, Manager, Financial Services

Proposed Recommendations

That the Board of Health for Peterborough Public Health:

- approve the 2015/2016 Infant & Toddler Development Program Audited Financial Statements in the amount of $242,823; and,
- approve the 2015/2016 Infant & Toddler Development Program Annual Program Expenditure Reconciliation.

Financial Implications and Impact

The Board of Health is required by contract with the Ministry of Children and Youth Services (MCYS) to provide the Ministry the 2015/2016 Infant & Toddler Development Audited Financial Statements.

The Province also requires that the Annual Program Expenditure Reconciliation be Certified by the Medical Officer of Health that the Annual Expenditure Reconciliation is true, correct and agrees with the books and records of the organization. The Chairperson of the Board must Certify that the Annual Program Expenditure Reconciliation and Certification by the Medical Officer of Health was received by the Board of Health.

Decision History

The Board of Health approved the 2015/2016 budget request of $244,435 including funding from the province of $242,423 on March 11, 2015.

As directed by the Board of Health, the budget reflects the actual occupancy costs and a more reasonable recovery of costs to administer the program. Operating costs continue to be limited to the approved funding level of $242,423. There have been no funding increases to the program since 2003. To balance the budget in 2015/2016 the board approved $1,922 of other health unit funds to be used. These funds were set aside for the program in prior years.

Background

The Infant & Toddler Development Program (ITDP) is supposed to be funded 100% by the MCYS. The Infant & Toddler Development program budget year began April 1, 2015 and ends March 31, 2016. The total funding allocation from the Ministry for the current year was $242,423. The operating budget has been fixed at $242,423 with no increases since 2002/2003. Deferred income has been used for several years now to balance the budget.

Rationale

The Audited expenditures for the year totalled $242,823 are lower than the approved budget due to savings in program travel this year.

A copy of the draft Auditors Report and Financial Statements are attached. The Audited Financial Statements are drafted in accordance with Generally Accepted Accounting Principles.

A copy of Annual Program Expenditure Reconciliation is attached.

Strategic Direction

The submission of the on the Annual Reconciliation Report along with the Audited Financial Statements will allow the Board to fulfill financial contractual obligations with the MCYS. By submitting these reports on a timely basis, the Ministry will continue to flow funds to the Board and allow the Ministry to consider approving the board's 2015/2016 budget submission. This will help the PPH in continuing to meet its mandate through coordinated efforts with the Healthy Babies, Healthy Children Program and the Child Health Program.

The Board of Health will need to continue to work with the Ministry to secure additional funding to support the on-going operations of the Infant & Toddler Development Program.

Contact:

Bob Dubay,
Manager, Financial Services
(705) 743-1000, ext. 286
bdubay@peterboroughpublichealth.ca

Attachments:

Attachment A – Draft Auditors Report and Financial Statements, Infant & Toddler Development Program
Attachment B – Draft Annual Program Expenditure Reconciliation, Infant & Toddler Development Program

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION I: SUMMARY, CERTIFICATION and VERIFICATION

SERVICE PROVIDER / DELIVERY AGENT: Peterborough County-City Health Unit

FOR THE YEAR ENDED: March 31, 2016

SERVICE CONTRACT/CFSA APPROVAL NUMBER: C23673 - 4

PART A: SUMMARY

LINE	SERVICES		Executive and Allotment Control	Total Eligible Expenditures (pending final Ministry review and approval)	Total Approved Ministry Funding	Summary of Revised Ministry Funding after Financial Flexibility (pending final Ministry review and approval)
100	Detail Code #	Service (Detail Code) Name				
101	A476	Infant Development	CYSEX034-AL09	$ 242,423	$ 242,423	$ 242,423
102	0			$ -	$ -	$ -
103	0			$ -	$ -	$ -
104	0			$ -	$ -	$ -
105	0			$ -	$ -	$ -
106	0			$ -	$ -	$ -
107	0			$ -	$ -	$ -
108	0			$ -	$ -	$ -
109	0			$ -	$ -	$ -
110	0			$ -	$ -	$ -
111	0			$ -	$ -	$ -
112	0			$ -	$ -	$ -
113	0			$ -	$ -	$ -
114	0			$ -	$ -	$ -
115	0			$ -	$ -	$ -
116	0			$ -	$ -	$ -
117	0			$ -	$ -	$ -
118	0			$ -	$ -	$ -
119	0			$ -	$ -	$ -
120	0			$ -	$ -	$ -
121	0			$ -	$ -	$ -
122	0			$ -	$ -	$ -
123	0			$ -	$ -	$ -
124	0			$ -	$ -	$ -
125	0			$ -	$ -	$ -
126	0			$ -	$ -	$ -
127	0			$ -	$ -	$ -
128	0			$ -	$ -	$ -
129	0			$ -	$ -	$ -
130	0			$ -	$ -	$ -
131	0			$ -	$ -	$ -
132	0			$ -	$ -	$ -
133	0			$ -	$ -	$ -
134	0			$ -	$ -	$ -
135	0			$ -	$ -	$ -
136	0			$ -	$ -	$ -
137	0			$ -	$ -	$ -
138	0			$ -	$ -	$ -
139	0			$ -	$ -	$ -
140	0			$ -	$ -	$ -
141	0			$ -	$ -	$ -
142	0			$ -	$ -	$ -
TOTAL				$ 242,423	$ 242,423	$ 242,423

PART B: CERTIFICATION BY SERVICE PROVIDER / DELIVERY AGENT AUTHORITY

I hereby certify that, to the best of my knowledge, the financial data in the Transfer Payment Annual Reconciliation to which this certification is attached, is true, correct, agrees with the books and records of the organization and has been prepared in accordance with the Technical Instructions and ministry financial policies provided by the Ministry of Community and Social Services and the Ministry of Children and Youth Services.

Signature of Service Provider / Delivery Agent Authority (LINE 143)

Dr. Rosana Salvaterra
Name of Service Provider/Delivery Agent Authority (LINE 143)

Medical Officer Of Health
Title of Service Provider/Delivery Agent Authority (LINE 143)

Date (dd/mm/yy) (LINE 150)

PART C: VERIFICATION BY THE BOARD OF DIRECTORS

The above certification, together with the Transfer Payment Annual Reconciliation, was received and approved by:

day of **(LINE 160)**

Chairperson of the Board of Directors:

Signature

Signature

Mr. Scott McDonald
Name of Chairperson or Designate

Title

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION IV: AUDITED FINANCIAL STATEMENT RECONCILIATION

SERVICE PROVIDER / DELIVERY AGENT: Peterborough County-City Health Unit

FOR THE YEAR ENDED: March 31, 2016

SERVICE CONTRACT/CFSA APPROVAL NUMBER: C23673 - 4

LINE			
400	**TOTAL GROSS REVENUES PER AUDITED FINANCIAL STATEMENTS**		$ 242,823
401	LESS: Non Funded Ministry (MCYS) Revenue (i.e. funding from other sources not related to ministry servic		$ -
402	**Adjustments for Revenues from Ministry Funding calculation**		
403	Less: Non Retainable Revenues		
404	Specify: Deferred program funding		$ 400
405	Specify:		$ -
406	Specify (e.g. Specific Operating Donations)		$ -
407	Specify (e.g. Inter-Agency Chargebacks)		$ -
408	Less: Amortization of Deferred Revenue		$ -
409	Less: Other (specify)_____		$ -
410	Less: Other (specify)_____		$ -
		Subtotal	$ 400
411	Add: One-Time Capital Expenditures Approved & not included in Revenue		$ -
412	Add: Other (specify)_____		$ -
413	Add: Other (specify)_____		$ -
414		**Subtotal**	$ -
415	**Total Revenue Reported (Line 400 - Line401 - Line 404 to Line 410 + Line 414)**		$ 242,423
420	**Total Approved Ministry Funding (Total of LINE 223)** *(Lines 415 and 420 should equal)*		$ 242,423
440	**TOTAL GROSS EXPENDITURES PER AUDITED FINANCIAL STATEMENTS**		$ 242,823
441	LESS: Non Funded Ministry (MCSS) Expenditures (i.e. expenditures from other services not related to ministry services)		$ -
442	**Adjustments for Inadmissible Expenditures related to Ministry Funded Programs**		
443	Less: Accruals (Payables greater than 30 day i.e. Vacation/Sick Accrual)		$ -
444	Less: Appropriations		$ -
445	Less: Amortization on Capital Assets		$ -
446	Less: Donations to Individuals or Organizations		$ -
447	Less: Fundraising Costs		$ -
448	Less: Loans to Clients or Staff		$ -
449	Less: Retainer Fees		$ -
450	Less: Provisions for Bad Debt		$ -
451	Less: In Kind		$ -
452	Less: Other (specify)_____		$ -
453	Less: Other (specify)_____		$ -
		Subtotal	$ -
	LESS: Other Adjustments		
455	Less: Expenditure Recoveries/ Offsetting Revenues		$ -
456	Less: Other : Deferred program funding		$ 400
457	Less:		$ -
		Subtotal	$ 400
460	ADD: Adjustments for Admissible Expenditures, attach prior approval documentation		
461	Add: One-Time Capital Expenditures Approved & Capitalized		$ -
462	Add: Other (specify)_____		$ -
463	Add: Other (specify)_____		$ -
		Subtotal	$ -
475	**Total Ministry (MCYS) Eligible Expenditures reported in the Audited Financial Statements**		$ 242,423
480	**Total Eligible Expenditures (Total of LINE 269)**		$ 242,423
490	Variance		$ -

Variance Explanation:

491	**Retained Earning**	$ -
492	**Total Assets**	$ -
493	**Total Debt**	$ -

(Please attach additional sheets if necessary or if the space is insufficient to complete the above reconciliation)

PETERBOROUGH COUNTY-CITY HEALTH UNIT

INFANT TODDLER DEVELOPMENT PROGRAM

STATEMENT OF REVENUES AND EXPENSES

FOR THE YEAR ENDED MARCH 31, 2016

INDEPENDENT AUDITORS' REPORT

To The Members Of The Board Of Health Of The Peterborough County-City Health Unit

Report on the Financial Statement
We have audited the accompanying statement of revenues and expenses of the Peterborough County-City Health Unit – Infant Toddler Development Program for the year ended March 31, 2016, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statement
Management is responsible for the preparation and fair presentation of this financial statement in accordance with Canadian Public Sector Accounting Standards, and for such internal controls as management determines are necessary to enable the preparation of this financial statement that is free from material misstatement, whether due to fraud or error.

Auditors' Responsibility
Our responsibility is to express an opinion on the financial statement based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether this financial statement is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in this financial statement. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of this financial statement, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of this financial statement in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of this financial statement.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, this financial statement presents fairly, in all material respects, the revenues and expenses of the Peterborough County-City Health Unit – Infant Toddler Development Program as at March 31, 2016 in accordance with Canadian Public Sector Accounting Standards.

Basis of Accounting and Restriction on Use
Without modifying our opinion, we draw attention to Note 1 to the financial statement, which describes the basis of accounting. The financial statement is prepared to assist the Peterborough County-City Health Unit – Infant Toddler Development Program to meet the requirements of the Health Unit. As a result, the financial statement may not be suitable for another purpose. Our report is intended solely for the Health Unit, Ministry of Children and Youth Services and the Ministry of Community and Social Services and should not be distributed to parties other than the Board of Health of the Peterborough County-City Health Unit and the Ministry of Children and Youth Services and the Ministry of Community and Social Services.

Chartered Professional Accountants
Licensed Public Accountants

Peterborough, Ontario
June 8, 2016

PETERBOROUGH COUNTY-CITY HEALTH UNIT
INFANT TODDLER DEVELOPMENT PROGRAM

STATEMENT OF REVENUES AND EXPENSES
For The Year Ended March 31, 2016

	Budget 2016 $ (Unaudited)	Actual 2016 $	Actual 2015 $
Revenues			
Ministry of Community and Social Services/Ministry of Children and Youth Services grant	242,423	242,423	242,423
City of Peterborough - Best Start	-	-	2,664
Other revenue	1,922	400	2,448
	244,345	242,823	247,535
Expenses			
Personal Services Expenses			
Salaries and wages	149,552	152,226	152,952
Employee benefits	43,370	41,278	44,057
	192,922	193,504	197,009
Other Operating Expenses			
Audit and legal	1,900	1,600	1,600
Rent and utilities	15,396	15,396	15,396
Materials and supplies	2,500	1,384	2,042
Office supplies, postage and advertising	1,885	1,832	1,849
Staff education and training	500	270	70
Travel	5,000	3,595	5,327
Allocated administration	24,242	24,242	24,242
	51,423	49,319	50,526
	244,345	242,823	247,535
Amount due to Province of Ontario	-	**-**	**-**

The accompanying notes are an integral part of this financial statement.

PETERBOROUGH COUNTY-CITY HEALTH UNIT
INFANT TODDLER DEVELOPMENT PROGRAM

NOTES TO THE FINANCIAL STATEMENT
For The Year Ended March 31, 2016

NOTE 1: SIGNIFICANT ACCOUNTING POLICIES

The statement of revenues and expenses of the Infant Toddler Development Program of the Peterborough County-City Health Unit has been prepared in accordance with the standards in the Chartered Professional Accountants Canada Public Sector Accounting (PSA) handbook. The more significant accounting policies are summarized below:

Accounting Entity

This financial statement comprises all of the activities for which the Infant Toddler Development Program of the Peterborough County-City Health Unit is legally accountable. The funding and financial reporting requirements of this program are separate and apart from the other functions of the Health Unit.

Tangible Capital Assets

Tangible capital assets are recorded at cost which includes all amounts that are directly attributable to acquisition, construction developments or betterment of the asset. The Infant Toddler Development Program has no significant capital assets.

Operating Grants

The Infant Toddler Development Program claims each year from the Ministry of Community and Social Services and the Ministry of Children and Youth Services grants equivalent to its net allowable operating costs. While these claims for allowable operating costs are recorded as revenue in the current year, the reimbursement for these costs is dependent ultimately upon their acceptance by the funders of the program.

Budget Data

Budget data is compiled from the budget approved by the Board of Health, with subsequent adjustments. Budget data is not subject to audit.

Recognition of Revenues and Expenses

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues as they become available and measurable, expenses are recognized as they are incurred and measurable as a result of receipt of goods and services and the creation of a legal obligation to pay.

Use of Estimates

The preparation of financial statements in compliance with Canadian Public Sector Accounting Standards requires management to make estimates and assumptions that affect the reported amounts of revenues and expenses during the year. Actual results could differ from the estimates, the impact of which would be recorded in future periods.

PETERBOROUGH COUNTY-CITY HEALTH UNIT
INFANT TODDLER DEVELOPMENT PROGRAM

NOTES TO THE FINANCIAL STATEMENT
For The Year Ended March 31, 2016

NOTE 2: PENSION PLAN

Certain employees of the Infant Toddler Development Program are eligible to be members of the Ontario Municipal Employees Retirement Fund which is a multi-employer final average pay contributor pension plan. Employer contributions made to the Fund during the year amounted to $12,944 (2015 - $13,707). These amounts are included in employee benefits expense in the statement of revenues and expenses.

To: All Members
Board of Health

From: Gregory Connolley, Chair, Governance Committee

Subject: **Committee Report: Governance**

Date: June 8, 2016

The Governance Committee met last on May 3, 2016. At that meeting, the Committee requested that the following items come forward to the Board of Health:

1. Meeting Minutes – March 15, 2016

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive for information, meeting minutes of the Governance Committee for March 15, 2016.

2. By-Laws, Policies and Procedures

Proposed Recommendation:

That the Board of Health for Peterborough Public Health approve changes to:
- 2-130 By-Law Number 4 Appointment of Auditor
- 2-160 By-Law Number 7, Execution of Documents;
- 2-211 Delegation of Authority;
- 2-348 Governance Committee Terms of Reference; and

be advised that the Governance Committee has reviewed the following document and recommends no further changes to:
- 2-20 Authority and Jurisdiction. (web hyperlink)

Please refer to the following documents:
a. 2-130 By-Law Number 4 Appointment of Auditor
b. 2-160 By-Law 7, Execution of Documents
c. 2-211 Delegation of Authority
d. 2-348 Governance Committee Terms of Reference

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
Tuesday, March 15, 2016 – 4:30 p.m.
Mississauga Lake Room, 185 King Street, Peterborough

Present:	**Mayor Mary Smith** **Deputy Mayor Fallis** **Mr. Greg Connolley, Chair** **Mayor Woodcock**
Regrets:	**Mr. Scott McDonald**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health** **Mr. Larry Stinson, Director of Operations** **Ms. Natalie Garnett, Recorder** (4:40 p.m.)

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1. Call to Order

Dr. Salvaterra called the Governance Committee meeting to order at 4:35 p.m.

2. Elections

2.1 Chairperson

Dr. Salvaterra called for nominations for the position of Chairperson for the Governance Committee for the Peterborough County-City Health Unit for the year 2016.

MOTION:
That Greg Connolley be appointed Chair of the Governance Committee for 2016.
Moved: Deputy Mayor Fallis
Seconded: Mayor Woodcock
Motion carried. (M-2016-001-GV)

Mr. Connolley assumed the Chair.

2.2 Vice Chairperson

Mr. Connolley called for nominations for the position of Vice Chairperson for the Governance Committee for the Peterborough County-City Health Unit for the year 2016.

MOTION:
That Deputy Mayor Fallis be appointed Vice Chair of the Governance Committee for 2016.
Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2016-002-GV)

3. Confirmation of the Agenda

MOTION:
That the Agenda be accepted as circulated.
Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-003-GV)

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the minutes of the Governance Meeting held December 1, 2015 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-004-GV)

7. Business Arising from the Minutes

8. Staff Reports

9. Consent Items

9.1 **Correspondence**

9.2 **Staff Reports and Presentations**

a. Board By-laws and Policies for Review
MOTION:

That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit advise the Board of Health at its next meeting that the Committee reviewed the following policies and recommends:

- *2-150, Remuneration of Members - Item 10 be amended to "The quarterly financial report presented to the Board of Health will provide details of the expenses related to the activities of the Board of Health."*
- *2-261, Appointments, Provincial Representatives – no changes recommended.*

Moved: Mayor Woodcock
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-005-GV)

b. Medical Officer of Health Performance Review

MOTION:
That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit advise the Board of Health:

- *Recommend approval of the PCCHU Medical Officer of Health (MOH) Performance Appraisal Form as amended; and*
- *Advise the Board of the upcoming MOH review process at the next Board of Health meeting.*

Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2016-006-GV)

9.3 **Committee Reports**

10. New Business

10.1 **Governance Committee Workplan (2016)**

MOTION:
That the Governance Committee approve the Governance Committee 2016 Workplan, as amended.
Moved: Deputy Mayor Fallis
Seconded: Mayor Woodcock
Motion carried. (M-2016-007-GV)

11. In Camera to Discuss Confidential Matters

12. Motions from In Camera for Open Session

13. Date, Time and Place of Next Meeting

Monday, May 9, 2016 at 4:30 p.m. in the Board Room, Peterborough County-City Health Unit, 185 King Street, Peterborough.

14. Adjournment

MOTION:
That the Governance Committee meeting be adjourned.
Moved by: Mayor Smith
Seconded by: Deputy Mayor Fallis
Motion carried. (M-2016-008-GV)

The meeting was adjourned at 6:03 p.m.

Chairperson

Medical Officer of Health

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-130	**Title:** By-Law Number 4 – Appointment of an Auditor
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:** **1989-10-11**
Signature:		**Author:** Director~~, Corporate Services~~ of Operations
Date (YYYY-MM-DD)**:**	~~2008-01-09~~ 2016-06-08	
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

By-Law Number 4
A By-Law to Provide for the Appointment of an Auditor

1. In this By-law:
   (1) "Board" means the Board of Health for ~~the Peterborough County-City Health Unit~~ Peterborough Public Health; and
   (2) "meeting" means an official gathering of the Board in one place to transact business.

2. In accordance with the Municipal Act, Section 296, Subsection (10), as the Board is a local board of more than one municipality, the auditor of the municipality which is responsible for the largest share of the operating costs of the local board is required to audit the local board.

3. The auditor shall:
   (1) audit the accounts and transactions of the Board;
   (2) perform such duties as are prescribed with respect to local boards under the Municipal Act and the Municipal Affairs Act;
   (3) perform such other duties as may be prescribed by the Board that do not conflict with the duties as set out in subsection (2) of section 3 of this By-law;
   (4) have a right of access at all reasonable hours to all books, records, documents, accounts and vouchers of the Board and is entitled to require from the Board such information and explanation as in his/her opinion may be necessary to carry out such duties as set out in subsections (2) and (3) of section 3 of this By-law; and

(5) be entitled to attend any meeting, to receive all notices relating to any such meeting and to be heard at any such meeting that he/she attends on any part of the business that concerns him/her as auditor.

(6) meet with the Board as requested.

(7) meet with the Board Committee responsible for audits twice annually.

This By-Law shall be deemed to have come in to force on the 11th day of October, 1989.

Dated at the City of Peterborough the 12th day of October, 1989.

Review/Revisions

On (YYYY-MM-DD)**:** 2014-09-03 (Governance Committee Review)
On (YYYY-MM-DD)**:** 2008-01-09
On (YYYY-MM-DD)**:** 2006-04-12
On (YYYY-MM-DD)**:** 2005-01-12

Peterborough County-City HEALTH UNIT
...because health matters!

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-160	**Title:** By-Law Number 7 – Execution of Documents
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:** **1989-10-11**
Signature:		**Author:** Director of Operations, ~~Corporate Services~~
Date (YYYY-MM-DD)**:** ~~2014-09-10~~ 2016-06-08		
Reference:		

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By-Law Number 7
Execution of Documents

1. In this By-law:
   1) "Act" means the Health Protection and Promotion Act;
   2) "Board" means the Board of Health for ~~the~~ Peterborough ~~County City Health Unit~~Public Health;
   3) "Chairperson of the Board" means the Chairperson elected under the Act;
   4) "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act;
   5) "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations; and
   6) "Director of Operations~~, Corporate Services~~" means the business administrator of the Board as defined in the Regulations under the Act.

2. Except as otherwise directed by the Board, the Chairperson and Vice-Chairperson of the Board, the Medical Officer of Health, Director of Operations~~, Public Health Programs~~ and the Assistant Director of Programs~~, Corporate Services~~ shall be authorized to sign any class of or particular contract, arrangement, conveyance, mortgage, obligation or other document.

3. Only one signature of the signing officers set out in section 2 of this By-law shall be required for a contract, arrangement, conveyance, mortgage, or other document with a pecuniary value of less than $~~25,000~~40,000. For a contract, arrangement, conveyance, mortgage, or other document with a pecuniary value of $~~25,000~~40,000 or more, two signatures of the signing officers set out in section 2 of this By-law shall be required. One signature will be the Chairperson of the Board of

Health or in the absence of the Chairperson, the Vice-Chairperson of the Board of Health. The second signature will be the Medical Officer of Health or in the absence of the Medical Officer of Health, the Director~~, Corporate Services~~Operations.

4. The Medical Officer of Health and/or Director of ~~Corporate Services~~Operations are authorized to sign Provincial Accountability Agreements as required.

This By-law shall be deemed to have come in to force on the 11th day of October, 1989.

Review/Revisions

On (YYYY-MM-DD)**:** 2014-09-10

On (YYYY-MM-DD)**:** 2012-09-12

On (YYYY-MM-DD)**:** 2010-10-28

On (YYYY-MM-DD)**:** 2006-03-06

On (YYYY-MM-DD)**:** 1998-10-28

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Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-211	**Title:** Delegation of Authority
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:** **2012-06-12**
Signature:		**Author:** Medical Officer of Health
Date (YYYY-MM-DD)**:** ~~2014-06-11~~ 2016-06-08		
Reference: Medical Officer of Health Position Description		

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POLICY

Policy Statement:

The Board of Health is responsible by legislation to superintend, provide or ~~provide and~~ ensure the provision of public health programs and services.

The Board delegates the day-to-day administration and oversight of the Health Unit to its Medical Officer of Health. The Medical Officer of Health may re-delegate certain functions as required.

Standard:

The Delegation of Authority also means the delegation of accountability and responsibility.

PROCEDURE

Except as otherwise noted, all administrative authority is delegated to the Medical Officer of Health. This includes ~~(~~but is not limited to~~):~~ all duties and responsibilities as outlined in the Medical Officer of Health job description as approved by the Board of Health.

- ~~Developing, recommending and implementing Policies and Procedures;~~
- ~~Interviewing, checking the references of, hiring and orienting Senior Managers;~~
- ~~Supervising preparation of annual capital and operating budgets;~~
- ~~Monitoring adherence to budget and recommending changes as required;~~
- ~~Implementing the Board's strategic plan and reporting progress to Board annually or as circumstances change;~~

- ~~Authorizing purchases, disbursements and signing cheques to the financial level delegated by the Board;~~
- ~~Supervising the day-to-day operations of the Peterborough County-City Health Unit;~~
- ~~Maintaining records as required by law;~~
- ~~Providing information and participating at Board of Health meetings;~~
- ~~Terminating all employees below the level of Medical Officer of Health. It is anticipated the Medical Officer of Health will consult the Board Chair before an employee is terminated.~~

Review/Revisions

On (YYYY-MM-DD)**:** 2014-06-11 (Board)

On (YYYY-MM-DD)**: 2014-05-22** (Governance)

On (YYYY-MM-DD)**:**

On (YYYY-MM-DD)**:**

On (YYYY-MM-DD)**:**

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-348	**Title:** Governance Committee, Terms of Reference
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2010-05-12**
Signature:		**Author:** Governance Committee
Date (YYYY-MM-DD)**:** ~~2015-03-11~~ 2016-06-08		
Reference:		

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Goal

1. To ensure that the Board of Health fulfils its legal, ethical, and functional responsibilities through adequate governance policy development, recruitment strategies, training programs, monitoring of board activities, and evaluation of board members' participation.

2. To promote and ensure effective governance by recommending to the Board of Health, Board of Health By-laws and policies and procedures that are relevant, current, and comprehensive.

Objectives

The Governance Committee will:

1. review and make recommendations to the Board regarding orientation of new members and the ongoing development of existing members;

2. be responsible to ensure that the By-law to select Board members for the Executive positions is followed and that no conflict, or perceived conflict is evident in the selection and voting process;

3. review, prepare and recommend revisions, where necessary, to Board of Health By-laws, policies and procedures;

4. advise the Board or a Board Committee of all corporate governance issues that the Committee determines ought to be considered by the Board or Committee as set out in an annual work plan;

5. oversee and advise on the annual selection of Board members for its standing Committees;

6. establish and administer a process for assessing the effectiveness of the Board, its Committees;

7. establish and administer a process for assessing the effectiveness of the Medical Officer of Health;

8. act as liaison between non-union staff and the Board of Health on matters related to compensation and working conditions.

Membership

The Committee will be composed of a minimum of three Board members in addition to the Chair of the Board.

The Committee will elect its own Chair and Vice-Chair at the first meeting of each calendar year.

Internal staff resources will be provided for the Committee through the Medical Officer of Health and the Director~~, Corporate Services.~~ of Operations.

Quorum

A majority of Committee members constitute a quorum.

Reporting

The Committee will provide its minutes, once approved, to the Board of Health at the next scheduled meeting.

The Chair will take motions and/or recommendations deemed appropriate by the Committee forward to the Board of Health at the next scheduled meeting.

Meetings

The Committee will meet a minimum of quarterly and may meet more frequently

Extraordinary meetings to address specific items may be held at the call of the Chair of the Governance Committee.

Time-limited sub-committees may be formed to address specific issues.

The Governance Committee will meet with other Board Committees as required.

Minutes

The ~~Administrative~~ Executive Assistant to the Board of Health, or designate, will record the proceedings at meetings and provide secretarial support to the Committee.

The minutes are circulated in draft to Committee members prior to the next Committee meeting. Minutes are corrected and approved at the next meeting of the Committee.

The approved minutes are signed by the recorder and the Chairperson. Original copies of the approved minutes are kept in a binder in the Administration office.

Agendas

Agendas will be prepared and distributed according to the format set forth in Section 4 – Agenda and Order of Business, as written in Board of Health By-Law #3, Calling of and Proceedings at Meetings.

Terms of Reference

The Terms of Reference of the Board of Health's Governance Committee will be reviewed and updated at the first meeting of each new year or more often as needed.

Review/Revisions

On (YYYY-MM-DD)**:** 2015-03-11 (Board)
On (YYYY-MM-DD)**:** 2013-02-13 (Board)
On (YYYY-MM-DD)**:** 2013-02-01 (Governance review)
On (YYYY-MM-DD)**:** 2011-09-11 (Board)
On (YYYY-MM-DD)**:** 2011-06-09 (Governance review)