Board of Health for the Peterborough
County-City Health Unit
AGENDA
Board of Health Meeting
4:45 p.m. Wednesday, February 13, 2013
(Council Chambers, County Court House
County of Peterborough, 470 Water Street)

1. Call to Order

1.1. Recognition of Past Chair – Deputy Mayor Andy Sharpe

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. **A Day In The Life – Sexual Health Nurse**
Presenters: Sue Marino, PHN

5. Confirmation of the Minutes of the Previous Meeting

5.1. **January 9, 2013**

6. Business Arising From the Minutes

7. Correspondence

8. Program Reports

8.1. **Q4 2012 Program Report**
Larry Stinson, Director, Public Health Programs
(Presentation Link)

8.2. **Q4 2012 Financial Report**
Bob Dubay, Accounting Supervisor

9. New Business

9.1. **Staff Report: Student Nutrition Programs:**
Best Practices, Actions for Sustainability and Call to Action
Carolyn Doris, Public Health Nutritionist
(Presentation Link)

9.2. **Staff Report: Audit Letter of Engagement**
Dr. Rosana Pellizzari, Medical Officer of Health

9.3. **Committee Report: Governance**
Mr. David Watton, Chair, Board of Health

9.4. **Committee Report: Property**
Mr. David Watton, Chair, Board of Health

10. By-Laws

11. In Camera to Discuss Confidential Personal and Property Matters

12. Date, Time, and Place of the Next Meeting
4:45 p.m. Wednesday, March 13, 2013; Council Chambers, County Court House County of Peterborough, 470 Water Street)

13. Adjournment

c: All Members, Board of Health
Medical Officer of Health
Directors

Board of Health for the
Peterborough County-City Health Unit
Minutes
Wednesday, January 9, 2013
(Council Chambers, County Court House
County of Peterborough, 470 Water Street)

Present:

Board Members: Mr. David Watton, Chair
Councillor Andrew Beamer
Councillor Henry Clarke
Mr. Jim Embrey
Mayor John Fallis
Mr. Paul Jobe
Councillor Lesley Parnell
Mayor Mary Smith
Chief Phyllis Williams

Regrets: Deputy Mayor Andy Sharpe

Staff: Mrs. Brittany Cadence, Supervisor, Communications Services
Ms. Karen Chomniak, Manager, Family Health
Mrs. Sharon Hele, Registered Nurse
Mrs. Barbara Matwey, Administrative Assistant, Recorder
Dr. Rosana Pellizzari, Medical Officer of Health
Mr. Larry Stinson, Director, Public Health Programs
Mrs. Alida Tanna, Administrative Assistant
Ms. Sarah Tanner, Supervisor, Oral Health Program
Mr. Brent Woodford, Director, Corporate Services

1. Call to Order

1.1 Welcome and Introductions

Dr. Pellizzari welcomed members back to the first meeting of the Board of Health for 2013.

1.2 Proceedings at Meetings

In accordance with Board of Health By-Law #3, Calling of and Proceedings at Meetings, Dr. Pellizzari called the meeting to order at 4:50 p.m.

2. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

3. Elections

3.1 Chairperson

Prior to calling for nominations for the position of Chairperson of the Board of Health for 2013, Dr. Pellizzari recognized outgoing Chairperson, Deputy Mayor Sharpe for his leadership and assistance during 2011 and 2012.

Dr. Pellizzari called for nominations from the floor for the position of Chairperson of the Board of Health for 2013.

Moved by	Seconded by
Mr. Jobe	Councillor Parnell

That Mr. David Watton be nominated Chairperson of the Board of Health for 2013.

-Carried – (M-13-01)

Dr. Pellizzari asked again if there were any further nominations for the position of Chairperson.

Dr. Pellizzari asked one last time if there were any further nominations for the position of Chairperson.

There being no further nominations for the position of Chairperson, Dr. Pellizzari declared nominations closed and asked Mr. Watton if he accepted the nomination. Mr. Watton agreed to let his name stand for the position of Chairperson.

Mr. Watton was acclaimed to the position of Chairperson of the Board of Health for the year 2013. He thanked Dr. Pellizzari for chairing the first part of the meeting and assumed the Chair.

3.2 Vice Chairperson

Mr. Watton called for nominations for the position of Vice-Chairperson of the Board of Health for 2013.

Moved by	Seconded by
Mr. Embrey	Mayor Smith

Chief Williams be nominated Vice-Chairperson of the Board of Health for 2013.

-Carried – (M-13-02)

Mr. Watton asked again if there were any further nominations for the position of Vice-Chairperson.

Mr. Watton asked one last time if there were any further nominations for the position of Vice-Chairperson.

There being no further nominations for the position of Vice-Chairperson, Mr. Watton declared nominations closed and asked Chief Williams if she accepted the nomination. Chief Williams agreed to let her name stand for the position of Vice-Chairperson.

Chief Williams was acclaimed to the position of Vice Chairperson of the Board of Health for the year 2013.

4. Appointments to Committees

4.1 Governance

Moved by Councillor Clarke — Seconded by Mayor Fallis

That the Board of Health approve the following appointments to the Governance Committee: Mayor Smith, Chief Williams, Jim Embrey

-Carried – (M-13-03)

4.2 Property:

Moved by Mayor Fallis — Seconded by Councillor Beamer

That the Board of Health approve the following appointments to Property Committee: Deputy Mayor Sharpe, Councillor Clarke, Councillor Parnell

-Carried – (M-13-04)

The Chairperson of the Board of Health is an ex-officio member of all Board Committees.

5. Establishment of Date and Time of Regular Meetings

Moved by Councillor Parnell — Seconded by Mayor Fallis

That the regular meetings for the Board of Health be held on the second Wednesday of each month (excluding July and August) starting at 4:45 p.m., or at the call of the Chairperson. - Carried - (M-13-05)

A listing of the Board of Health meeting dates with locations for 2013 is as follows:

Location: Council Chambers, County Court House, 470 Water Street
Dates: January 9, February 13, March 13, April 10

Location: Curve Lake First Nation *(to be confirmed)*
Date: May 8

Location: Hiawatha First Nation *(to be confirmed)*
Date: June 12

Location: General Committee Room, City Hall, 500 George St. N. *(to be confirmed)*
Dates: September 11, October 9, November 13, December 11

6. Establishment of Honourarium for 2013

Moved by
Councillor Clarke

Seconded by
Mayor Fallis

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

- Defer until the February 13, 2013 meeting.

- Carried - (M-13-06)

7. Confirmation of the Agenda

Moved by
Councillor Parnell

Seconded by
Mayor Fallis

That the agenda be approved as circulated.

- Carried - (M-13-07)

8. Delegations and Presentations

8.1 A Day in The Life – Travel Clinic Nurse
Sharon Hele, RN

9. Confirmation of the Minutes of the Previous Meeting

Moved by
Councillor Clarke

Seconded by
Mr. Jobe

That the minutes of the Board of Health meeting held on December 12, 2012 be approved.

- Carried - (M-13-08)

10. Business Arising From The Minutes

Nil.

11. Correspondence

Moved by Councillor Parnell — Seconded by Mayor Smith

That the following documents be received for information.

- Carried - (M-13-09)

1. Association of Local Public Health Agencies (alPHa) Fall 2012 Newsletter and Save the Date flyer for the 2013 Winter Symposium.
2. Letter dated November 29, 2012 from Linda Stewart, Executive Director, (alPHa) regarding a draft updated version of alPHa's Boards of Health Section Policies and Procedures.
3. Letter dated December 17, 2012 from the Hon. Deb Matthews in response to Chairman Sharpe's letter dated September 24, 2012 regarding capital funding.
4. Letter dated December 19, 2012 from the Hon. Deb Matthews regarding one-time funding for the Healthy Communities.
5. Letter dated December 21, 2012 from the Hon. Deb Matthews regarding funding to support the Smoke-Free Ontario Strategy.
6. Letter dated January 4, 2013 from Dr. Pellizzari to the Premier McGuinty, Hon. John Milloy and Hon. Deb Matthews regarding food insecurity.
7. Resolutions from other Health Units:
   Haliburton, Kawartha, Pine Ridge District
   - Discretionary Benefits and Community Start-Up and Maintenance Benefits

Board members were asked to contact Alida Tanna with their interest in attending the alPHa 2013 Winter Symposium.

12. Program Reports

Nil.

13. New Business

13.1 Staff Report and Presentation: Healthy Babies, Healthy Children Program
Karen Chomniak, Program Manager

Ms. Chomniak provided an update on the funding received from the Ministry.

Moved by Mr. Embrey — Seconded by Councillor Parnell

That the Board of Health for the Peterborough County-City Health Unit approve the $100,000 increase in base funding for one (1.0) new full-time equivalent (FTE) public health nurse (PHN) position to support the delivery of our Healthy Babies, Healthy Children (HBHC) Program.

-Carried – (M-13-10)

13.2 Presentation: Oral Health Update
Sarah Tanner, Supervisor

Ms. Tanner provided an update on the fixed and mobile dental clinics. She informed the Board that both clinics were operating within budget this year.

13.3 Staff Report: 2012 Year-End Donations
Brent Woodford, Director, Corporate Services

Moved by Councillor Clarke — Seconded by Mayor Fallis

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, *2012 Year-End Donations,* for information.

-Carried – (M-13-11)

13.4 Staff Report: 2012 Year-End Complaints
Presenter: Dr. Rosana Pellizzari, Medical Officer of Health

Moved by Councillor Parnell — Seconded by Mayor Fallis

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, *2012 Year-End Complaints,* for information.

-Carried – (M-13-12)

13.5 PCCHU Organizational Chart
Dr. Rosana Pellizzari, Medical Officer of Health

A copy of the organizational chart was provided to the Board of Health.

13.6 Training Needs for the Board in 2013
Dr. Rosana Pellizzari, Medical Officer of Health

Dr. Pellizzari discussed training needs for the Board in 2013, and referenced the table of contents from the Board's orientation manual as a source for potential topics. It was noted that items addressed at alPHa conferences throughout the year could be the source of training and/or presentations to the Board.

Members attending the February 2013 were asked to be mindful of this in their report back to the Board at the March 13, 2013 meeting.

14. Committee Reports

Nil.

15. In Camera to discuss Confidential Personnel and Property Matters

Nil.

16. Date, Time, and Place of the Next Meetings

February 5, 2013, 4:00pm, Board/Management Strategic Planning Session, location to be provided. Chief Williams is unable to attend. The information will be prepared and forwarded ahead of time.

February 13, 2013, 4:45pm, Board of Health Meeting, Council Chambers, County Court House, County of Peterborough, 470 Water Street.

17. Adjournment

Moved by
Mr. Jobe

Seconded by
Councillor Clarke

That the meeting be adjourned.

- Carried – (M-13-13)

The meeting adjourned at 6:02 p.m.

_____
Chairperson

_____
Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: February 13, 2013

Recommendation:

That the following documents be received for information and acted upon as deemed appropriate.

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1. Letter dated January 11, 2013 from Dr. Pellizzari to Minister Aglukkaq and Dr. Butler-Jones, with copies to MP Del Mastro regarding food insecurity. **REF: P. 2-3**

2. Letter dated January 22, 2013 from Chairman Watton to MPP Leal regarding social assistance benefits. **REF: P. 4**

3. Letter dated January 30, 2013 from Dr. Pellizzari to Mayor Bennett and City Council Members, with copies to Brian Horton, CAO, regarding a Mandatory Food Handler Certification By-Law. **REF: P. 5-19**

4. Letter dated January 31, 2013 from Gordon Fleming, Association of Local Public Health Agencies (alPHa), regarding sodium. **REF: P. 20-22**

5. Letter dated February 1, 2013 from Minister Milloy to Dr. Pellizzari, in response to her original letter dated January 4, 2013, regarding social assistance benefits. **REF: P. 23-24**

6. Letter dated February 5, 2013 from alPHa regarding the Winter Symposium and Board of Health Section meeting. **REF: P. 25-44**

7. Resolutions from other Health Units:

   Northwestern
   - Oral Health **REF: P. 45-46**

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

January 11, 2013

Hon. Leona Aglukkaq, P.C., M.P., Minister of Health
Dr. David Butler-Jones, Chief Public Health Officer

Dear Minster Aglukkaq and Dr. Butler-Jones:

At the December 12, 2012 meeting of the Board of Health of the Peterborough County-City Health Unit the issues of income inequity and food insecurity were discussed. The Canada Prenatal Nutrition Programs (CPNP) were highlighted as a national initiative with positive results and a direct impact on healthy birth outcomes. The Board of Health learned that despite these findings, the CPNP have not had any budget increases since their inception in 1997. The Board of Health is urging the Federal government to enhance funding for the Canada Prenatal Nutrition Program immediately.

Canada Prenatal Nutrition Programs (CPNP) provides access to health professionals and community experts at a weekly program where nutritious food and prenatal vitamins are also provided. Two national comprehensive evaluations have found that participation in a CPNP reduces preterm births, low birth weight babies and poor neonatal health and improves breastfeeding incidence and duration rates. This contributes to overall healthcare cost savings.[1,2]

Babies First is the Peterborough based CPNP that operates at the Peterborough Family Resource Centre (PFRC) weekly. The emphasis is on good nutrition, decreasing poor health outcomes and provision of breastfeeding support. Community partnerships are at the heart of the CPNP model. The Peterborough County City Health Unit provides in kind support from their Registered Dietitian and Infant Development Worker which improves the financial viability of this initiative.

Despite increased food costs and other rising program costs, the staff at Babies First has had to work with a 1997 based budget. This level of funding has meant reduced food access and increased reliance on donations from Kawartha Food Share (food bank system). Staff from the PFRC report that Babies First is not in a position to actively recruit new participants since they do not have the capacity to take on larger numbers, limiting the service's potential impact.[3]

The Board of Health believes that programs with measured positive impact on health outcomes are achieving a cost savings in the health care system. The Canada Prenatal Nutrition Program is clearly one such program, and with increased levels of funding more women and their families can benefit.

10 Hospital Drive, Peterborough, ON K9J 8M1 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

In closing, we look forward to working with you, as well as our active community partners to address the need for CPNP budget improvements. Thank you for your immediate attention to this matter.

Sincerely,

Original signed by

Rosana Pellizzari, MD, MSc, CCFP, FRCPC
Medical Officer of Health, Peterborough County-City Health Unit

/at

cc: Dean Del Mastro, MP Peterborough

References

1. Muhajarine, N et al , "Understanding the Impact of the Canada Prenatal Nutrition Program: A Quantitative Evaluation" Canadian Public Health Association, Vol. 103, Supplement 1, S26 – S31 Sept/Oct 2012

2. Public Health Agency of Canada, Summative Evaluation of CPNP 2004- 2009, June 2010. Accessed on November 20, 2012: http://www.phac-aspc.gc.ca/about_apropos/evaluation/reports-rapports/2009-2010/cpnp-pcnp/summary-resume-eng.php

3. Personal Communication, Nicola Lyle, Team Leader, Antrim/Norwood sites, Peterborough Family Resource Centre, November 21, 2012

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Peterborough County-City
HEALTH UNIT
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January 22, 2013

Mr. Jeff Leal, MPP Peterborough
236 King Steet West
Peterborough, ON K9J 7L8

Dear Mr. Leal:

I am writing to express appreciation on behalf of the Board of Health for your efforts in bringing forward to your provincial colleagues the concerns of the Peterborough community with respect to reduced provincial funding for Discretionary Benefits and the elimination of Community Start-Up and Maintenance Benefits for people who receive support from Ontario Works and the Ontario Disability Support Program.

The December 27th, 2012 announcement of a one-time grant from the provincial government to help municipalities transition to the new Community Homelessness Prevention Initiative in 2013-14 demonstrates a recognition of the great needs that exist in terms of essential housing and homelessness supports in our community. Although the municipality has not yet developed a detailed plan for the funding, we feel the $1.5 million to be received in Peterborough could make a considerable contribution over the next year to meeting the emergency housing needs of those people who formerly received the 'Community Start-Up and Maintenance Benefit'.

We continue to look to you for support for reversing the reductions in funding to Discretionary Benefits for social assistance recipients. Although the Municipality has committed funding to provide the full range of benefits until the end of April, 2012, after that time funding for items such as baby equipment, children's recreational subsidies and dentures is at considerable risk. The public health impact of the loss of these benefits is considerable.

We look forward to continuing to work with you to support the well-being of some of our most vulnerable populations in Peterborough City and County.

Yours in health,

Original signed by

David Watton
Chair, Board of Health
Peterborough County-City Health Unit

/at

January 30, 2013

SENT VIA EMAIL: jkennedy@peterborough.ca

Mayor Daryl Bennett and Members of Council
c/o Mr. John Kennedy
City Clerk, City of Peterborough
500 George St. N.
Peterborough, ON K9H 3R9

Dear Mayor Bennett and Members of City Council:

Re: Mandatory Food Handler Certification By-Law

The Ontario Ministry of Health and Long-Term Care directs public health programs and activities through The Ontario Public Health Standards, 2008. Included in these standards is the Food Safety Program Standard whose goal is to prevent or reduce the burden of food-borne illness. One of the activities performed by the Peterborough County-City Health Unit (PCCHU) to achieve this goal is the provision of the Food Handler Training and Certification Course.

The Food Handler Training Certification Course is attended by staff of food premises as well as volunteers, students and those seeking employment. The six hour course covers the role of the Health Unit, basic microbiology, safe food handling techniques, personal hygiene and sanitation. It concludes with an exam and successful participants receive a certificate.

PCCHU has offered the Course on a regular basis, free of charge, since 1997. Since that time, over 11,000 people have been certified. Despite the large number of attendees, inspections of moderate and high risk food premises in 2010 found that 38% in the County and 21% in the City did not have a certified food handler on staff.

For many years there has been anticipation that the province would amend existing regulation to make food handler training mandatory as is the case in five other provinces in Canada. This has never come to fruition and as a result, some municipalities have created their own by-laws. Currently the municipalities of Brant, Hamilton, London, Middlesex, Niagara, Toronto and parts of Essex County have passed by-laws regarding safe food handling.

These by-laws generally require that at least one certified food handler be present at all times when food is being prepared in moderate and high risk food premises. These include restaurants, take-outs, grocery stores, nursing homes, daycares, chip trucks and supermarkets. Enforcement of these by-laws is done by Public Health Inspectors during routine inspections of food premises.

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On December 19, 2012, the County of Peterborough, after extensive consultation with its lower-tier municipalities, passed such a by-law. Since PCCHU's area includes both Peterborough County and the City of Peterborough, having a similar by-law in both jurisdictions would be ideal. Sections 8, 9 and 10 of the Municipal Act authorize the City to pass such a by-law.

Studies have shown that educating food handlers in food premises has been shown to increase compliance and reduce food-borne illness. Having a by-law in place in the City of Peterborough would further PCCHU's goal of preventing or reducing the burden of food-borne illness and help make the City of Peterborough an even healthier place to live and visit.

Sincerely,

Original signed by

Rosana Pellizzari, MD, MSc, CCFP, FRCPC
Medical Officer of Health, Peterborough County-City Health Unit

/at

Encl.

cc: Brian Horton, CAO, City of Peterborough

10 Hospital Drive, Peterborough, ON K9J 8M1 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

The Corporation of the County of Peterborough

By-law No. 2012 - 86

A By-law to regulate Mandatory Food Handler Certification in Moderate-risk and High-risk Food Premises in the County of Peterborough

Whereas Section 10(2) of the Municipal Act, 2001, S.O. 2001, c. 25 (hereinafter referred to as "the Act") as amended, permits councils of local municipalities to pass by-laws and make regulations for the health, safety and well-being of persons within the municipality;

And Whereas the Health Protection and Promotion Act, R.S.O. 1990, c. H-7 (hereinafter the "HPPA") sets out numerous regulations applicable to, inter alia, food premises the purpose of which is the protection and promotion of public health, including the duty of every medical officer of health to inspect or cause the inspection of food premises and any food and equipment thereon or therein;

And Whereas it has been determined that requiring mandatory food handler certification is important to help ensure the health, safety and well-being of the inhabitants of the County of Peterborough;

And Whereas section 425 of the Act authorizes the County of Peterborough to pass by-laws providing that a person who contravenes a by-law of the County of Peterborough is guilty of an offence;

And Whereas the Act further authorizes the County of Peterborough to delegate its authority, to impose fees or charges on persons for services or activities provided or done by or on behalf of it, to provide for inspections and inspection orders, and to make orders to discontinue activity or to do work;

And Whereas at the County Council Meeting of April 20, 2011, County Council passed resolution 3-2011 as follows

> "Be it resolved that County Council receive the delegation from Chris Eaton, Public Health Inspector, Peterborough County-City Health Unit concerning the Mandatory Food Handler Certification By-law; and further
>
> Be it resolved that the Health Unit be requested to contact the local Townships to arrange a similar presentation to the Township Councils; and further
>
> Be it resolved that County Council directs staff to request from each municipality within the County a resolution stating its position on having a County-wide mandatory food handler certification by-law.";

And Whereas at the following County Council Meetings held in 2011, County Council received the Township's responses and passed a resolution at each meeting directing that the draft Mandatory Food Handler Certification by-law be provided to all Townships for review and comment prior to passage of the Mandatory Food Handler Certification By-law:

Township	Township Meeting Date	County Council Meeting Date
Asphodel-Norwood	June 14, 2011	September 7
Cavan Monaghan	June 15, 2011	August 3
Douro-Dummer	August 2, 2011	August 17
Galway, Cavendish & Harvey	June 28, 2011	August 3
Havelock-Belmont-Methuen	August 29th letter	September 21, 2011
North Kawartha	June 21, 2011	June 29, 2011
Otonabee-South Monaghan	August 15, 2011	November 16, 2011
Smith-Ennismore-Lakefield	June 28, 2011	August 3, 2011

And Whereas at the County Council Meeting of May 2, 2012, County Council accepted the recommendation of the Clerk in her report "Mandatory By-law to regulate Mandatory Food Handler Certification in Moderate-Risk and High-risk Premises in the County of Peterborough" wherein she recommended that: "County Council directs staff to provide the draft by-law to regulate Mandatory Food Handler Certification in Moderate-risk and High-risk Food Premises in the County of Peterborough to the local Townships for comments by Council resolution by May 30th;

And Whereas at the June 6, 2012 Regular County Council Meeting, County Council received the Township of Douro-Dummer's resolution dated May 17, 2012 supporting the draft by-law;

And Whereas at the June 6, 2012 Regular County Council Meeting, County Council received the Township of Smith-Ennismore-Lakefield's resolution dated May 22, 2012 requesting that the Health Unit incorporate a staged offence system in order to differentiate varying degrees of infractions, from first offence (i.e. warning) to multiple offences (i.e. fines) and advising the County of the Township's support of the draft by-law;

And Whereas at the June 27, 2012 Regular County Council Meeting, County Council received the Township of Otonabee-South Monaghan's email dated June 4, 2012 enclosing the May 28, 2012 resolution and the Food Handling Report requesting the County revise the draft by-law taking into consideration the comments contained in the report and forwarding to all Peterborough County municipalities a revised draft by-law prior to final adoption;

And Whereas at the August 1, 2012 Regular County Council Meeting, County Council received the Township of Cavan Monaghan's resolution dated May 22, 2012 and the Township of North Kawartha's resolution dated June 26, 2012 supporting the draft by-law;

And Whereas at the County Council Meeting of August 1st, 2012, County Council received the delegation from the Medical Officer of Health and the Public Health Inspector concerning the draft by-law and requested that the questions raised in the May 28, 2012 Township of Otonabee-South Monaghan's resolution be answered in writing;

And Whereas at the Regular County Council Meeting of November 7, 2012, County Council received the Peterborough County-City Health Unit's letter dated October 12, 2012 concerning the proposed Mandatory Food Handler Training By-law and directed that the Health Unit letter be provided to the Township of Otonabee-South Monaghan for review by the Township Council;

And Whereas at the Regular County Council Meeting of December 7, 2012, County Council received the Township of Asphodel-Norwood's resolution dated November 13, 2012, supporting the proposed by-law as drafted;

And Whereas at the Regular County Council Meeting of December 7, 2012, County Council received the Township of Havelock-Belmont-Methuen's letter dated November 28, 2012 and its November 12, 2012 resolution suggesting that the County request the Health Unit to reconsider the Mandatory Food Handler Certification By-law with the intent of enhancing the current restaurant inspection program to achieve the necessary education of restaurant owners as part of that inspection program without introducing an increased financial burden on the restaurant owners;

And Whereas at the Regular County Council Meeting of December 19, 2012, County Council received the Township of Galway-Cavendish and Harvey's letter dated December 5, 2012 and its November 6, 2012 resolution supporting the implementation of a by-law to regulate mandatory food handler certification in moderate-risk and high-risk food premises in the County of Peterborough;

And Whereas at the Regular County Council Meeting of December 19, 2012, County Council received the Clerk's report;

Now Therefore the Council of the Corporation of the County of Peterborough in Session duly assembled enacts as follows, that:

Article 1.0 – Definitions

1.1 In this by-law:

a. **accredited program** means:

i. The Peterborough County-City Health Unit's Food Handler Certification Program;

ii. A food handler training and certification program offered by a health unit or health department in the Province of Ontario; or

iii. A food handler training and certification program that has been accredited by the Medical Officer of Health;

b. **certified food handler** means a food handler who holds a valid food handler certificate and whose responsibilities include supervising the preparation, processing, packaging, service and/or storage of food;

c. **County** means, as the context requires, The Corporation of the County of Peterborough or the geographic area of the County of Peterborough;

d. **Council** means the Council of the County of Peterborough;

e. **food** means food or drink for human consumption and includes an ingredient of food or drink for human consumption;

f. **food handler** means any person who works at a moderate-risk food premise or a high-risk food premise handling or coming in contact with food or drink during its preparation, processing, storage, handling, display, distribution, transportation, sale, service, or offering for sale;

g. **food handler certificate** means a certificate issued to a person by the provider of an accredited program certifying that the person has successfully completed that accredited program;

h. **food premise** means a premises where food is manufactured, processed, prepared, stored, handled, displayed, distributed, transported, sold or offered for sale, but does not include a private residence or food premises excepted from the application of R.R.O. 1990, Reg. 562 (the Food Premises Regulation under the Health Protection and Promotion Act) as set out in section 2 of that Regulation;

i. **high-risk food premise** means a food premise assigned as high risk by the Medical Officer of Health having reference to the most current version of the Risk Categorization Model provided by the Ministry of Health and Long-Term Care;

j. **Medical Officer of Health** means the Medical Officer of Health of the Peterborough County-City Health Unit or his or her designate;

k. **moderate-risk food premise** means a food premise assigned as moderate risk by the Medical Officer of Health having reference to the most current version of the Risk Categorization Model provided by the Ministry of Health and Long-Term Care;

l. **Officer** means a Public Health Inspector who is employed by the Peterborough County-City Health Unit;

m. **operator** means a person who has responsibility for or control over an activity carried on at a moderate-risk food premise or a high-risk food premise and there may be more than one operator of the same food premise;

n. **person** means, as the context requires: a natural person; an association; a corporation; a body politic or a partnership whether acting by themselves or by a servant, agent or employee and the heirs, executors, administrators, successors and assigns or other legal representative of such person; and

o. **premises** means lands and structures, or either of them, and includes:

   i. Water;

   ii. Ships and vessels;

   iii. Trailers and portable structures designed or used for residence, business or shelter; or

   iv. Trains, railway cars, vehicles and aircraft.

p. **Township** means any one of the following lower-tier municipalities located within the County:

Township of Asphodel-Norwood
Township of Cavan Monaghan

Township of Douro-Dummer
Township of Galway, Cavendish & Harvey
Township of Havelock-Belmont-Methuen
Township of North Kawartha
Township of Otonabee-South Monaghan
Township of Smith-Ennismore-Lakefield

Article 2.0 – Interpretation

2.1 The headings and subheadings used in this by-law shall not form a part of it, but shall be deemed to be inserted for convenience of reference only.

2.2 The requirements of this by-law are in addition to any requirements contained in any other applicable by-laws of the County or applicable provincial or federal statutes or regulations.

2.3 Unless the context otherwise requires, words imparting the singular number shall include the plural, and words imparting the masculine gender shall include the feminine, and further, the converse of the foregoing also applies where the context requires.

Article 3 – Offences for Operators and Food Handlers

3.1 No operator shall permit a moderate-risk food premise or high-risk food premise to operate without at least one certified food handler working in a supervisory capacity.

3.2 No food handler who, when working as the certified food handler, shall fail to produce for inspection his or her food handler certificate and a photo identification card upon the request of an Officer or of the Medical Officer of Health.

Article 4.0 – Food Handler Training and Certification

4.1 The Medical Officer of Health may accredit any food handler training and certification program upon being satisfied that the program is equivalent to the Peterborough County-City Health Unit's Food Handler Certification Program, having regard to the standards contained in the "Food Safety Protocol" of the Ontario Public Health Standards, 2008, issued under the Health Protection and Promotion Act, as amended.

4.2 Every provider of a food handler training and certification program seeking accreditation under Article 4.1 shall:

a. Provide the Medical Officer of Health with such information as the Medical Officer of Health considers necessary to evaluate the program; and

b. Pay the prescribed application fee for accreditation.

4.3 Every provider of an accredited program shall provide the Medical Officer of Health with such information as the Medical Officer of Health reasonably considers necessary to:

a. Evaluate, monitor and audit the program, including but not limited to, the lessons, materials, texts, examinations and qualifications of the instructors used in the program; and

b. Determine the validity of food handler certificates issued by the provider including, but not limited to, the attendance records, course submissions, examination results and true copies of the certificates issued.

4.4 The Medical Officer of Health may terminate the accreditation of any food handler training and certification program upon being satisfied that the program has ceased to be equivalent to the Peterborough County-City Health Unit's food handler certification program or that the program provider has failed to comply with Articles 4.2 or 4.3.

4.5 Unless terminated sooner by the Medical Officer of Health, the accreditation of a food handler training and certification program is valid for five years.

4.6 A provider of an accredited program may issue a food handler certificate to any natural person who has successfully completed an accredited program.

4.7 Unless terminated sooner by the Medical Officer of Health, a food handler certificate is valid for five years from the date of issue.

Article 5.0 – Inspections and Orders

5.1 In accordance with the conditions set out in sections 435 and 437 of the Municipal Act, 2001, including the provision of notice to an occupier, an Officer may enter a moderate-risk food premise or a high-risk food premise at any reasonable time for

the purpose of carrying out an inspection to determine whether or not the following are being complied with:

a. This by-law;

b. A direction, requirement or order made under this by-law; or

c. An order made under section 431 of the Municipal Act, 2001 in respect of a contravention of this by-law.

5.2 An Officer may, for the purposes of an inspection under Article 5.1:

a. Require the production for inspection of documents or things relevant to the inspection;

b. Inspect and remove documents or things relevant to the inspection for the purpose of making copies or extracts;

c. Require information from any person concerning a matter related to the inspection; or

d. Alone, or in conjunction with a person possessing special or expert knowledge, make examinations or take tests, samples or photographs necessary for the purposes of the inspection.

5.3 An inspection order made under Article 5.1 may be served personally or by registered mail to the last known address of such persons affected by it as the Officer making the order determines. Service by registered mail shall be deemed to have taken place five (5) business days after the date of mailing.

5.4 Where service cannot be given in accordance with Article 5.3, sufficient service is deemed to have taken place when the Officer places a placard containing the order in a conspicuous place on the property where the contravention occurred.

5.5 An Officer may, pursuant to an order under section 438 of the Municipal Act, 2001, undertake an inspection for a purpose described in Article 5.1 and exercise powers described in Article 5.2 where he or she has been prevented or is likely to be prevented from carrying out an inspection under Articles 5.1 and 5.2, provided that:

a. Unless otherwise provided in the order, the conditions set out in section 435 of the Municipal Act, 2001 apply; and

b. In the case of an order authorizing an inspection of a room or place actually being used as a dwelling, the occupier is given notice concerning the inspection in accordance with subsection 438(5) of the Municipal Act, 2001.

5.6 If an Officer is satisfied that a contravention of this by-law has occurred, he or she may make an order requiring the person who contravened the by-law or who caused or permitted the contravention or the owner or occupier of the property on which the contravention occurred to discontinue the contravening activity.

5.7 An order under Article 5.6 shall set out:

a. Reasonable particulars of the contravention adequate to identify the contravention and the location of the property on which the contravention occurred; and

b. The date or dates by which there must be compliance with the order.

5.8 If an Officer is satisfied that a contravention of this by-law has occurred, he or she may make an order requiring the person who contravened the by-law or who caused or permitted the contravention or the owner or occupier of the property on which the contravention occurred to do work to correct the contravention.

5.9 An order under Article 5.8 shall set out:

a. Reasonable particulars of the contravention adequate to identify the contravention and the location of property on which the contravention occurred;

b. The work to be done; and

c. The date or dates by which the work must be done.

5.10 An order to discontinue contravening activity made under Article 5.6 or an order to do work made under Article 5.8 may be served personally or by registered mail to the last known address of:

a. The owner or occupier of the property where the contravention occurred; and

b. Such other persons affected by it as the Officer making the order determines.

Service by registered mail shall be deemed to have taken place five (5) business days after the date of mailing.

5.11 Where service cannot be given in accordance with Article 5.10, sufficient service is deemed to have taken place when the Officer places a placard containing the order in a conspicuous place on the property where the contravention occurred.

Article 6.0 – Administration and Enforcement

6.1 The Medical Officer of Health is authorized to administer and enforce this by-law and has the delegated authority granted by Council to execute the provisions of the by-law, including the imposition of conditions as necessary to ensure compliance with this by-law.

6.2 Fees or charges for services and activities provided under this by-law shall be set and approved by the Board of Health for the Peterborough County-City Health Unit from time to time.

6.3 Unpaid fees or charges set and approved under Article 6.2 constitute a debt to the County and may be added to the Township tax roll and collected in the same manner as municipal taxes.

6.4 The Medical Officer of Health may assign or appoint Officers to enforce this by-law who shall have the authority to:

a. Carry out inspections;

b. Make orders to requiring an operator or any person to discontinue activities which contravene this by-law;

c. Make orders requiring an operator or any person to undertake work to correct contraventions of this by-law; or

d. Give immediate effect to any order; and

e. Otherwise enforce this by-law.

6.5 The Medical Officer of Health may assign duties or delegate tasks under this by-law whether in his or her absence or otherwise.

6.6 This by-law may be cited as the “Mandatory Food Handler Certification By-law”.

6.7 If a court declares any provision of this by-law invalid, it is the intention of Council that the remainder of the by-law shall continue to be in force and effect.

Article 7.0 – Penalties

7.1 Any person who contravenes any provision of this by-law is, upon conviction, guilty of an offence and is liable to the penalty imposed by applicable law, which is recoverable pursuant to the Provincial Offences Act*:*

a. Upon a first conviction, to a minimum fine of $500 and a maximum fine of $5,000; and

b. Upon a subsequent conviction, to a minimum fine of $2,500 and a maximum fine of $25,000.

7.2 Despite Article 7.1, where the person convicted is a corporation, the corporation is liable:

a. Upon a first conviction, to a minimum fine of $2,500 and a maximum fine of $25,000; and

b. Upon a subsequent conviction, to a minimum fine of $5,000 and a maximum fine of $50,000.

7.3 At the discretion of the Peterborough County-City Health Unit, charges may be laid for offences committed in contravention of this by-law using the certificate of offence set fine procedure set out under Part 1 of the Provincial Offences Act, R.S.O. 1990, CH. P.33, or any successor legislation, for the offences enumerated in short form in Schedule “A” of this by-law.

7.4 Schedule “A” offences shall not be utilized until the amounts of the fines in Schedule “A” have been set by the Regional Senior Justice for the Superior Court of Ontario.

Article 8.0 – Effective Date

8.1 Save and except Article 3.1 and 3.2, the by-law shall come into force and effect on the day it is passed and enacted.

8.2 Articles 3.1 and 3.2 of the by-law as it relates to high-risk food premises shall come into effect on January 1, 2014.

8.3 Articles 3.1 and 3.2 of the by-law as it relates to moderate-risk food premises shall come into effect on January 1, 2015.

Read a first, second and third time and passed in Open Council this 19th day of December, 2012.

_____

J. Murray Jones Warden

c/s

_____

Sally Saunders Clerk

County of Peterborough

Mandatory Food Handler Certification By-Law

By-law # 2012 - 86

Schedule “A”

Part 1 Provincial Offences Act

Short Form Offences and Set Fines

Item	Column 1 Short Form Wording	Column 2 Offence Creating Provision	Column 3 Set Fine
1.	Operator failed to ensure at least one certified food handler working in a supervisory capacity in a moderate-risk or high-risk food premise.	Article 3.1	$250
2.	When requested by an Officer of the Medical Officer of Health, food handler failed to produce a valid food handler certificate and photo identification card when working as a certified food handler	Article 3.2	$125

Note: The general provision for the offences listed above is section 61 of the Provincial Offences Act, R.S.O. 1990, c. P.33

From: Gordon Fleming [gordon@alphaweb.org]
Sent: Thursday, January 31, 2013 11:18 AM
To: allhealthunits
Subject: [allhealthunits] FW: [CSPI] Debate Begins in House of Commons on Sodium-Reduction Bill

ATTENTION
Public Health Nutritionists
Medical Officers of Health
Chairs, Boards of Health
****

Hi All,

Please see below for information courtesy of CSPI on advocacy actions related to Bill C-460, The Sodium Reduction Strategy for Canada Act. The joint statement includes signatures from the alPHa President as well as the COMOH Section Chair, in keeping with alPHa Resolution A11-10.

Gordon Fleming, B.A., BASc, CPHI(C)
Manager, Public Health Issues
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, Ontario
(416) 595-0006, ext 23
(416) 595-0030 Fax

From: cspi-bounces@list.web.net [mailto:cspi-bounces@list.web.net] **On Behalf Of** cspi@list.web.net
Sent: Thursday, January 31, 2013 8:34 AM
To: CSPI@list.web.net
Subject: [CSPI] Debate Begins in House of Commons on Sodium-Reduction Bill

Debate Begins in Parliament on Bill to Implement

Sodium Reduction Strategy for Canada

Lowering Sodium Would Save 16,000 Lives[i][i]*, $3 Billion*[ii][ii] *Annually*

OTTAWA (January 31, 2013)—Debate is scheduled to begin tomorrow in the House of Commons on *Bill C-460, Sodium Reduction Strategy for Canada Act*. Bill Jeffery made the following comment at a news conference in the Centre Block of the House of Commons:

> *I am Bill Jeffery, National Coordinator of the Centre for Science in the Public Interest, which is a non-profit health advocacy organization focusing on nutrition issues. Our Ottawa office is supported largely by nearly 100,000 Canadian subscribers to our Nutrition Action Healthletter. CSPI does not accept any funding from industry or government. I was part of Minister Aglukkaq's 25-person Sodium Working Group that unanimously proposed the strategy that is at the heart of Bill C-460.*

This year, as many as 16,000 Canadians will die needlessly from heart attacks, heart failure, and strokes caused by excess dietary sodium, three-quarters of which is added to foods by food manufacturers and restaurants. Something has to be done. CSPI strongly supports Bill C-460. In doing so, we join at least 35 other health groups and experts. The need to reduce sodium in the food supply is recognized by the World Health Organization, the US Institute of Medicine, and a unanimous Political Declaration of the United Nations General Assembly.

The interim goal of reducing average sodium intake from about 3,400 mg per person per day to 2,300 has been embraced by the Prime Minister and premiers. Provincial health ministers even called for Health Canada to draft regulations in case voluntary measures failed.

Unfortunately, the voluntary approach has failed. Food companies have even failed to report on their sodium-reduction efforts to the Federal Government, as shown last June when Health Canada's progress report relied on three-year-old data that its own officials had to painstakingly gather. Bill C-460 would ensure better accountability of companies to their customers and to the government. Without the bill,

- *food manufacturers and restaurants will continue to hide from consumers unsafe levels of sodium in their foods; and*
- *provincial governments will continue to be saddled with high Medicare bills for sodium-related treatment costs and productivity losses.*

We urge all MPs to quickly enact the Sodium Reduction Strategy for Canada Act.

-30-

For information: Contact Bill Jeffery at 613-244-7337 (x 1) or bjeffery@cspinet.org and **see** http://www.cspinet.org/canada/foodsodium.html See the joint-statement in support of *Bill C-460* endorsed by nearly three dozen experts and health groups at http://cspinet.org/canada/pdf/jan30-2013.c-460.jointstatement.pdf

Sodium Reduction Strategy for Canada which was recommended, unanimously, to the Minister of Health in July 2010: http://www.hc-sc.gc.ca/fn-an/alt_formats/pdf/nutrition/sodium/strateg/reduct-strat-eng.pdf

Bill C-460, Sodium Reduction Strategy for Canada Act, introduced in the House of Commons in November 2012: http://www.parl.gc.ca/content/hoc/Bills/411/Private/C-460/C-460_1/C-460_1.PDF

Note to editors: Respected scientific bodies have called for regulations mandating gradual reductions of sodium in processed foods, including a report of a U.S. Institute of Medicine (IOM) panel, chaired by a former head of the US Food and Drug Administration, Dr. Jane E. Henney. That committee concluded that more than 40 years of voluntary actions were an abysmal failure. Much federal and provincial government nutrition policy is based on reports of the IOM. See: Henney JE, Chair. *Strategies to Reduce Sodium Intake in the United States.*

I.O.M. Washington. 2010. Available on-line at: http://books.nap.edu/openbook.php?record_id=12818 Also, the World Health Organization concluded in its 2007 report: "In countries where there have been recommended goals but little or no progress, it may now be time for legislative action to be enforced with an adequate monitoring system.• See: WHO. *Reducing Salt in Populations: A report of WHO Forum and Technical Meeting.* Paris/Geneva. 2007 at PDF p. 42. Available on-line at: http://www.who.int/dietphysicalactivity/reducingsaltintake_EN.pdf

References

Bill Jeffery, LLB, National Coordinator
Centre for Science in the Public Interest (CSPI)
Suite 2701, CTTC Bldg.
1125 Colonel By Drive
Ottawa, Ontario K1S 5R1 Canada
Tel: 613-244-7337 (ext. 1)
jefferyb@istar.ca
http://www.cspinet.ca

CSPI is an independent health advocacy organization with offices in Ottawa and Washington. CSPI's advocacy efforts are supported by more than 100,000 subscribers to the Canadian edition of its Nutrition Action Healthletter, on average, one subscribing household within a one block radius of every Canadian street corner. CSPI does not accept industry or government funding and Nutrition Action does not carry advertisements.

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[i][i] E.g., Havas S, Roccella EJ, et al. Reducing the public health burden from elevated blood pressure levels in the United States by lowering intake of dietary sodium. *American Journal of Public Health.* 2004; 94(1):19-22. And Dickinson BD and Havas S. Reducing the population burden of cardiovascular disease by reducing sodium intake: A report of the [AMA] Council on Science and Public Health. *Archives of Internal Medicine.* 2007; 167:1460-1468. Both estimated 150,000 deaths can be prevented annually in the U.S. by reducing sodium; the population is approximately nine times greater than Canada's. See also He FJ, MacGregor GA. How far should salt intake be reduced? *Hypertension. 2003; 42:1093-99 at 1097. Available at* http://hyper.ahajournals.org/cgi/reprint/42/6/1093 which estimated that 52,000 deaths could be prevented by lowering sodium consumption in the U.K., whose population is approximately double Canada's.

[ii][ii] Van Vliet BN, Campbell NR; Canadian Hypertension Education Program. Efforts to reduce sodium intake in Canada: why, what, and when? *Canadian Journal of Cardiology.* 2011 Jul-Aug;27(4):437-45. Joffres MR, Campbell NRC, Manns B, et al. Estimate of the benefits of a population-based reduction in dietary sodium additives on hypertension and its related health care costs in Canada. *Canadian Journal of Cardiology*. 2007;23:437-43. See also Bibbins-Domingo K, Chertow GM, et al. Projected Effect of Dietary Salt Reductions on Future Cardiovascular Disease. *New England Journal of Medicine*. 2009;1-10 at 7 which estimated a reduction in health care costs alone in the U.S. of $57 billion to $96 billion annually for an 1,800 mg decrease in sodium consumption.

Ministry of Community and Social Services

Minister's Office

Hepburn Block
Queen's Park
Toronto ON M7A 1E9
Tel.: (416) 325-5225

Ministère des Services sociaux et communautaires

Bureau du Ministre

Édifice Hepburn
Queen's Park
Toronto (Ontario) M7A 1E9
Tél.: (416) 325-5225

Ontario

FEB 01 2013

Dr. Rosana Pellizzari
Medical Officer of Health
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, Ontario
K9J 8M1

Dear Dr. Pellizzari:

Thank you for your letter regarding food security and social assistance in Ontario. I appreciate the time you have taken to write and I welcome the opportunity to respond.

Improving Ontario's social assistance programs builds on the progress we have already made in reducing poverty over the past decade. This includes raising social assistance rates again this fall for a cumulative 14.9 per cent since taking office, implementing the Ontario Child Benefit to help more than one million children, introducing the new Ontario Trillium Benefit to help low-income families, and raising the minimum wage by almost 50 per cent since 2003.

I have noted your comments about food insecurity and the Special Diet Allowance. I have also shared your comments and concerns with the appropriate staff in my ministry.

We heard from a number of communities about the removal of the Community Start-Up and Maintenance Benefit from social assistance. Municipalities told us it will be difficult to transition to the Community Homelessness Prevention Initiative (CHPI) without reducing services. That is why we are providing an additional $42 million in one-time grants to local service managers to provide housing supports to vulnerable Ontarians, including social assistance recipients, while municipalities develop and implement their CHPI plans.

As you know, on October 24, 2012, the Commission for the Review of Social Assistance in Ontario released its final report. We asked the Commission to find ways to make social assistance simpler, easier to understand, and financially sustainable. The Commission's report makes 108 recommendations for transforming the social assistance system.

The report makes it clear that there are no simple solutions to successfully transform Ontario's social assistance programs. That is why this government is going to take the time, working with our partners both inside and outside of government, to discuss the implications of transformation, and begin creating a responsible roadmap for success.

.../cont'd

In the short term, we will look at changes that will make a positive difference in the lives of clients, such as:

- making improvements to existing social assistance employment services for those who are able to work, to help ODSP clients identify their employment goals and access the services and supports they need for success;
- determining the best ways to simplify and streamline the system by introducing more modern and effective service delivery for clients;
- working with the employer community on how to better connect those receiving social assistance, including people with disabilities, to the workforce; and
- continuing to involve and inform municipalities and First Nations as we form the basis for a renewed Poverty Reduction Strategy.

Addressing the system's complex challenges and gaps will continue to require the active involvement of our government and our other service delivery partners and business leaders.

At this time, we are reviewing the Commission's recommendations and considering an action plan for moving forward with reforming Ontario's social assistance system.

I note you have also sent your letter to Premier Dalton McGuinty and the Honourable Deb Matthews, Minister of Health and Long-Term Care. I trust they will give your concerns every consideration.

Our government is committed to making progress in the coming months toward achieving the objectives outlined in the Commission's report. Our goal remains ensuring that the social assistance system is there for those who need it.

Once again, thank you for writing.

Sincerely,

John Milloy
Minister

c: Premier Dalton McGuinty
Honourable Deb Matthews, Minister of Health and Long-Term Care
Laurie Scott, MPP, Haliburton–Kawartha Lakes–Brock
Jeff Leal, MPP, Peterborough

IMPORTANT UPDATE

February 5, 2013

To All Members of Ontario Boards of Health

Dear Board of Health Member,

This package will provide you with the latest information about the upcoming 2-day Association of Local Public Health Agencies *2013 Winter Symposium*.

For those of you who may be considering attending an alPHa event for the first time, alPHa's Board of Health Section, is made up of individuals like you who sit on boards of health across Ontario. Three times a year, alPHa provides an opportunity for you and your colleagues to get together to learn, discuss issues and share experiences.

On February 14th and 15th, alPHa has an exciting slate of learning and networking opportunities planned for you. Thursday, February 14th will start with a Board of Health Section meeting in the morning. The agenda package for the meeting is attached. Of special note is the afternoon session which will be a board of health best practices work shop with a focus on the Ontario Organizational Standards. The workshop will be led by Vicki Bales who is a dynamic speaker and an expert in organizational governance. More information about Vicki is attached. The workshop has been planned as an interactive session for board of health members and you can expect to leave with a solid understanding of best practices for your governance role. On Thursday evening you will have the opportunity to relax with your colleagues at a reception from 5:00 to 6:30 p.m.

The morning of Friday, February 15th will be a plenary session for all alPHa members. This will be an important opportunity to provide input into the strategic plan for the public health sector that is being developed by the Chief Medical Officer of Health. Come and have your say.

The agendas for this 2-day series of meetings are attached, as well as the registration form. I hope to see you at the Radisson Admiral Toronto-Harbourfront on the shores of Lake Ontario in downtown Toronto.

Sincerely,

Linda Stewart,
Executive Director

attachments

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
www.alphaweb.org

Providing leadership in public health management

To All Members of Ontario Boards of Health

MORNING SESSION

AGENDA
Boards of Health Section Meeting

Thursday, February 14, 2013 ● 8:30 AM – 12:00 PM
Admiral Ballroom, Radisson Admiral Toronto-Harbourfront, 249 Queen's Quay West, Toronto

CHAIR: Al Edmondson
Middlesex London Board of Health

7:30	Registration and Continental Breakfast
8:30	**1. Welcome and Call to Order**
	2. Approval of Agenda
	3. Introduction of Attendees *An opportunity for members of boards of health across Ontario to say hello.*
8:45 – 9:30	**4. Business Items** 4.1 November Section Meeting Minutes – *attached for approval* 4.2 OCCHA Update – *attached* 4.3 alPHa Update – *Linda Stewart, Executive Director, alPHa* 4.4 Section Policy and Procedures Update – *attached for approval*
9:30 – 10:30	**5. Board of Health Updates** 5.1 Strategic Planning at Northwestern Health Unit *Alex Berry, Quality Improvement Officer, Northwestern Health Unit* 5.2 Education Partnership in Middlesex-London *Al Edmondson, Middlesex-London BOH*
10:30 – 11:00	**BREAK**
11:00 – 12:00	**6. Association of Municipalities of Ontario (AMO) Update** *Presentation and discussion with Monika Turner, AMO's Director of Policy*
12:00	**7. Adjournment**
12:00 – 1:00	**LUNCH** (provided)

AFTERNOON SESSION

Boards of Health Section Workshop

Thursday, February 14, 2013 ● 1:00 PM – 4:30 PM
Admiral Ballroom, Radisson Admiral Toronto-Harbourfront, 249 Queen's Quay West, Toronto

~ An Interactive session with facilitator and governance expert, Vicki Bales ~

Goals

1 To increase awareness of the accountability framework and best practice requirements governing Boards of Health rooted in the
   - Ontario Public Health Organizational Standards (primary focus)
   - Current Public Health Accountability Agreements between the Ministry of Health and Long-term Care and Boards of Health

2 To provide opportunities to learn from and share ideas about board best practices with colleagues

Agenda – Summary

1:00 1. Introduction to Session

1:10 2. Accountability Framework for Members of BOHs

1:25 3. Board of Health Jeopardy

1:40 4. Best Practices and Board Operations

2:30 BREAK

3:00 5. Trusteeship

3:45 6. Leadership and Community Engagement

4:05 7. Self-Evaluation

4:20 8. Wrap-Up

Vicki Bales

Vicki Bales
President, Vicki Bales Consulting Inc.
97 Golfview Avenue
Toronto ON M4E 2K3
Phone: 416-690-6597
Email: v-r.bales@sympatico.ca

Vicki has operated a successful Ontario-wide management consulting practice focusing on the not-for-profit sector since the early 1990s, specializing in organizational capacity building.

Capable board governance is a critical element for ensuring that an organization has the capacity to thrive. Vicki's work in this area includes:

- The development and redesign of an accreditation and quality management system for Ontario community health centres—one of the first Ontario-based systems to include a focus on governance
- The development of an organizational capacity building tool for the United Way of Greater Toronto that included a process for assessing governance and strategic leadership and ultimately building a learning plan to address any gaps or potential areas for improvement
- Board development and mentoring with a diverse array of agencies including immigrant serving agencies, organizations serving Aboriginal and First Nations peoples, AIDS service organizations, community health centres, mental health and addictions services, community support services and associations of agencies
- Organizational assessments on behalf of the United Way of Toronto, the Canadian Centre for Accreditation (as part of accreditation reviews) and at the request of organizations themselves that has included a focus on board as well as other agency practices
- The development of a variety of board/governance tools including
    - Surveys and questionnaires designed to evaluate board effectiveness on an ongoing basis and support related board development
    - Learning guides for board member orientation
    - Governance policies that guide the board operations and a board's relationship with the CEO.

In addition, she has:

- experience as an executive in the provincial government responsible for social policy development and the management of multi-year projects in adults' and children's services
- a background in research focusing on organizational and individual learning. (Vicki holds a Ph.D. in education from the University of Toronto.)
- volunteer experience as a board member with a number of community-based organizations in Toronto.

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

Providing leadership in public health management

DRAFT MINUTES
Boards of Health Section General Meeting
Thursday, November 8, 2012 – 8:30 AM to 12:00 PM
Port Credit North/Centre Ballroom, Waterside Inn, Mississauga, ON

PRESENT:

Al Edmondson (Chair)	Middlesex-London	Mike Poeta	North Bay Parry Sound
Janice Mills	Brant	John Albanese	Northwestern
Ron Carnahan	Chatham-Kent	Russ Fortier	Northwestern
Gary Barton	Eastern Ontario	Julie Roy	Northwestern
Gerry Bertrand	Eastern Ontario	Doug Squires	Northwestern
Mary Johnson	Eastern Ontario	Jim Embrey	Peterborough
Bob Kilger	Eastern Ontario	Pat Bamford	Porcupine
Robert Kirby	Eastern Ontario	Gilles Chartrand	Porcupine
Todd Lalonde	Eastern Ontario	Joseph Matko	Porcupine
Marcel Leduc	Eastern Ontario	Mike Milinkovich	Porcupine
Andre Rivette	Eastern Ontario	Sue Perras	Porcupine
Ron Poste	Hastings & P.E.	Michael Shea	Porcupine
Judy Masters	Haliburton, Kawartha	Brenda Spencer	Sudbury
Bud Clayton	Kingston, Frontenac	Maria Harding	Thunder Bay
Charles Simonds	Kingston, Frontenac	Doug Heath	Thunder Bay
Jack Butt	Leeds, Grenville	John MacEachern	Thunder Bay
Gurinderpal Grewal	Leeds, Grenville	Joe Virdiramo	Thunder Bay
Marcel Meyer	Middlesex-London	Abdul Fattah	Toronto
John Millson	Middlesex-London	Amanda Rayburn	Wellington-Dufferin
Viola Poletes Montgomery	Middlesex-London		

Linda Stewart	alPHa
Susan Lee	alPHa
Suchita Jain	alPHa

GUESTS: Muriel Abbott, Social Determinants of Health Nurse, Middlesex-London Health Unit
Nancy Summers, Manager, Family Health Services, Middlesex-London Health Unit
Na-Koshie Lamptey, Associate Medical Officer of Health, Sudbury & District Health Unit
Brenda Spencer, Board Member, Sudbury & District Health Unit

REGRETS: Richard Pollock, BOH Member, Timiskaming

1.0 WELCOME AND INTRODUCTIONS

The Chair called the Section meeting to order at 8:33 AM. Members introduced themselves.

The agenda for the meeting was approved by consensus.

2.0 BUSINESS ITEMS

June Section Meeting Minutes

The minutes of the June 12, 2012 meeting were approved on a motion by M. Johnson (Eastern Ontario) which was seconded by R. Fortier (Northwestern) and carried.

OCCHA Update

A written report on the Ontario Council of Community Health Accreditation (OCCHA) was distributed. alPHa's executive director announced that alPHa is seeking a volunteer board of health representative to the OCCHA board of directors. Expressions of interest should be sent to alPHa's Susan Lee.

alPHa Update

A copy of the draft alPHa newsletter was distributed. The final version will be released after the conference and will contain updates not mentioned in the draft edition. L. Stewart noted recent association activities as follows:

- Both the office of the Chief Medical Officer of Health and Public Health Ontario are currently undergoing strategic planning processes. alPHa has provided input into those processes. alPHa is also reviewing its own strategic plan.
- alPHa has sent a letter to the province advocating the inclusion of a capital expenditure line in health unit budgets.
- alPHa will launch its new website on Monday, November 12. Members will receive their own login and temporary password. Use of the new website is voluntary. Feedback on the site is welcomed.
- Through alPHa, public health has indicated to the province that it wants to be part of the evaluation process on influenza vaccinations by Ontario pharmacists.
- The next alPHa conference will be held on February 14 and 15, 2013 in Toronto.

3.0 BOARD GAME ON THE SOCIAL DETERMINANTS OF HEALTH

Members at each table played the board game The Last Straw! to gain a better understanding of the social determinants of health and the interplay between individual and community forces on individuals. Afterward, members shared their experiences and learnings. One participant remarked that while fun to play, the board game did not seem to provide enough solutions to the life course obstacles encountered throughout the game. Despite this, there appeared to be a high level of member engagement at each table.

L. Stewart thanked Niagara Region Public Health for the introduction of the game and loan of game sets.

4.0 PANEL DISCUSSION

Muriel Abbott and Nancy Summers of Middlesex-London Health Unit, and Na-Koshie Lamptey and Brenda Spencer of Sudbury & District Health Unit presented on their work in incorporating the social determinants of health into local strategic planning.

Key points from Middlesex-London's PowerPoint presentation were as follows:

- Public health has a major role to play in health equity, particularly with priority populations.
- Because the root causes of the social determinants of health are complex, public health can't address these on its own and therefore requires partnerships between various sectors.
- In Middlesex-London, the goal is to have a paradigm shift to achieve health equity
- This was achieved in four ways, i.e., by addressing programs and services, developing a framework for advocacy, collaborating with other sectors, supporting staff through professional development.
- Challenges have included transformational change of organization/staff, difficulty in measuring outcomes, the language around SDOH and health equity is not always common, difficulty in making the language of SDOH meaningful with the general public, and incorporating other promising practices into daily work.
- The health unit is still in the early stages with much work to complete in the future.

Key points from Sudbury's PowerPoint presentation were as follows:

- Planning is key.
- Health equity is important in boards of health strategic plans because there is a demonstrated need in the community and it's the board's responsibility to provide programs addressing needs; and also, the Ontario Public Health Standards provides directions on addressing SDOH.
- Health units need to identify strategic priorities and translate them into board of health endorsement and staff practice.
- Structures/processes that guided Sudbury's strategic priorities included:
    - Community presentations and staff development on SDOH
    - BOH position statement and review of public health programs
    - Putting greater focus on SDOH (e.g. creation of working groups)
- Enabling factors: provincial commitment and interest, a supportive board of health, MOH leadership and commitment, structures and resources (local health equity office, 2 public heath nurses, etc) and embedding health equity in health unit planning processes.
- Target setting is done in initial steps, intermediate and long term steps.
- Bottom line: Strategic plans are important enablers to help staff and management prioritize and frame their work to level up health, and are important tools for sharing your health equity vision and priorities with community partners and citizens. Strategic plans alone aren't enough; other supportive structures/processes are necessary.

5.0 GPOUP DISCUSSION

Following the health equity presentations, questions were asked and the following was noted:

- Provincial funding for the two SDOH Public Health Nurse positions at each health unit is 100 percent funding.
- Quantitative targets are a long way off. In general, the development of targets is very challenging for health units, which need to be sure the right things are being targeted.
- Setting priorities is also a major challenge because of competing priorities.
- A good strategic plan is one way to handle overwhelming challenges. Public health is not able to fix all SDOH problems, but can have a significant role in making other sectors aware of SDOH.

After the discussion, the Middlesex-London and Sudbury presenters were thanked by the Chair.

6.0 ADJOURNMENT

The meeting adjourned at 11:50 AM.

Ontario Council on Community Health Accreditation
Advancing Quality in Public Health

3370 South Service Road
Burlington, Ontario L7N 3M6
Tel: 905-639-6367 **Fax:** 905-639-6534
E-mail: info@occha.org **Website:** www.occha.org

Report from OCCHA
Summary of Activities
October - December 2012

Mission Statement

The Ontario Council on Community Health Accreditation promotes accountability and excellence in public health programs and services.

Mandate

- ✓ To establish, review and revise accreditation standards related to governance, administration, program planning, implementation, monitoring and evaluation.
- ✓ To enhance knowledge through consultation and shared experience.
- ✓ To measure agency performance against peer set standards, provide comprehensive reports and confer accreditation awards.
- ✓ To promote and facilitate continuous quality improvement in public health units through consultation across Ontario public health units.
- ✓ To work in partnership with other community health organizations and relevant provincial ministries to promote excellence in public health programs and services.

Key Initiatives for 2012 - 2013

1. Conduct accreditation surveys and annual reviews of public health units across Ontario.
2. Initiate formal evaluation of the accreditation program, "*Advancing Quality in Public Health"*.
3. Expansion of the OCCHA quality framework for public health units in support of continuous quality improvement and performance management.
4. Identification and/or development of tools/resources to support public health units in their implementation of the Ontario Public Health Organizational Standards.
5. Ongoing consultation and collaboration with the Ministry of Health and Long Term Care in support of public health performance management and accountability.

OCCHA's Accreditation Program – Implementation and Evaluation

The accreditation process, *Advancing Quality in Public Health*, links to the OCCHA quality framework for public health units, operates on a three year cycle and includes an annual one day review component in support of continuous quality improvement. Additional tools which have been developed to support this process include:

1. On-line surveys for boards of health, staff members and community partners;
2. An annual health unit questionnaire, and
3. An annual review summary report, which includes outstanding areas of improvement, areas of follow-up in support of CQI, additional OPHS program review components and a review of any organizational changes to a public health unit.
4. An accreditation evidence spreadsheet to facilitate ongoing efforts to meet accreditation standards and preparation of evidence. This spreadsheet identifies the frequency of review, specific examples and evidence required as well as linkage to the OPHS and organizational standards.

The OCCHA Board of Directors has developed a work plan for the formal evaluation of the accreditation program, *"Advancing Quality in Public Health"*. The evaluation process will include a review of both the accreditation standards and process. The OCCHA Board of Directors would like to invite your input and participation in this process. Should your organization wish to provide any feedback on the accreditation standards or process to facilitate our review, or should you wish to participate in this process, please contact meighanfinlay@occha.org or phone us at (905)639-6367.

Information on the accreditation process can be found on the OCCHA website at www.occha.org. Accreditation documents and tools are available upon request at info@occha.org or by contacting OCCHA at (905)639-6367.

OCCHA offers ongoing support to all health units through on-site presentations and program updates. For further information on the accreditation process, please contact Meighan Finlay, Executive Director, at meighanfinlay@occha.org.

OCCHA's Accreditation Fees

The fee structure for accreditation blends the survey and annual maintenance fees into one annual standardized fee. As of January 2013, this fee will be $8,000 per year. This includes all costs associated with the on-site review (including both the initial on-site review and annual reviews), ongoing health unit support during the preparation phases; as well as the ongoing maintenance and enhancement of accreditation tools, documents and processes. This fee also includes information sharing between accredited health units through teleconferencing and other events (e.g., workshops, presentations, surveyor training).

Quality Framework and Quality Performance Targets

The OCCHA quality framework for public health units can be found on the OCCHA website. To support this framework, OCCHA has identified quality performance targets for all of the OCCHA standards. The targets will be incorporated into the accreditation process to facilitate participation in the process and to identify areas of innovation across public health units. The OCCHA Board is also consulting with public health units towards the enhancement of the framework to ensure linkages with the organizational standards. Should you wish further information on the quality framework or supporting quality documents/tools, please visit the OCCHA website at www.occha.org or contact Bev Russ at bevruss@occha.org.

Public Health Performance Management and Accountability

The Ontario Public Health Standards (OPHS) have been incorporated into the accreditation standards. OCCHA continues to review the accreditation standards to ensure consistency with the Ontario Public Health Organizational Standards (OPHOS).

Further, the OCCHA Board of Directors supports the efforts of the Ministry of Health and Long-Term Care to develop and implement the accountability framework and continues to collaborate with the Ministry of Health and Long-Term Care to facilitate public health units in their implementation of the organizational standards.

2012-2013 OCCHA Board of Directors

Chair:	Iqbal Kalsi (Association of Supervisors of Public Health Inspectors of Ontario)
Vice-Chair:	Heather Kemp (Ontario Public Health Libraries Association)
Past-Chair:	Elaine Murkin (Ontario Society of Nutrition Professionals in Public Health)
Sec – Treasurer:	Penny Lavalley (ANDSOOHA – Public Health Nursing Management
Member:	Catherine Bloskie (Association of Ontario Public Health Business Administrators)
Member:	Gurinderpal Grewal (alPHa, Board of Health Section)
Member:	Dr. Joyce Sinton (Ontario Association of Public Health Dentistry)
Member:	Allan Northan (alPHa, COMOH)
Member:	Kathy Braet (Health Promotion Ontario)
Member:	TBD (Association of Public Health Epidemiologists of Ontario)
Member:	TBD (OPHA)

ITEM 4.3
alPHa Update – Board of Health Representation

The following is a summary of BOH Section representation on committees and boards outside of alPHa.

1. Funding Review Working Group

- Representatives: Jack Butt, Chair (Provincial Appointee), Leeds Grenville and Lanark District Board of Health
  Gilles Chartrand, Municipal Representative, Porcupine Board of Health

2. Public Health Performance Management Working Group

- Representative: Abdul Fattah, Citizen Member, Toronto Board of Health

3. Joint Ministries/Boards of Health Accountability Agreement Committee (JMB)

- Representatives: Mary Johnson, Citizen Member, Eastern Ontario Board of Health
  Abdul Fattah, Citizen Member, Toronto Board of Health

4. OCCHA Board of Directors

- Representative: Gurinderpal Grewal, Provincial Appointee, Leeds, Grenville and Lanark District Board of Health

November 29, 2012

Dear Board of Health Member:

At its November 20, 2012 meeting, the alPHa Boards of Health Section (BOH) Executive Committee reviewed possible changes to the Section policies and procedures to address the issues that arose during the June 12, 2012 BOH Section election. Attached are the resulting recommended updates to the policies and procedures for your consideration. The updates are highlighted in blue for your convenience.

At the June 12, 2012 BOH Section election there was confusion about the following:

1. Who can vote for BOH Section Executive Committee members?

   Background: Health unit staff attending alPHa conferences are welcome to attend BOH Section meetings. Some staff thought they were eligible to vote for BOH Section Executive Committee representatives to alPHa's Board of Directors and did so. This is clearly not permitted in the BOH Section Policies and Procedures. It should also be noted that the HPPA does not allow health unit staff to sit as a voting member of the Board of Health. The medical officer of health (MOH) is entitled to attend all BOH meetings.

   Based on the following references, the *Membership* section of the policies and procedures document has been updated to include a footnote to clarify that BOH staff are not eligible to sit as BOH members, and, therefore, not eligible to vote for representatives to the BOH Section Executive Committee on alPHa's Board of Directors.

   References:

   4(e) Any board of health member of a member agency shall qualify to be a voting delegate at large at any general meeting of the Section. (BOH Section P&P)

   6(k) All Boards of Health section members eligible to vote at the general meeting will participate in the election for each regional representative. (BOH Section P&P)

   Part VI Section 51(3) No person whose services are employed by a board of health is qualified to be a member of the board of health. (HPPA)

   Part VI Section 70. The MOH of a BOH is entitled to notice of and to attend each meeting of the board and every committee of the board, but the board may require the MOH to withdraw from any part of the meeting at which the board or a committee of the board intends to consider a matter related to the remuneration or the performance of the duties of the MOH. (HPPA)

2. Must voters be present at the meeting to cast a vote? Is proxy voting allowed?

   Background: It is not clear, but there may have been some proxy votes submitted during the June 12 BOH Section meeting. Confusion about proxy voting may have arisen from the fact that proxy votes are permitted during alPHa's AGM and absentee voting was discussed at the AGM the day before. The BOH Section Policies and Procedures are silent on proxy voting, but practice has been that proxy voting is not allowed and voters are required to be present in the room.

   To document current practice regarding proxy voting, wording has been added to the attached draft updated policies and procedures.

3. Timing of Ballot Distribution

   Background: The timing of the distribution of the ballots may have contributed to the confusion at the June 12 meeting. Ballots are usually distributed at the meeting, but for the June 12 meeting, ballots were included in the meeting package. This resulted in BOH members being in possession of the ballot in advance of the meeting. It isn't completely clear, but it appears that some members gave their completed ballot to a colleague to hand in for them at the meeting.

   The draft updated policies and procedures have been updated to clarify that ballots will be handed out during the meeting after the candidates' speeches, just prior to the vote.

4. Is there a desired order to candidates' speeches?

   Background: One of the candidates asked about the order of speeches during the meeting. The policies and procedures are silent on this question, so the BOH Section Executive Committee discussed possible approaches and has recommended that alphabetical order by last name is specified in the policies and procedures document.

   The draft updated policies and procedures have been updated for both regular and tie voting to clarify that candidates will speak in alphabetical order by last name.

Based on this information, BOH Section representatives will be asked to vote on a motion to approve the updates in the attached draft updated version of the Boards of Health Section Policies and Procedures at the Section meeting on February 14-15, 2013. I trust that your receipt of this information will satisfy the requirement to provide 60 days notice for proposed amendments.

Thank you for your attention to these important procedural matters. I look forward to seeing you in February.

Yours truly,

Al Edmondson
BOH Section Chair

attachment

The changes recommended by the BOH Section Executive Committee are highlighted in blue for consideration of BOH Section membership at their February 14-15, 2013 meeting.

Association of Local Public Health Agencies (alPHa)

BOARDS OF HEALTH SECTION POLICIES AND PROCEDURES

Name

1. The name of the organization shall be: "The Boards of Health Section", hereinafter referred to as the Section.

Objectives

2. The objectives of the Section shall be:

   (a) To represent the views of boards of health as members of the Association of Local Public Health Agencies.

   (b) To promote and maintain a high standard of public health service in Ontario.

   (c) To work with other organizations which, from time to time, may exhibit similar objectives in the universal furtherance of a high standard of public health service in Ontario.

   (d) To promote the mutual helpfulness and procure harmonious action among the Boards of Health in the province.

   (e) To encourage legislation for the betterment of public health and to be available to cooperate with the Ministry of Health and Long-Term Care as consultants in the development of provincial policies and programs.

   (f) To endorse conferences and seminars to promote education and interaction amongst the membership.

Membership

3. (a) Active Membership in the Section shall be open to all active members of the boards of health, appointed or elected to serve a local, regional or municipal jurisdiction in Ontario[1]. Active members shall have full voting privileges at Section general meetings and shall be eligible, under Article V of the constitution to vote at the annual meeting of the Association of Local Public Health Agencies.

[1] No person whose services are employed by a board of health is qualified to be a member of the board of health, HPPA, Section 51(3).

(b) Honourary Membership may be designated, at the discretion of the Section Executive, to any former Section Chair. Honourary membership is for life and honorary members shall have no voting privileges.

(c) An Honourary member, at their own expense, may:

i. Attend Boards of Health Section meetings or parts thereof subject to approval of the Chair;
ii. Enjoy discounted registration rates for alPHa Conferences and regular Boards of Health Section meetings;
iii. Receive periodic updates from the BOHs Section Executive; and
iv. Represent alPHa / BOH Section on selected internal and external committees and working groups subject to approval of the BOH Section Executive Committee

Meetings and Procedures

4. (a) The general membership shall meet semi-annually: once at the Annual Conference of alPHa; and once in conjunction with the February All Members Meeting. Special general meetings may be held, at the call of the Chair, between meetings.

(b) A quorum for the transaction of business for the Section annual meeting shall consist of representatives from no fewer than fifty-one percent of member boards of health.

(c) The procedure for the order of business shall be those set forth in "Robert's Rules of Order" and shall prevail at all meetings.

(d) The Chair of the Section Executive shall preside over meetings and carry a vote. In the event of a tie vote on any motion or resolution the motion is defeated.

(e) Any board of health member of member agency shall qualify to be a voting delegate at large at any general meeting of the Section.

Executive Committee

5. (a) The Section will designate seven (7) members to make up one third of the Board of Directors of the Association of Local Public Health Agencies. These members will be elected for 2 year terms by the membership and constitute the Executive Committee of the Section. The Executive Committee of the Section will include:

- a Chair
- a Vice-Chair
- and 5 members-at-large

(b) The Executive Committee shall meet at times and places as deemed necessary by the Chair to conduct the business of the Section. At other times the Executive Committee of the Section will maintain a continuity of effort through correspondence or directly through the alPHa Secretariat.

(c) The Section Executive may, from time to time, or upon direction from the alPHa Board, strike special committees or recruit from the membership special representatives to ad hoc committees.

(d) A quorum for the transaction of business at a Section Executive Committee meeting shall be four (4).

(e) No member of the Executive Committee of the Section shall receive any remuneration or honorarium from the Association of Local Public Health Agencies for acting as such.

(f) Attendance – It shall be the policy of the Section that any member who has two (2) absences in a row, or a total of three (3) during the same year, without giving prior notice of their absence, will be reminded by the Chair via official letter. After a total of four (4) absences, or three (3) in a row during the same year, without giving prior notice of their absence, the member will be deemed to have resigned from the Section unless exempted by a Section resolution.

Elections

6. (a) Elections for members of the Section Executive Committee shall be held each year during the alPHa Annual Conference.

(b) Elected or appointed members of a member board of health or health committee of a regional municipal council may be elected to the Section Executive. Termination of election or appointment at the local level will terminate membership of the Section and its Executive Committee.

(c) The Executive shall have the power to fill any vacancy within 60 days, if they so choose.

(d) The Boards of Health Section Executive shall consist of seven (7) members, elected at the inaugural meeting of the Association, four (4) for two (2) year terms, the remaining three (3) for one (1) year terms. Thereafter, all newly-elected members of the Executive shall serve two (2) year terms. This shall promote continuity of experienced Executive members.

(e) Nominations will be accepted until five (5) business days prior to the commencement the Annual Conference of the Association of Local Public Health Agencies, at which time all Section Executive candidates will be allowed up to 2 minutes each for a brief statement of position. Candidates will speak in alphabetical order by last name.

(f) Ballots shall be distributed to eligible voters upon the conclusion of the Section Executive candidate's speeches.

~~(f)~~(g) Board of Health voting delegates will be asked to elect from the slate of nominees the number of candidates to fill the number of Section Executive vacancies.

~~(g)~~(h) Nominations must be submitted in writing from the respective Board of Health, bearing the signatures of two (2) Board of Health members from the sponsoring Board and that of the nominee. A nomination form that shall be supplied by the Association of Local Public Health Agencies. A biography of the nominee outlining their suitability for candidacy, as well as a motion passed by the sponsoring Board of Health are also required to be submitted with the nomination form. The future meeting expenses for directors will be paid by the sponsoring health unit.

~~(h)~~(i) Representation on the Section Executive will include one (1) representative from each of the following regions of Ontario: North West, North East, South West, Eastern, Central East, Central West, and Toronto, as defined by the Ministry of Health and Long-Term Care (see Appendix).

~~(i)~~(j) The Executive Committee of the Section will endeavour to include at least one (1) representative from a Municipal Board of Health, meaning a Board that is separate from Council but where staff operations are integrated with the municipal administrative structures; at least one (1) representative from a Regional/Single-Tier Board of Health, meaning a Board where the Regional Council or a standing committee of Regional Council acts as the Board of Health; and at least one (1) member from an autonomous Board of Health, meaning a Board that is independent from local government.

~~(j)~~(k) In general, candidates nominated by their Boards of Health must be present at the Annual General Meeting of the Association of Local Public Health Agencies to stand for election. However, absences may be permitted at the discretion of the existing Executive Committee in the case of emergency, catastrophic, or compulsory events that prevent a candidate from being present at an election.

~~(k)~~(l) All Boards of Health section members eligible to vote at the general meeting will participate in the election for each regional representative.

(m) Voting by proxy will not be permitted for the election of the Boards of Health Section Executive. Each boards of health section member present shall carry a single vote.

~~(l)~~(n) Candidates shall be acclaimed to a position on the Section Executive where the candidate meets all of the nomination requirements and is the sole candidate in their region.

~~(m)~~(o) The Executive Director of the Association of Local Public Health Agencies or designate shall preside over the election and shall not vote. In the case of a tie vote, the tied candidates will be allowed up to 2 minutes each for a brief statement of position. Candidates will speak in alphabetical order by last name. Immediately following the statements, eligible voters will be asked to vote for one of the tied candidates.

(p) Ballots shall be collected by Association of Local Public Health Agency staff and votes shall be counted by a team consisting of one (1) staff member of the Association of Local Public Health Agencies and one (1) member of the Boards of Health Section Executive Committee.

Chair

7. (a) Immediately following the election of the Section Executive Committee members, the new committee shall elect a Chair.

   Note: The Chair also serves on the Executive Committee of the alPHa Board of Directors.

   (b) It shall be the duty of the Section Chair (or designate) to preside over all Section meetings, to preserve order and, to enforce the Section Policies and Procedures. The Section Chair shall decide all questions of order subject to the appeal by a member to the meeting.

   (c) It shall also be the duty of the Section Chair to provide a report of the Section's activities to the alPHa Board of Directors regularly.

Vice-Chair

8. It shall be the duty of the Vice-Chair, in the absence of the Chair, to preside and perform all duties pertaining to the office of the Chair.

Amendments and Alterations

9. (a) The Section Policies and Procedures may be amended at an annual or special general meeting of the Section with a quorum by a consensus vote.
   (b) Notice of proposed amendments shall be circulated to each member board of health and health committee 60 days in advance of the meeting at which the proposed amendment will be presented.

Approved by the General Membership
Board of Health Section, ALOHA
June 7, 1988

Amended by the General Membership
Board Trustee Section, ALOHA
June 23, 1991 and June 15, 1992

Amended by the General Membership
Board of Health Section, alPHa
June 10, 2002

Amended by the General Membership
Board of Health Section, alPHa
January 29, 2004

Amended by the General Membership
Board of Health Section, alPHa
December 6, 2007

Amended by the General Membership
Boards of Health Section, alPHa
June 14, 2011

Amended by the General Membership
Boards of Health Section, alPHa
February 10, 2012

Appendix – Ontario Boards of Health by Region

	REGION	BOARDS OF HEALTH
1	NORTH WEST REGION	Northwestern Thunder Bay
2	NORTH EAST REGION	Algoma North Bay Parry Sound Porcupine Sudbury Timiskaming
3	SOUTH WEST REGION	Chatham-Kent Elgin St. Thomas Grey Bruce Huron Lambton Middlesex London Oxford Perth Windsor-Essex
4	CENTRAL WEST REGION	Brant Haldimand Halton Hamilton Niagara Waterloo Wellington Dufferin
5	CENTRAL EAST REGION	Durham HKPR Peel Peterborough Simcoe Muskoka York Region
6	TORONTO	Toronto
7	EASTERN REGION	Eastern Hastings KFLA Leeds Grenville Ottawa Renfrew

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

January 3, 2013

Honourable Dalton McGuinty, Premier of Ontario
Legislative Building
Room 281
Queen's Park
Toronto, ON M7A1A1

Dear Premier McGuinty:

At its meeting held December 5, 2012, the Board of Health for Northwestern Health Unit approved Resolution # 96-2012 endorsing the Report of the Chief Medical Officer of Health (CMOH), Oral Health – More Than Just Cavities (2012):

WHEREAS dental decay is the most common chronic childhood disease in children and adolescents; is five times more common than asthma; is one of the main reasons preschool children receive a general anesthetic; and is the second most expensive disease category in Canada (Health Canada, 2010); and

WHEREAS 47% of Canadian children have had dental disease by six years of age and 96% of adults have had dental disease in their lifetime (Health Canada, 2010); and

WHEREAS oral health and overall health are inextricably linked and oral disease can lead to infection, pain, abscesses, chewing problems, poor nutritional status, damaged self-esteem, loss of sleep; and may affect school performance, ability to learn and potential to thrive (US Department of Health and Human Services, 2000);

NOW THEREFORE BE IT RESOLVED that the Board of Health for the Northwestern Health Unit urges the Government of Ontario to endorse and support the report of the Chief Medical Officer of Health for Ontario, Dr. Arlene King, "Oral Health - More Than Just Cavities", April 2012, that urges the government to:

- *conduct a review of current policies and mechanisms to ensure all Ontarians have access to optimally fluoridated drinking water;*
- *conduct an immediate review of how publicly funded dental programs and services are monitored and evaluated;*
- *consider how to improve the integration and/or alignment of low-income oral health services within the broader health care system; and*
- *explore opportunities to improve access to and awareness of oral health services to First Nations people in Ontario*

/2

AND FURTHER BE IT RESOLVED that copies of this resolution be forwarded to the Premier of Ontario; the Minister of Health and Long-Term Care; Public Health Ontario; the Association of Local Public Health Agencies; the Ontario Public Health Association; Local Members of Parliament and the Provincial Parliament; Northwestern Health Unit obligated municipalities; and all Ontario Boards of Health.

References

Health Canada, 2010. *Canadian Health Measures Survey (CHMS), Oral Health Statistics 2007-2009.* http://www.hc-sc.gc.ca/hl-vs/pubs/oral-bucco/fact-fiche-oral-bucco-stat-eng.php

U.S. Department of Health and Human Services, 2000. *Oral Health in America: A Report of the Surgeon General*—Chapter 5. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. Retrieved from: http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/sgr/chap5.htm

Oral Health – More Than Just Cavities. April 2012. http://www.health.gov.on.ca/en/common/ministry/publications/reports/oral_health/oral_health.pdf

We commend Dr. Arlene King, CMOH, for her Report that recognizes the crucial importance of oral health for overall health and the need for preventive oral health services to be available to all Ontarians. We urge the government of Ontario to support the Report's recommendations and take action towards increased measures to address dental decay.

Yours in Health,

Original Signed by

John Albanese, Chair
Board of Health for Northwestern Health Unit jalbanese@nwhu.on.ca

c: Honourable Deb Matthews, Minister of Health and Long-Term Care
Dr. Arlene King, Chief Medical Officer of Health
Greg Rickford, MP Kenora
John Rafferty, MP Thunder Bay-Rainy River
Sarah Campbell, MPP Kenora-Rainy River
Bill Mauro, MPP Thunder Bay-Atikokan
Public Health Ontario
Association of Local Public Health Agencies
Ontario Public Health Association
Northwestern Health Unit obligated municipalities
All Ontario Boards of Health
Dr. Jim Arthurs, Medical Officer of Health
Mark Perrault, CEO
Board of Health correspondence

PETERBOROUGH COUNTY-CITY HEALTH UNIT
Q4 2012 PROGRAM REPORT
(October 1 – December 31, 2012)

Definitions
Frequently Used Acronyms

Mandatory Programs

Child Health
Chronic Disease Prevention
Food Safety
Foundational Standard
Health Hazard Prevention and Management
Infectious Diseases Prevention and Control
Prevention of Injury and Substance Misuse
Public Health Emergency Preparedness
Rabies Prevention and Control
Reproductive Health
Safe Water
Sexual Health, Sexually Transmitted Infections and Blood Borne Infections
Tuberculosis Prevention and Control
Vaccine Preventable Diseases

Other

Communications
Genetics
Infant and Toddler Development Program
Sewage Disposal Program

Board of Health Quarterly Reporting Definitions

✓ = **Compliant**	Have met the requirements of this standard for the operating year. No further action required.
↑ = **On Target**	Completion of operational plans will result in full compliance. Some activities may have taken place, but not all have been completed. Applies to requirements that do not have quarterly expectations.
Ø = **Partially Compliant**	Completion of operational plans will result in partial compliance of requirements. Some elements within this requirement have been achieved.
🛈 = **Compliant to Date**	Completion of operational plans will result in full compliance. For requirements that have quarterly expectations, these expectations have been met.
✖ = **Not Compliant**	Not able to meet most elements within this requirement.

Frequently Used Acronyms

BOH	Board of Health
CE-LHIN	Central East Local Health Integration Network
CINOT	Children In Need of Treatment
CFK	Care For Kids
CME	Continuing Medical Education
GIS	Geographic Information Systems
HBHC	Healthy Babies, Healthy Children
HCF	Healthy Communities Fund
HCO	Healthy Communities Ontario
HKPR	Haliburton, Kawartha, Pine Ridge
iPHIS	Integrated Public Health Information System
KPRDSB	Kawartha Pine Ridge District School Board
MCYS	Ministry of Children and Youth Services
MHP	Ministry of Health Promotion
MOE	Ministry of the Environment
MOH	Medical Officer of Health
MOHLTC	Ministry of Health and Long-Term Care
NBP	Nobody's Perfect
NRT	Nicotine Replacement Therapy
OAHPP	Ontario Agency for Health Protection and Promotion
PCCHU	Peterborough County-City Health Unit
PHAC	Public Health Agency of Canada
PHI	Public Health Inspector
PHN	Public Health Nurse
PRHC	Peterborough Regional Health Centre
PVNCCDSB	Peterborough Victoria Northumberland and Clarington Catholic District School Board

Child Health Q4 2012

(Managers: Karen Chomniak for Child Health, Nobody's Perfect; and Healthy Babies Healthy Children; Patti Fitzgerald/Sarah Tanner for Oral Health)

Goal: To enable all children to attain and sustain optimal health and developmental potential.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current), in the areas of:						Data collection for the six month breastfeeding survey will continue until we have at least 150 completed telephone responses (currently we have 119). Staff participated in an 'environmental scan' for a *Locally Driven Collaborative Project* working to streamline and standardize breastfeeding data collection across Ontario. Preliminary reports (national and local) were received from the University of Ottawa from the International Parenting Survey – Canada, in which the Health Unit partnered. Refer to Requirement #3 for information on Oral Health surveillance.
• Positive parenting;	✓	↑	↑	↑	✓	
• Breastfeeding;	✓	↑	↑	↑	✓	
• Healthy family dynamics;	✓	↑	↑	↑	✓	
• Healthy eating, healthy weights, and physical activity;	✓	↑	↑	↑	✓	
• Growth and development; and	✓	↑	↑	↑	✓	
• Oral health.	✓	↑	↑	↑	✓	
2. The board of health shall conduct surveillance of children in schools and refer individuals who may be at risk of poor oral health outcomes in accordance with the *Oral Health Assessment and Surveillance Protocol, 2008* (or as current), and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	See Requirement #10 for information on Oral Health. Approval to electronically populate student information from the Public Board of Education database into the mobile application of Oral Health Information Support System (OHISS) has not yet been received. Until the Public School Board approval is received, and the formatting issue is resolved, staff continue to manually input student information.
3. The board of health shall report oral health data elements in accordance with the *Oral*	✓	↑	↑	↑	✓	Automated electronic reporting of Oral Health screening data to the Ministry is completed routinely through the Oral Health Information Support System (OHISS) database.

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Health Assessment and Surveillance Protocol, 2008 (or as current).						
Health Promotion and Policy Development						
4. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and the creation or enhancement of supportive environments to address:						A Perinatal Mood Disorders (PMD) Collaborative meeting was held on October 25. Results from the Evaluation Strategy for distribution of the PMD Resource Package were shared. Collaborative members reviewed Echo's Postpartum Depression Standards Project draft document "*The Organization of Perinatal Mental Health Services in Ontario",* and provided feedback.
• Positive parenting;	✓	↑	↑	↑	✓	In partnering with the SSFC massage program, Family Health programs received free massage gift certificates to be offered to clients experiencing symptoms of depression.
• Breastfeeding;	✓	↑	↑	↑	✓	
• Healthy family dynamics;	✓	↑	↑	↑	✓	
• Healthy eating, healthy weights, and physical activity;	✓	↑	↑	↑	✓	Materials to promote the Family HEALTH*line* were distributed to health care providers. Twenty-five percent of Family Physicians and Nurse Practitioners have received an 18-Month Well-Baby Visit Information session.
• Growth and development; and	✓	↑	↑	↑	✓	
• Oral health						Staff coordinated breastfeeding expert Teresa Pitman as guest speaker for local health care providers.
These efforts shall include: a. Conducting a situational assessment in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); and b. Reviewing, adapting, and/or providing behaviour change support resources and programs.						Staff attended a Peterborough Triple P Positive Parenting Program (TP) Steering Committee meeting and a Peterborough Nobody's Perfect (NBP) Advisory Committee meeting. Staff worked with the Canadian Hearing Society- Peterborough (CHS) to facilitate their provision of NBP to Deaf clients. TP seminars were provided in partnership with the Peterborough Family Resource Centre. The NBP newsletter was distributed to facilitators and community. Redevelopment of the Oral Health Program web content was initiated. The Oral Health Team supported the Provincial postcard campaign to build support for adults who cannot afford emergency dental care. Working with the Basic Needs Committee, 900 postcards were distributed and over 500 were signed and presented to Jeff Leal, MPP.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
5. The board of health shall increase public awareness of: • Positive parenting; • Breastfeeding; • Healthy family dynamics; • Healthy eating, healthy weights, and physical activity; • Growth and development; and • Oral health These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	 ✓ ✓ ✓ ✓ ✓ ✓	 ↑ ↑ ↑ ↑ ↑ ↑	 ↑ ↑ ↑ ↑ ↑ ↑	 ↑ ↑ ↑ ↑ ↑ ↑	 ✓ ✓ ✓ ✓ ✓ ✓	Staff launched a Skin-to-Skin campaign including internal and external bus ads, posters, web content, banner displays, and FYI submission for health care providers. Skin-to-Skin supports positive parenting, growth and development, and breastfeeding.
6. The board of health shall provide, in collaboration with community partners, parenting programs, services, and supports, which include: a. Consultation, assessment, and referral; and b. Group sessions.	✓	↑	↑	↑	✓	Three NBP group series were provided in collaboration with community partners. Staff provided two NBP one-on-one series to clients of the Healthy Babies, Healthy Children program (HBHC). Staff provided 21Triple P parenting (TP) consultations and three TP seminars. Oral health staff presented to Early Childhood Educator students at Sir Sanford Fleming College on the care of children's teeth and to the local Nurse Practitioners group on Dental Services available and options for referral and information sharing.
7. The board of health shall provide advice and information to link people to community programs and services on the following topics: • Positive parenting; • Breastfeeding; • Healthy family dynamics; • Healthy eating, healthy weights, and	 ✓ ✓ ✓ ✓	 ↑ ↑ ↑ ↑	 ↑ ↑ ↑ ↑	 ↑ ↑ ↑ ↑	 ✓ ✓ ✓ ✓	Public Health Nurses (PHN's) completed 109 telephone consultations on the Family HEALTH*line*, on a variety of child health related topics. See also #6, regarding positive parenting. Since October of 2010, eligibility cards for dental treatment and preventive services under *Healthy Smiles Ontario* (HSO) have been issued to 458 children and youth, along with 139 renewals; $164,022.66 in HSO claims have been processed.

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Requirement	Status 2011	Status 2012				Comments
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physical activity; • Growth and development; and • Oral health.	✓ ✓	↑ ↑	↑ ↑	↑ ↑	✓ ✓	Information on Early Childhood Tooth Decay is provided quarterly at Teen Prenatal Supper Club classes. Information on the Children In Need of Treatment (CINOT) financial assistance program, the Healthy Smiles Ontario dental program, and Health Unit Dental Services was provided to The Peterborough Poverty Reduction Network's Neighbours in Action Committee at Prince of Wales Public School for a health fair. Handouts on Early Childhood Tooth Decay were included in a package that was forwarded by Child Health to physicians and nurse practioners to give to parents of 18 month old children.
8. The board of health shall provide, in collaboration with community partners, outreach to priority populations to link them to information, programs, and services.	✓	↑	↑	↑	✓	Staff worked in collaboration with the YMCA to promote and support the Young Moms Working Out group. Food boxes from the YWCA and other incentives, such as water bottles and T-shirts, were distributed to participants over the 10 week sessions. Based on survey feedback regarding their interests, staff organized three education sessions for the moms, including: Nutrition for Moms and Children, Sedentary and Physical Activity Guidelines for Children Aged 0-4, Best Start's *Have a Ball* activities for play, and Healthy Relationships. Staff worked with HBHC, YWCA Crossroads, CHS and the New Canadians Centre to support the provision of NBP. 235 new clients were seen for treatment in the Community Dental Health Centre, many requiring more than one appointment. 12 clients were provided dentures under a pilot program. The Dental Treatment Assistance Fund (DTAF) provides financial assistance up to the amount of $200 for individuals who have no dental benefits and require emergency treatment; 8 individuals were assisted through DTAF.
Disease Prevention						
9. The board of health shall provide all the components of the Healthy Babies Healthy Children Program in accordance with the *Healthy Babies Healthy Children Protocol,*	Ø	Ø	Ø	Ø	Ø	See Reproductive Health report.

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2008 (or as current) (Ministry of Children and Youth Services).						
10. The board of health shall conduct oral screening in accordance with the *Oral Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Each school year, oral health staff perform oral health screening on Grade 2 students using OHISS III (mobile application) to record and determine each school's screening intensity level based on Grade 2 results: • High Intensity (≥ 14% students with 2 or more decayed teeth). • Medium Intensity (≥ 9.5 % to <14% students with 2 or more decayed teeth). • Low Intensity (< 9.5% students with 2 or more decayed teeth). Further grades in each elementary school are also screened based on the school's screening intensity level. In the *2011/2012 school year*, staff screened a total of 4,215 children in Peterborough County and City schools.
11. The board of health shall facilitate access and support for families to complete screening tools to monitor their child's health and development, and provide a contact for families to discuss results and arrange follow-up.	✓	↑	↑	↑	✓	The Nipissing District Developmental Screen (NDDS) for early identification of developmental delays was disseminated through NBP series and by partner agencies.
12. The board of health shall provide the Children in Need of Treatment (CINOT) Program in accordance with the *Children in Need of Treatment* (CINOT) *Program Protocol, 2008* (or as current). For CINOT-eligible children, the board of health shall provide referrals to oral health care providers and monitor the action taken.	✓	🛈	🛈	🛈	✓	To date, 85 children and youth were deemed eligible for financial assistance and referred for treatment and follow-up through the CINOT program in the fourth quarter.
13. The board of health shall provide or ensure the provision of the essential clinical preventive oral health services at least annually in accordance with the *Preventive Oral Health Services Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	At the time of oral health screening, eligible children are offered professionally-applied topical fluoride, pit and fissure sealants and scaling. Preventive services are provided at the CDHC.

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Health Protection						
14. The board of health shall review drinking water quality reports for its municipal drinking water supply(ies) where fluoride is added. These reports shall be reviewed at least monthly and, where necessary, action shall be taken in accordance with the *Protocol for the Monitoring of Community Water Fluoride Levels, 2008* (or as current).	✓	🛈	🛈	🛈	✓	Monthly reports are received from Peterborough Utilities Water Treatment Plant, and reviewed by the Dental Consultant to ensure that levels of fluoride remain within the approved range.

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Chronic Disease Prevention Q4 2012

(Manager: Hallie Atter; Donna Churipuy)

Goal: To reduce the burden of preventable chronic diseases of public health importance.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current), in the areas of: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation.	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑	↑ ↑ ↑ ↑ ↑ ✓	↑ ↑ ↑ ↑ ↑ ✓	✓ ✓ ✓ ✓ ✓ ✓	**Nutrition** Updated City of Peterborough Community Food maps through City Planning dept. Updated the Nutrition component of the Community Assessment Report and completed the Situational Assessment for the Operational Plan. Completed a report for the Board of Health on the status of food security locally with recommendations for Board of Health actions. **Physical Activity (including the Built Environment and Access to Recreation)** Reviewed current research and practices of other municipalities to determine best practice for the transportation policy and health outcomes. **Tobacco Use Prevention** The City Solicitors office was provided with up to date trending data regarding the use of waterpipes among youth.
2. The board of health shall monitor food affordability in accordance with the *Nutritious Food Basket Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	**Nutrition** Responded to inquiries from other Health Units and provinces regarding implementation of the Nutritious Food Basket (NFB) protocol. Participated in NFB Task Group to create a set of province-wide recommendations for the 2013 reports.
Health Promotion and Policy Development						
3. The board of health shall work with school boards and/or staff of elementary, secondary, and post-secondary educational						**Nutrition** Participated in meetings to explore licensing for Ontario Society of Nutrition Professionals in Public Health (OSNPPH) of *Sip Smart BC*, a campaign and school

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settings, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies, and the creation or enhancement of supportive environments to address the following topics: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation. These efforts shall include: a. Assessing the needs of educational settings; and b. Assisting with the development and/or review of curriculum support.	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑	↑ ↑ ↑ ↑ Ø ↑	↑ ↑ ↑ ↑ Ø ↑	✓ ✓ ✓ ✓ Ø ✓	curriculum program focused in increasing awareness of sugar-sweetened beverages. Provided consultation to school boards and schools to support compliance with local School Board Nutrition policy. Supported the launch of the Nutrition Tools for School. Met with three secondary schools regarding Healthy Eating projects. Provide support to build the capacity of the Food For Kids (FFK) Program including: • Attended FFK Steering Committee meetings. • Supported the launch of the Ontario Farm to School Challenge in local schools. • Reviewed FFK funding, donations, and distribution of funding to school programs. • Supported schools in applying for Metro Green Apple grants. • Created and began distribution of 2011-12 FFK Peterborough and County Annual Report. • Created a work plan for long-term fund development for FFK. **Physical Activity (including the Built Environment and Access to Recreation)** Contributed to planning, implementation and evaluation of a P*eer-Led Intramural Leadership* workshop which reached approximately 83 students in grades 6-8 and approximately 15 teacher/teaching assistants in nine City and County schools. Met with Community Partners to plan the delivery of the Swim to Survive Program. Participated in the Active and Safe Routes to School Committee and assisted Peterborough GreenUp with the implementation of Car-free School Days. **Alcohol** See Prevention of Injury and Substance Misuse Standard Requirement #2. **Healthy Schools and Youth** Staff coordinated four Health Units to produce a regional Healthy Schools display and provided nine resource showcase displays for PVNCCDSB staff. A PCCHU post-secondary school activity scan was completed and distributed.

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						Staff completed a Healthy School grant report for secondary school projects. Staff launched the Healthy Schools model with PVNCCDSB in collaboration with the Haliburton Kawartha Pine Ridge District Health Unit (HKPRDHU). A Healthy Schools pilot project was initiated with Rhema Christian School. Staff developed curriculum linked resource links for teachers and resources for administrators to post on the Healthy Schools section of the new PCCHU website. In collaboration with HKPRDHU, staff updated a parent resource for School Board kindergarten registration packages, in collaboration with HKPRDHU. **Youth Engagement** Two Student Nurses from Trent University spent October and November working with a grade 6/7 class at Armour Heights Elementary school, where they taught critical thinking and media literacy learning skills as it related to ACTION Week, and the tobacco industry. **Tobacco Use Prevention** Phase 1Teen Cessation evaluation report was drafted. Due to limited staff capacity, Phase 2 of the Cessation-Connectedness Pilot downsized to two schools with a modified evaluation plan. Provided one-time student cessation support sessions at two additional schools – TASS and Peterborough Alternative and Continuing Education (PACE). **Cancer Prevention** Two Trent University Nursing students participated in the planning, implementation and evaluation of a Cancer Screening Day for women 50 years of age and over.
4. The board of health shall use a comprehensive health promotion approach to increase the capacity of workplaces to develop and implement healthy policies and programs, and to create or enhance supportive environments to address the following topics:						**Workplace Health** Provided direct support to the following workplaces: • PCCHU provided support to the Organizational Culture Work Group. • Kawartha Participation Projects. • City of Peterborough. • Canadian Mental Health Association - Nutrition display for the Staff Wellness Fair.

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• Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; • Work stress; and • Exposure to ultraviolet radiation. These efforts shall include: a. Conducting a situational assessment in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); and b. Reviewing, adapting, and/or providing behaviour change support resources and programs.	✓ ✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑ ↑	↑ ↑ ↑ ↑ Ø ↑ ↑	↑ ↑ Ø ↑ ↑ ↑ x	✓ ✓ Ø ✓ ✓ ✓ x	Provided brief support to five workplaces seeking information on such issues as: work stress, work-life balance, mental health. Provided support to workplaces through: • Updated resources to Health at Work website. • Provided an article regarding reducing stress through active in a December newsletter. • Distributed two e-Bulletins. Co-hosted a dinner event for 92 attendants on October 24 with the Human Resources Professionals Association, Peterborough Chapter. The speaker was Andrew Harkness, member of the Canadian Standards Association (CSA) Technical Committee that developed the Psychological Health and Safety in the Workplace Standard. Promoted the new Psychological Health and Safety in the Workplace Standard via the *Workplace Health Matters* e-Newsletter, Dr. Pellizzari's December column in the *Examiner* and at the Human Resources Professionals Association, Peterborough Chapter November Showcase. **Cancer Prevention** As part of the cost containment strategy for 2012 the topic area of exposure to ultraviolet radiation for this requirement was not completed.
5. The board of health shall collaborate with local food premises to provide information and support environmental changes through policy development related to healthy eating and protection from environmental tobacco smoke.	✓	X	X	Ø	Ø	**Nutrition** Nutrition staff report to the Board calling for support regarding the second reading of MPP, France Gélinas' private members Bill 86: Healthy Decisions for Healthy Eating Act, 2012, that was slated to be reintroduced at the Ontario Legislature on October 18, 2012. **Tobacco Use Prevention** Information was provided to the City Solicitor's office and City Council to support a waterpipe bylaw prohibiting the establishment of waterpipe lounges in City food premises.
6. The board of health shall work with municipalities to support healthy public policies and the creation or enhancement of						**Nutrition** Presented to day care directors and supervisors on possible partnership opportunities with Raising the Bar Peterborough and PCCHU.

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supportive environments in recreational settings and the built environment regarding the following topics: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation.	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑	↑ ↑ ↑ ↑ ↑ ↑	↑ ↑ ↑ ↑ ↑ ↑	✓ ✓ ✓ ✓ ✓ ✓	Participated in the Peterborough Community Garden Network (PCGN) which supports the City of Peterborough's Community Garden Policy. The PCGN met with City staff to work on community garden plot holder agreements. Presented and participated in the Food and Farming Summit. The Summit resulted in an action group linked to Sustainable Peterborough to work on food and farming policy at the local level. Participated in City of Peterborough Louis Street site consultations. As part of the Community Food Network, provided input into the City of Peterborough Housing and Homelessness Consultation process. **Alcohol** See Prevention of Injury and Substance Misuse Standard Requirement #2. **Physical Activity** Submitted PCCHU recommendations to the City of Peterborough regarding their review of bylaws that govern active transportation. Submitted PCCHU recommendations to the City of Peterborough regarding their review of their sidewalk strategic plan. Submitted PCCHU recommendations to the County of Peterborough regarding their proposed draft transportation master plan. **Cancer Prevention** Staff met with Jeff Leal regarding support for the ban on indoor tanning for youth under the age of 18. **Youth Engagement** Staff met with three of the four Townships interested in developing a rural youth engagement strategy and provided *Youth Engagement 101* training to staff that will be involved with this project in 2013.

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						In November, staff presented *Youth Moving us Forward* which showcased examples of current Youth Engagement work at a national conference.
Disease Prevention						
7. The board of health shall increase the capacity of community partners to coordinate and develop regional/local programs and services related to: • Healthy eating, including community-based food activities; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation. These efforts shall include: a. Mobilizing and promoting access to community resources; b. Providing skill-building opportunities; and c. Sharing best practices and evidence for the prevention of chronic diseases	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑	↑ ↑ ↑ Ø Ø ↑	↑ ↑ ↑ ↑ ↑ ↑	✓ ✓ ✓ ✓ ✓ ✓	**Nutrition:** Reviewed and updated Nobody's Perfect facilitator's guide and lesson plan on infant feeding. Delivered supermarket tours providing information on healthy eating, label reading and chronic disease. Participated as member of Baby-Friendly Initiative (BFI) Committee to help with upcoming Health Unit BFI re-designation in 2013. Partnered with YWCA on packing and delivery of 1,193 Just Food boxes to the City and County. Provided orientation to a Medical Resident on infant and toddler nutrition recommendations and local/provincial nutrition supports. Participated on local committees working on improving access to food including the Peterborough Community Food Network, Nourish Subcommittee, PCGN, FFK Peterborough, Healthy Communities, Centre for Social Innovation and Peterborough Gleans. Developed promotional materials for the Nourish Project including a bookmark and brochure. Participated on site visits and site planning for the Nourish Project. Participated on provincial committees working on issues related to healthy eating/healthy weights including the Ontario Society of Nutrition Professionals in Public Health (Nutrition Tools for Schools, Secondary Schools Environmental Support and School Nutrition Workgroup, Family Health Nutrition Advisory Group) and the Nutritious Food Basket Work Group.

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						Physical Activity (including the Built Environment and Access to Recreation) Participated on the Access to Recreation Working Group (which includes seven community partners). Forged new relationship with Fleming College's Fitness and Health Promotion program and the Access to Recreation Working Group. Attended the Healthy Peel By Design conference to learn about the successes of New York City built environment initiatives. Shared these learnings with Access to Recreation partners. Participated on the International Trails Day Planning Committee. Met with the Chair of Sport Kawartha to review their Trillium application and provide recommendations. **Healthy Communities** Healthy Communities Coordinator supported the work of the: • Access to Recreation Working Group. • Access to Healthy Foods Working Group. • Access to Mental Health Services and Mental Health Promotion Working Group. Co-coordinated the Peterborough Partners for Wellness Mental Health Promotion Planning Day. Participated in the Eastern Region Healthy Communities Coordinator Network. **Alcohol** See Prevention of Injury and Substance Misuse Standard Requirement #3. **Youth Engagement** Youth from across the Central East region produced a video PSA available here that supported a Twitter campaign designed to raise awareness about marketing tactics used by the tobacco industry.

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						PCCHU hosted a Youth Advocacy Training Institute training. Over the past two years, the youth team has been working with our provincial partner to co-create a curriculum based on *Big Industry Denormalization and Media Literacy*. The Peterborough Regional Health Centre (PRHC), John Howard Society of Peterborough, Peterborough Drug Strategy, City of Peterborough, and PCCHU banded together to bring in Erin Walsh, a leading expert on healthy adolescent development. Erin's workshop on *Teens: Why they do what they do*, was well received by the 165 participants at Market Hall. The YSPI (Youth Service Provider Information) App was completed in December in its pilot phase. The App will connect youth in the area to services they may require. Our Student Peer Leaders hosted two focus groups at The Spill as part of the Board's strategic planning process. The focus groups were designed to capture youth input into the new plan.
8. The board of health shall provide opportunities for skill development in the areas of food skills and healthy eating practices for priority populations.	✓	↑	↑	↑	✓	**Nutrition** Presented healthy eating recommendations with an emphasis on promoting a healthy body image for post-partum mothers attending YMCA *Young Moms Working Out*. Supported local childcare cooks via Raising the Bar Cooks network by providing recommendations and resources for menu improvement/development in childcare and after school program settings as per the DNA and Canada's Food Guide to Healthy Eating. Supported families via the Peterborough Family Resource Centre (PFRC) by providing healthy eating recommendations for infants/toddlers/preschoolers via Families Connect/Steps and Stages and introducing solid food workshops. Presented to Family Health staff and the Children's Aid Society (CAS) with updates re: food security; nutrition resources and recommendations for young families. Presented on infant/toddler/preschooler nutrition recommendations, with an emphasis on picky eaters and school lunch prep, to parents from New Canadian Centre.

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						Presented to Family Health Team Registered Dietitians with updates re: food security; nutrition resources and recommendations for community members. Facilitated eight *Collective Kitchens* in the City and three *Collective Kitchens* in the County. Supported the PCGN to host a canning workshop in November. Led 70 *Come Cook with Us* classes for 160 youth, parents, seniors and single adults, including New Canadians and First Nations community members, in the City of Peterborough, Bridgenorth, Lakefield, Apsley, and Millbrook. Participated at the Canada Prenatal Nutrition Program (CPNP) Babies First by conducting nutrition assessments, answering nutrition questions, and conducting Lunch 'n Learn sessions on healthy eating and feeding your baby.
9. The board of health shall ensure the provision of tobacco use cessation programs and services for priority populations.	✓	↑	↑	↑	✓	**Tobacco Use Prevention** **C**ollaborated with area high schools to implement Phase 2 of the School-Based Cessation and Connectedness project. Ongoing provision of group cessation support for women who are pregnant and recently pregnant. Provided leadership development opportunities among community women who have participated in the *Choose to Be…Smoke Free* cessation support group.
10. The board of health shall collaborate with community partners to promote provincially approved screening programs related to the early detection of cancers.	✓	↑	↑	↑	✓	**Cancer Prevention** A Cancer Screening Day took place in collaboration with Primary Health Care Services of Peterborough, Peterborough Clinic, Breast Assessment Centre at the PRHC, Trent University Nursing Program, St. Peter's High School and Paul Asta Hairstyling School. Staff provided a presentation to Central East Integrated Cancer Prevention and Screening Network sharing highlights and evaluation results of the Cancer Screening Day. In collaboration with the Central East Integrated Cancer Prevention and Screening Network, staff provided a Cancer Screening Update for Primary Care Providers at PRHC Grand Rounds.

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	4th	1st	2nd	3rd	4th	
11. The board of health shall increase public awareness in the following areas: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; • Exposure to ultraviolet radiation; • Benefits of screening for early detection of cancers and other chronic diseases of public health importance; and • Health inequities that contribute to chronic diseases. These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	↑ ↑ ↑ ↑ Ø ↑ ↑ ↑	↑ ↑ ↑ ↑ Ø ↑ ↑ ↑	✓ ✓ ✓ ✓ Ø ✓ ✓ ✓	**Nutrition** Provided a community food programs display for the Peterborough Public Library. Provided an FYI article on newly released: Nutrition for Healthy Term Infants recommendations from Birth to Six Months– A joint statement of *Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada.* Coordinated a three part healthy breakfast/healthy cooking segments for CHEX 5 o'clock show and provided interview on food security recommendations to Peterborough Examiner. Prepared a media release regarding delivery of locally grown carrots to school breakfast programs through the Ontario Farm to School Challenge. Participated in two three-part segments on the CHEX 5 O'Clock featuring Food For Kids, school breakfast programs and Kawartha Food Share. Presented on healthy eating recommendations including Canada's Food Guide and Sodium reduction messaging for seniors group in Apsley. Updated and promoted *Food in Peterborough* web site which highlights all food programs in Peterborough City and County. Worked with YWCA Food Security Advocacy project on the *Nourish Peterborough* blog site. Provided a Sodium Reduction display for Annual Diabetes Expo. **Alcohol** See the Prevention of Injury and Substance Misuse Standard Requirement #4. **Physical Activity (including the Built Environment and Access to Recreation)** As part of the Active and Safe Routes to School Committee, issued a press release about International Walk to School Day.

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	4th	1st	2nd	3rd	4th	
						Tobacco Use Prevention Transit advertisements to increase awareness of smoke free policies in multi-unit dwellings were implemented. **Cancer Prevention** Participated in Breast Cancer Awareness Day at Lansdowne Place Mall promoting benefits of screening for early detection of cancers.
12. The board of health shall provide advice and information to link people to community programs and services on the following topics: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; • Screening for chronic diseases and early detection of cancers; and • Exposure to ultraviolet radiation.	 ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ↑ ↑ ↑ ↑ ↑ ↑ ↑	 ↑ ↑ ↑ ↑ ↑ ↑ ↑	 ↑ ↑ ↑ Ø Ø ↑ ↑	 ✓ ✓ ✓ Ø Ø ✓ ✓	**Alcohol** See the Prevention of Injury and Substance Misuse Standard Requirement #4. **Physical Activity (including the Built Environment and Access to Recreation)** Wrote article for spring 2013 school newsletter regarding daily physical activity. Continued discussions with the Peterborough Regional Health Centre (PRHC) Stroke Rehabilitation program and other Access to Recreation Working Group members regarding the development of a Heart Wise program for Peterborough. Heart Wise is a certified fitness program for people living with chronic disease. Included physical activity guidelines in the new 18-month well child visit parent packages which are being delivered to area physicians over the next three months.
13. The board of health shall implement and enforce the Smoke-Free Ontario Act[8] in accordance with provincial protocols, including but not limited to the *Tobacco Compliance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	**Tobacco Use Prevention** 29 workplaces and public places were inspected. 69 tobacco vendors were tested for compliance to youth access regulations under the *Smoke Free Ontario Act.* Two vendors were charged. 63 vendors were inspected for compliance with tobacco vendor display and promotion regulations.

Status Legend: **✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant**

Food Safety Q4 2012 (Manager: Atul Jain)

Goal: To prevent or reduce the burden of food-borne illness.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct surveillance of: • Suspected and confirmed food-borne illnesses; and • Food premises in accordance with the *Food Safety Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Surveillance of Emergency Department visits were conducted and analyzed bi-weekly to identify unreported clusters of illnesses which could be food-related. The Health Unit investigated an outbreak of salmonella linked to a restaurant in Peterborough. As of January 4, 2013, 16 total cases (13 lab-confirmed and 3 probable) have been reported.
2. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	Ø	Ø	Ø	Ø	✓	Reports from our existing database were reviewed for statistical data. This requirement needs additional IT and reporting capacity. This will be accomplished in 2013.
3. The board of health shall report Food Safety Program data elements in accordance with the *Food Safety Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	To date, the Ministry of Health and Long-Term Care (MOHLTC) has requested completion rates for high risk food premises for the period January 1-December 31, 2012, as part of the Accountability Agreements. We have a 86.9% completion rate.
Health Promotion and Policy Development						
4. The board of health shall ensure food handlers in food premises have access to training in safe food-handling practices and principles in accordance with the *Food*	✓	↑	↑	↑	✓	Fifteen Food Handler courses were presented in the fourth quarter with 286 successful attendees certified. Year-to-date 2012: 58 courses, 1,252 certified. Year-to-date 2011: 73 courses; 1,738 certified

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Safety Protocol, 2008 (or as current).						The County approved the by-law for mandatory Food Handler training at local food premises. The new by-law takes effect for high-risk food premises on January 1, 2014 and for moderate-risk food premises on January 1, 2015.
5. The board of health shall increase public awareness of food-borne illnesses and safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2008* (or as current) by: a. Adapting and/or supplementing national and provincial food safety communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑	↑	↑	✓	There were 59 visits to the main Food Safety page on the PCCHU website and eight visits to the Food Premises Disclosures Pages. There was one tweet about *Food Safety Tips for the Holidays*. As part of their routine inspections, Public Health Inspectors (PHIs) also distribute report cards for display in restaurants. Approximately 45 students in the culinary program of Sir Sandford Fleming college attended a presentation of *What to Expect from a Health Inspection*. All staff of a long-term care residence attended *An Overview of Food Safety* presented by a PHI. A presentation to food handlers was conducted for the Kids Breakfast Club Program. A link was posted on the PCCHU website to Health Canada's information on the importance of handling fresh produce safely to reduce the risk of food borne illness. The Health Unit posted a link providing additional information and a list of recalled products that may contain E.coli 0157:H7 bacteria related to the XL Foods Inc. beef recall. The Health Unit issued a media release concerning an outbreak of lab-confirmed cases of Salmonella linked to a restaurant in Peterborough. The Health Unit ordered the restaurant closed until testing could determine the source. The Health Unit posted a link to Health Canada's information reminding Canadians of the risks of consuming unpasteurized fruit juice and cider.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Disease Prevention/Health Protection						
6. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to: • Suspected and confirmed food-borne illnesses or outbreaks; • Unsafe food-handling practices, food recalls, adulteration, and consumer complaints; and • Food-related issues arising from floods, fires, power outages, or other situations that may affect food safety in accordance with the Health Protection and Promotion Act; the *Food Safety Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Fourteen food complaints were investigated. Year-to-date 2012: 95 Year-to-date 2011: 56 See #5 above.
7. The board of health shall inspect food premises and provide all the components of the Food Safety Program within food premises as defined by the Health Protection and Promotion Act and in accordance with the Food Premises Regulation (O. Reg. 562); the *Food Safety Protocol, 2008* (or as current); and all other applicable Acts.	✓	↑	↑ Ø ↑	↑ ↑ ↑	✓ ✓ ✓	High risk: 132 compliance inspections and 30 re-inspections. Year-to-date 2012: 548 compliance inspections and 159 re-inspections. Year-to-date 2011: 557 compliance inspections and 142 re-inspections. Moderate risk: 253 compliance inspections and 79 re-inspections. Year-to-date 2012: 980 compliance inspections and 339 re-inspections. Year-to-date 2011: 951 compliance inspections and 171 re-inspections. Low risk: 64 compliance inspections and 12 re-inspections. Year-to-date 2012: 262 compliance inspections and 44 re-inspections. Year-to-date 2011: 248 compliance inspections and 39 re-inspections.

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Foundational Standard Q4 2012 (Manager: Larry Stinson)

Goal: Public health practice responds effectively to current and evolving conditions, and contributes to the public's health and well-being.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Population Health Assessment						
1. The board of health shall assess current health status, health behaviours, preventive health practices, health care utilization relevant to public health, and demographic indicators in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Completed additional analysis of PCCHU breastfeeding surveillance data including post-partum depression (also applied to Requirements (Req.) 2, 3, 6, 7). Completed historical analysis of Nobody's Perfect client and session data (Req. 2, 4). Analyzed and reported on National Pollutant Release Inventory data to monitor sources/concentrations of environmental contaminants (Req. 2, 7) Additional analyses of health status data included: opioid related emergency department visits, hospitalizations, and deaths; deaths related to Sudden Infant Death Syndrome; updated live birth and pregnancy statistics; analysis of potential impact of second-hand smoke in multi-unit dwellings.
2. The board of health shall assess trends and changes in local population health in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	(See Req. 1 and 6) With a few exceptions, all epidemiological analyses conducted involve the assessment of trends.
3. The board of health shall use population health, determinants of health and health inequities information to assess the needs of the local population, including the identification of populations at risk, to determine those groups that would benefit most from public health programs and services (i.e., priority populations).	✓	↑	↑	↑	✓	The Foundational Standards (FS) team continued to support the development of the Board of Health's strategic plan. They identified a need for separate consultations with vulnerable groups such as young parents and low income marginalized people. Analyzed child poverty focus group data for Social Determinants of Health (SDOH) Public Health Nurse (PHN) needs assessment.
4. The board of health shall tailor public health programs and services to meet local	✓	↑	↑	↑	✓	Hosted a Mental Health Planning Day with 26 health and social services representatives. It was facilitated by Lisa Tolentino.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
population health needs, including those of priority populations, to the extent possible based on available resources.						Organized a consultation for the City's Housing and Homelessness Plan with the Home Response Coalition. Organized an internal consultation to gain input from PCCHU staff toward the City's Housing and Homelessness Plan. Supported the subcommittee of the Home Response Coalition in development of a local risk assessment scale and associated resource list and decision tree for clients living in squalor. Expected completion date: Jan/Feb. 2013. Worked with the Child and Reproductive Health programs to finalize the Skin to Skin campaign.
5. The board of health shall provide population health information, including determinants of health and health inequities to the public, community partners, and health care providers, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Made the Poverty Game available for Telecare and Fleming College training (90 people). Hosted the film, *Solar Momas* as part of a poverty awareness film festival at the Peterborough Public Library. Worked with IT staff and students at Crestwood High School to develop a local version of the SDOH video, *Lets Talk About Health*. Completion is expected in January, 2013. Prepared and delivered a presentation to the Kawartha Pine Ridge District School Board (KPRDSB) School Equity Contacts on *The Role of Educators in Addressing Poverty in Schools and the Community* (30 teachers). Posted follow-up materials on the PCCHU website. On an ongoing basis, the Health Unit provides data and health information/reports related to chronic disease, health behaviours and risk factors, health outcomes, health hazards and infectious diseases to relevant audiences (Req. 7).
Surveillance						
6. The board of health shall conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health indicators, as required by the Health Protection and Promotion Act and	✓	↑	↑	↑	✓	Surveillance activities conducted by the Health Unit included the following activities: • ongoing use of a syndromic surveillance system to monitor visits to local hospital emergency departments; • in conjunction with local school boards, monitoring absences due to illnesses; • contacting sentinel physician for reports on visits due to selected symptoms;

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in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* or as current).						• reviewed emergency department admissions for reportable communicable diseases; and • monitored outbreaks of communicable diseases in the community, region, province and across the country. Statistics Canada, the Public Health Agency of Canada (PHAC), and academic journal newsfeeds were monitored for pertinent surveillance and research information which is then distributed to appropriate staff. Assisted in salmonella outbreak investigation.
7. The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Relevant syndromic surveillance data was utilized to monitor the state of influenza and respiratory illness in Peterborough and it assisted in a community outbreak being declared. The following surveillance information was provided to the public and/or community partners: • bi-weekly surveillance data examining emergency department visits, school absenteeism due to illness, and community and facility outbreaks; and • monthly communicable disease reports distributed internally.
Research and Knowledge Exchange						
8. The board of health shall engage in knowledge exchange activities with public health practitioners, policy-makers, community partners, health care providers, and the public regarding factors that determine the health of the population and support effective public health practice gained through population health assessment, surveillance, research, and program evaluation.	✓	↑	↑	↑	✓	In partnership with the SDOH PHN from the Haliburton, Kawartha, Pine Ridge District (HKPRD) Health Unit provided a presentation to the Northumberland/Peterborough Regional Children and Family Services Advisory Council on the SDOH and their impacts on children. Attended a community stakeholders meeting for the Support Team for Abuse Response Today (START) service hub for women experiencing violence or abuse. Participated in the SDOH PHN provincial network.

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Requirement	Status 2011	Status 2012				Comments
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9. The board of health shall foster relationships with community researchers, academic partners, and other appropriate organizations to support public health research and knowledge exchange.	✓	↑	↑	↑	✓	Links with Trent University were established in 2012. The Health Unit is participating in two Locally Driven Collaborative Projects with Public Health Ontario (PHO).
10. The board of health shall engage in public health research activities, which may include those conducted by the board of health alone or in partnership or collaboration with other organizations.	✓	↑	↑	↑	✓	Assisted with the development of four surveys for external use (Tobacco Use Student Intake; Flu Clinic Evaluation; Condom Sense Campaign; Multi-Unit Dwelling survey planning).
Program Evaluation						
11. The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes.	✓	↑	↑	↑	✓	Ongoing evaluation activities continued for Come Cook With Us, Nobody's Perfect, and the Teen Prenatal Supper Club. The evaluation components required for the Baby-Friendly Initiative (BFI) redesignation were reviewed.
12. The board of health shall conduct program evaluations when new interventions are developed or implemented, or when there is evidence of unexpected operational issues or program results, to understand the linkages between inputs, activities, outputs, and outcomes.	Ø	↑	↑	↑	✓	Input was provided on the evaluation components of the Skin to Skin campaign. Evaluation indicators for 2013 for Communications and Information Technology were developed.
13. The board of health shall use a range of methods to facilitate public health practitioners' and policy-makers' awareness of the factors that contribute to program effectiveness.	✓	↑	↑	↑	✓	PCCHU planning and reporting processes continue to be of interest to other Health Units across the province. The Epidemiologist and the Health Promoter – Planning, Evaluation and Grants have both fulfilled numerous information requests from Health Unit colleagues about our partnership inventory, our planning process and tools, and our quarterly reporting template for the Board of Health.

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FOUNDATIONAL STANDARDS PRINCIPLES: In addition to the Requirements outlined under the Foundational Standard, some health unit activities are guided by the principles of "Impact," "Capacity," and "Partnership and Collaboration." These activities are outlined below:						
Impact: The Board of Health shall strive to influence broader societal changes that reduce health disparities and inequities.	✓	↑	↑	↑	✓	Met with Jeff Leal, along with other community partners, to discuss public health impacts of cuts to discretionary and housing benefits. Revised and publicly released a report through the Income Security Work Group of the Peterborough Poverty Reduction Network (PPRN) on *Discretionary Benefits and Housing Benefits (CSUMB): Finding the Solution for 2013 and Beyond*. Attended meetings of the Joint Services Committee, Committee of the Whole and City Council, to track municipal policy development and budget allocations to social assistance benefits. Met with municipal councilors to provide information on the public health impact of social assistance benefits and a *Made in Peterborough* solution for funding. Prepared a presentation for the Medical Officer of Health (MOH) to present to the Municipal Budget Committee during the public consultations on the 2013 budget. A Food Security report was provided to the Board of Health. Provided input into various drafts of a report released by the Wellesley Institute on *The Real Cost of Cutting the Community Start-Up and Maintenance Benefit: A Health Equity Impact Assessment.* Provided input to the County Transportation Plan with respect to the importance of public transit for low income people. Worked with Health Unit staff and Social Services staff to clarify the impact of a local land claim settlement on access to benefits for aboriginal populations.
Capacity-Building: The Board of Health shall provide on-going staff development and skill-building related to public health competencies.	✓	↑	↑	↑	✓	Provided staff training on the SDOH to six new PCCHU staff. Worked with Management staff to plan for the elimination of the SDOH Work Group and the transition of its functions.

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						Planning for 2013 was completed with programs developing brief situational assessments, logic models (where appropriate), operational plans, and in some cases, evaluation plans. Seven joint planning discussions were also held on the following topics: Built Environment/Municipal Policy; Daycares; Health Professionals; Healthy Kids; Healthy Schools and Youth; SDOH; and Substance Misuse Including Tobacco. An action plan document based on these joint planning discussions has been prepared and will be monitored by the Program Management Team.
Partnership and Collaboration: The Board of Health shall foster the creation of a supportive environment for health through community and citizen engagement in the assessment, planning, delivery, management and evaluation of programs and services.	✓	↑	↑	↑	✓	Participated in community networks which address the SDOH and planned and implemented community services for vulnerable populations: • Ontario Disabilities Support Program (ODSP) Support Project; • PPRN Basic Needs Work Group; • PPRN Income Security Work Group; • PPRN Neighbours in Action Work Group; • Healthy Communities Mental Health Work Group; • Peterborough Under-Served Health Care Coalition (PUSH-CC); • Homelessness Coordinating Committee; • Home Response Coalition; • Senior's Planning Table; • Abuse Prevention of Older Adults Network; • Partners in Aging Well Coalition; and • Emergency Community Interface Group. Support has been provided to the Food for Kids (FFK) Steering Committee and its Fund Development Work Group. Work also continued to find funds to support the Dental Treatment Assistance Fund (DTAF). A plan to present the funding needs of FFK and DTAF to local service clubs was developed and will be implemented in 2013. Proposal development support was also provided for a Public Health Agency of Canada proposal for a community climate change project that PCCHU would host. Attended the Neighbours in Action health fair at Prince of Wales public school.

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Health Hazard Prevention and Management Q4 2012 (Manager: Donna Churipuy)

Goal: To prevent or reduce the burden of illness from health hazards[32] in the physical environment.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
1. The board of health shall conduct surveillance of the environmental health status of the community in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).	✓	↑	↑	✓	✓	
2. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	
Health Promotion and Policy Development						
3. The board of health shall increase public awareness of health risk factors associated with the following health hazards: • Indoor air quality;	✓	↑	↑	↑	✓	Messages about the health effects of exposure to extreme cold were released to the general public as part of the activation of the Extreme Cold Response Plan. The Activity Sign and the Health Unit website were updated with information on radon.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
• Outdoor air quality; • Extreme weather; • Climate change; • Exposure to radiation; and • Other measures, as emerging health issues arise. These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓ ✓ ✓ ✓					
4. The board of health shall assist community partners to develop healthy policies related to reducing exposure to health hazards. Topics may include, but are not limited to: • Indoor air quality; • Outdoor air quality; • Extreme weather; and • Built environments.	✓ ✓ ✓ ✓	↑	↑	↑	✓	Staff participated in Sustainable Peterborough Climate Change Working Group meetings.
Disease Prevention/ Health Protection						
5. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to respond to and manage health hazards in accordance with the Health Protection and Promotion Act; the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Risk Assessment and*	✓	↑	↑	↑	✓	Staff are available to respond 24/7 to manage health hazards.

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<tr><th rowspan="2">Requirement</th><th>Status 2011</th><th colspan="4">Status 2012</th><th rowspan="2">Comments</th></tr>
<tr><th>4th</th><th>1st</th><th>2nd</th><th>3rd</th><th>4th</th></tr>
<tr><td></td><td>Inspection of Facilities Protocol, 2008 (or as current).</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>6.</td><td>The board of health shall inspect and assess facilities where there is an elevated risk of illness associated with exposures that are known or suspected to be associated with health hazards in accordance with the Risk Assessment and Inspection of Facilities Protocol, 2008 (or as current).</td><td>Ø</td><td>×</td><td>×</td><td>×</td><td>Ø</td><td>As part of the cost containment strategy for 2012, this requirement was not fully completed, however arenas and funeral homes were inspected.</td></tr>
<tr><td>7.</td><td>The board of health shall implement control measures to prevent or reduce exposure to health hazards in accordance with the Identification, Investigation and Management of Health Hazards Protocol, 2008 (or as current) and the Risk Assessment and Inspection of Facilities Protocol, 2008 (or as current).</td><td>✓</td><td>↑</td><td>↑</td><td>↑</td><td>✓</td><td>There were 212 inspections, re-inspections and public contacts related to health hazard abatement, non-communicable disease for the fourth quarter of 2012. Specifically, the subjects of the investigations were:
<table>
<tr><th>Activity</th><th>Oct 2012</th><th>Nov 2012</th><th>Dec 2012</th><th>Total Q4 2012</th><th>2012 Year-to-Date</th><th>2011 Year-to-Date</th></tr>
<tr><td>Air Quality – Arenas</td><td>--</td><td>14</td><td>9</td><td>23</td><td>42</td><td>29</td></tr>
<tr><td>Air Quality – Institutional</td><td>3</td><td>--</td><td>--</td><td>3</td><td>5</td><td>7</td></tr>
<tr><td>Air Quality – Residential</td><td>2</td><td>5</td><td>6</td><td>13</td><td>41</td><td>90</td></tr>
<tr><td>Air Quality – Outdoor</td><td>--</td><td>1</td><td>--</td><td>1</td><td>12</td><td>6</td></tr>
<tr><td>Animal Excrement</td><td>1</td><td>--</td><td>--</td><td>1</td><td>49</td><td>46</td></tr>
<tr><td>Asbestos Inquiry/Complaint</td><td>--</td><td>--</td><td>--</td><td>--</td><td>19</td><td>12</td></tr>
<tr><td>Bedbug Identification</td><td>4</td><td>1</td><td>1</td><td>6</td><td>60</td><td>64</td></tr>
<tr><td>Bedbug Investigation</td><td>17</td><td>10</td><td>6</td><td>33</td><td>394</td><td>257</td></tr>
<tr><td>Bird Complaints (geese, pigeons, etc.)</td><td>--</td><td>6</td><td>2</td><td>8</td><td>15</td><td>3</td></tr>
<tr><td>Chemical Inquiry/Complaint</td><td>--</td><td>--</td><td>--</td><td>--</td><td>1</td><td>6</td></tr>
<tr><td>Funeral Home Inspections</td><td>1</td><td>4</td><td>6</td><td>11</td><td>13</td><td>11</td></tr>
<tr><td>Garbage Complaints</td><td>4</td><td>2</td><td>3</td><td>9</td><td>63</td><td>81</td></tr>
<tr><td>Giant Hogweed</td><td>--</td><td>--</td><td>--</td><td>--</td><td>3</td><td>2</td></tr>
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<tr><td>Grave Disinterments</td><td>--</td><td>--</td><td>--</td><td>--</td><td>3</td><td>--</td></tr>
<tr><td>Hantavirus</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td><td>1</td></tr>
<tr><td>Heating Complaints</td><td>9</td><td>23</td><td>4</td><td>36</td><td>93</td><td>116</td></tr>
<tr><td>House Disrepair/Sanitation Complaints</td><td>3</td><td>4</td><td>4</td><td>11</td><td>92</td><td>33</td></tr>
<tr><td>Insect Complaints</td><td>7</td><td>4</td><td>5</td><td>16</td><td>133</td><td>275</td></tr>
<tr><td>Lead Inquiry/Complaint</td><td>--</td><td>--</td><td>--</td><td>--</td><td>1</td><td>--</td></tr>
<tr><td>Migrant Farm Worker Facility Inspection</td><td>--</td><td>--</td><td>--</td><td>--</td><td>5</td><td>3</td></tr>
<tr><td>Mould Investigation</td><td>16</td><td>11</td><td>6</td><td>33</td><td>351</td><td>451</td></tr>
<tr><td>Playground Inspections</td><td>1</td><td>1</td><td>--</td><td>2</td><td>24</td><td>29</td></tr>
<tr><td>RF/WIFI</td><td>--</td><td>--</td><td>--</td><td>--</td><td>27</td><td>10</td></tr>
<tr><td>Rodent Complaints</td><td>--</td><td>--</td><td>--</td><td>--</td><td>9</td><td>10</td></tr>
<tr><td>Sewage Complaints</td><td>--</td><td>--</td><td>--</td><td>--</td><td>13</td><td>20</td></tr>
<tr><td>Sharps</td><td>--</td><td>--</td><td>--</td><td>--</td><td>6</td><td>2</td></tr>
<tr><td>TCE</td><td>--</td><td>2</td><td>4</td><td>6</td><td>268</td><td>1</td></tr>
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<tr><td>8. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the Infectious Diseases Protocol, 2008 (or as current).</td><td>✓</td><td>↑</td><td>↑</td><td>↑</td><td>✓</td><td>No activities were conducted during this quarter.</td></tr>
<tr><td>9. The board of health shall maintain systems to support timely and comprehensive communication with all relevant health care and other community partners about identified health hazard risks.</td><td>✓</td><td>↑</td><td>↑</td><td>↑</td><td>✓</td><td>Notification systems were reviewed and updated to ensure timely communication with health care and community partners.</td></tr>
</table>

Status Legend: **✓ = Compliant ↑ = On Target Ø = Partially Compliant 🄸 = Compliant to Date × = Non Compliant**

Infectious Diseases Prevention and Control Q4 2012 (Manager: Edwina Dusome)

Goal: To prevent or reduce the burden of infectious diseases of public health importance.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report infectious disease data elements in accordance with the Health Protection and Promotion Act and the *Infectious Diseases Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	Staff entered reportable disease data into the Integrated Public Health Information System (iPHIS) as per the protocol.
2. The board of health shall conduct surveillance of: • Infectious diseases of public health importance, their associated risk factors, and emerging trends; and • Infection prevention and control practices of inspected premises associated with risk of infectious diseases of public health importance in accordance with the *Infectious Diseases Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	Infection prevention and control practices were reviewed for selected premises by Public Health Inspectors (hair salons, tattoo and body piercing parlours, group homes, etc.) during inspections. Monthly surveillance reports were prepared by the Epidemiologist.
3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	Epidemiological analysis of surveillance data was prepared and distributed by the Epidemiologist.

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Health Promotion and Policy Development						
4. The board of health shall work with community partners to improve public knowledge of infectious diseases of public health importance and infection prevention and control practices in the following areas: • Epidemiology of infectious diseases of public health importance that are locally relevant; • Respiratory etiquette; • Hand hygiene; • Vaccinations and medications to prevent or treat infectious diseases of public health importance; • Infection prevention and control core competencies, incorporating both Routine Practices (including personal protective equipment) and Additional Precautions (transmission-based precautions); and • Other measures, as new interventions and/or diseases arise. These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑	↑	↑	✓	Staff responded to telephone inquiries and conducted inservices where needed. Staff consulted, upon request, with community partners: long-term care facilities, schools, hospital, day nurseries, pharmacies, and primary care practices on infectious disease, vaccine related or infection control related issues.
5. The board of health shall participate on committees, advisory, bodies, or networks that address infection prevention and control practices of, but not limited to, hospitals and LTCHs, which shall include	✓	↑	↑	↑	✓	Staff attended infection control meetings in long-term care homes, and infection control meetings at the hospital. They assisted organizations with the preparation of response plans for infectious diseases and offered, upon request, information to local school boards. Staff attended outbreak control meetings in long term care facilities.

Status Legend: **✓ = Compliant ↑ = On Target Ø = Partially Compliant 🄸 = Compliant to Date × = Non Compliant**

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
consultation on the development and/or revision of: • Infection prevention and control policies and procedures; • Surveillance systems for infectious diseases of public health importance; and • Response plans to cases/outbreaks of infectious diseases of public health importance.						
6. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care and other service providers of: • The local epidemiology of infectious diseases of public health importance; • Infection prevention and control practices; and • Reporting requirements for reportable diseases, as specified in the Health Protection and Promotion Act.	✓	↑	↑	↑	✓	Staff provided information to local partners on communicable diseases and the requirement to report diseases. They provided information on infectious disease and infection and prevention and control via the For Your Information newsletter. Staff worked with partners (long-term care, day nurseries, hospital, schools, etc.) to monitor and reduce the incidence of communicable diseases through regular inspections. Staff conducted educational sessions at the hospital on reportable diseases. Staff arranged for a presentation on tuberculosis for health care providers. Staff arranged presentations on antibiotic resistant organisms and vaccinations for the general public and partners. Staff distributed information to long term care facilities and the hospital to assist with influenza preparation.
Disease Prevention						
7. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to infectious diseases of public health importance in accordance with the Health Protection and Promotion Act; the Mandatory Blood Testing Act; the *Exposure of Emergency Service Workers to Infectious Diseases Protocol, 2008* (or as	✓	🛈	🛈	🛈	✓	The PCCHU has a 24/7 response plan in place.

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
current); the *Infectious Diseases Protocol, 2008* (or as current); the *Institutional/Facility Outbreak Prevention and Control Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).						
8. The board of health shall provide public health management of cases and outbreaks to minimize the public health risk in accordance with the *Infectious Diseases Protocol, 2008* (or as current); the *Institutional/Facility Outbreak Prevention and Control Protocol, 2008* (or as current); and provincial and national protocols on best practices.	✓	↑	↑	↑	✓	Staff provided management of outbreaks. The total number of outbreaks investigated this year to date is: 41. Staff provided information to local health care providers on influenza.
9. The board of health shall ensure that the medical officer of health or designate receives reports of complaints regarding infection prevention and control practices and responds and/or refers to appropriate regulatory bodies in accordance with applicable provincial legislation and in accordance with the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current).	✓	🗓	🗓	🗓	✓	Staff are available to receive and respond to infection prevention and control complaints regarding infection prevention and control practices to appropriate regulatory bodies. The total number of complaints received this year to date is: 2.
10. The board of health shall ensure that the medical officer of health or designate receives reports of and responds to complaints regarding infection prevention and control practices in settings for which no regulatory bodies exist, particularly personal services settings. This shall be done in accordance with the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current) and the	✓	🗓	🗓	🗓	✓	Staff are available to receive and respond to infection prevention and control complaints in settings where no regulatory bodies exist. The total number of complaints received this year to date is: 0.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Infection Prevention and Control Practices Complaint Protocol, 2008 (or as current).						
11. The board of health shall respond to local, provincial/territorial, federal and international changes in disease epidemiology by adapting programs and services.	✓	🛈	🛈	🛈	✓	Staff adapted programs as directed by the Ministry of Health and Long Term Care (MOHLTC), such as providing more detailed follow-up for selected diseases such as influenza, listeria, pertussis, salmonella, etc.
12. The board of health shall supplement provincial efforts in managing risk communications to the appropriate stakeholders on identified risks associated with infectious diseases of public health importance based on local epidemiology and epidemiological information.	✓	↑	↑	↑	✓	Staff provided telephone consultation, presentations, and media releases to supplement provincial risk communication efforts. The For Your Information newsletter was distributed to health care providers.
13. The board of health shall communicate in a timely and comprehensive manner with all relevant health care providers and other partners about urgent and emerging infectious disease issues.	✓	↑	↑	↑	✓	Staff disseminated information to health care providers through alerts, surveillance reports and the For Your Information Newsletter.
Health Protection						
14. The board of health shall inspect settings associated with risk of infectious diseases of public health importance in accordance with the *Infection Prevention and Control in Licensed Day Nurseries Protocol, 2008* (or as current); the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	Staff inspected day nurseries and personal service settings as directed in the protocol. The number of day nurseries inspected this year to date: 20. The number of personal service settings inspected this year to date: 57.

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Prevention of Injury and Substance Misuse Q4 2012

(Managers: Hallie Atter - Substance Misuse Prevention; Injury Prevention)

Goal: To reduce the frequency, severity, and impact of preventable injury and of substance misuse.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						

1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current), in the areas of:
• alcohol and other substances;
• falls across the lifespan;
• road and off-road safety; and
• other areas of public health importance for the prevention of injuries.
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						Injury Prevention (IP)
						Reviewed documents that included Injury Prevention surveillance data and emerging trends including:
						• The Ontario's Chief Coroner's Pedestrian Death Review report.
						• The Ontario's Chief Coroner's *Cycling Death Review* report.
						• Journal articles and papers regarding injury prevention and active transportation as it relates to vulnerable road users (i.e. pedestrians, cyclists etc.) in order to inform official Health Unit comment on the following:
						  • 10-year Housing and Homelessness Plan for the City and County of Peterborough;
						  • County of Peterborough's Transportation Master Plan; and
						  • City of Peterborough's Review of Bylaws Regulating Active Forms of Transportation.
						
						Completed a presentation to the Board of Health on the status of *Falls Across the Ages* in Peterborough County and City.
						
						Substance Misuse Prevention
						Conducted surveillance regarding any perceived changes due to reduced availability of OxyContin and submitted bi-weekly reports to the Ministry of Health.

Health Promotion and Policy Development						
2. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive						**Injury Prevention** Working with a variety of partners and stakeholders to influence both local and provincial policy and programs that will address falls and other injuries including: • *Ontario A Million Messages* (OAMM) Steering Committee (childhood injury prevention); • Peterborough Risk Watch Network (childhood injury prevention);

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🄸 = Compliant to Date × = Non Compliant

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
environments that address the following: • Alcohol and other substances; • Falls across the lifespan; • Road and off-road safety; and may include • Other areas of public health importance for the prevention of injuries as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓ ✓ ✓ ✓	↑ ↑ X X	↑ ↑ Ø Ø	↑ ↑ Ø Ø	✓ ✓ Ø Ø	• Community partners to build a strategy around child car restraints; • Partners In Aging Well Coalition; • Central East Local Health Integration Network (LHIN) and neighbouring Health Units; and • Ministry of Transportation's Eastern Regional Planner. Collaborated with the Nutrition and Physical Activity programs on the Trent Centre for Community Based Education research project on daycare policies. See Chronic Disease Prevention Standard Requirement #6. Provided injury perspective the Ten Year Housing and Homelessness Plan for the City and County of Peterborough, the County of Peterborough's Transportation Master Plan, and the City of Peterborough's Review of Bylaws Regulating Active Forms of Transportation. **Substance Misuse** In order to foster a multi-sectoral approach to reducing the harms from substance use, staff have: • co-facilitated meetings of Peterborough Drug Strategy (PDS) Steering Committee; • shared information on best practice with the Municipal Drug Strategy Coordinators Network of Ontario through bi-monthly teleconference meetings; • participated in presenting the PDS to the County Warden and County Council; and • met with representatives at Hiawatha First Nation to discuss collaboration. In order to reduce the harms from alcohol through policy and supportive environments, staff have: • presented to two Township Councils on municipal alcohol policy (MAP); • supported three townships in the development/updating of their MAP; • participated in the new provincial Alcohol Management In Municipalities Working Group teleconferences to share information on effectively supporting MAPs/local alcohol policy and action; and • promoted new web-based resources on brief interventions regarding alcohol use to physicians.
3. The board of health shall use a comprehensive health promotion approach to increase the capacity of priority						**Injury Prevention** Worked with community partners to develop a car seat safety strategy that addresses the gaps and barriers associated with the correct installation and use of car seats.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
populations to prevent injury and substance misuse by: a. Collaborating with and engaging community partners; b. Mobilizing and promoting access to community resources; c. Providing skill-building opportunities; and d. Sharing best practices and evidence for the prevention of injury and substance misuse.	✓ ✓ ✓ ✓	↑ ↑ ↑ ↑	↑ ↑ ↑ ↑	↑ ↑ ↑ ↑	✓ ✓ ✓ ✓	This included coordinating a Saint John Ambulance Car Seat Technician training course for Auxiliary Police volunteers and members of the Curve Lake Health Centre. As a member of The Peterborough Risk Watch Network, supported the *Look First, Think Twice and Choose Smart!* Safety Contest pilot. Collaborated with community partners, the PCCHU School Health Liaison and the Physical Activity Program to facilitate participation of schools in the Life Saving Society's *Swim to Survive* program. See Chronic Disease Prevention Standard Requirement #7. Organized a Consumer Product Safety presentation by Health Canada for the Family Health Team as well as affiliated community partners such as the Children's Aid Society. Re-engaged members of the Partners In Aging Well coalition (after a gap in staffing) in order to move coalition work ahead in 2013. This included updating members on provincial/regional activities and orienting new Coalition members. Collaborated with a neighboring Health Unit to further develop a learning tool for front line staff/volunteers/students in the prevention of falls in the older adult population. **Substance Misuse Prevention** To increase the capacity of priority populations to avoid and respond to overdoses, staff have: • hosted a train-the-trainer session on overdose prevention; • participated in teleconference with health partners in the province to advocate and educate to make overdose prevention tools and resources more available; and • supported a partner agency in writing a business case for Central East Local Health Integration Network (CE-LHIN) funding related to overdose prevention. Co-hosted meetings of the Four County Harm Reduction Coalition and the Peterborough Drug Awareness Coalition to share current programs and plan initiatives.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🄸 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
						Co-wrote a Trillium Foundation grant to support youth engagement around tobacco and marijuana use. To increase local capacity to provide school-based peer-delivered drug prevention messaging, staff: • provided refresher-trainings to Peer Leaders in three high schools who will provide three hours of drug prevention messaging in 22 Grade 8 classrooms; and • supported logistical elements of the CBC program (transportation, t-shirts, group development, evaluation, etc.). Initiated a pilot program to train/mentor youth with lived experience of drug use to tell their stories. Hosted a meeting with a national expert on cannabis and local providers of services to women who are pregnant and post partum to increase knowledge of impacts of parental cannabis use on child development. Collaborated on planning the implementation of a PHO funded locally developed collaborative project research on increasing adherence to the Low Risk Drinking Guidelines. Hosted a teleconference about the role and mandate of the eight new Community Care Access Centre (CCAC) mental health nurses.
4. The board of health shall increase public awareness of the prevention of injury and substance misuse in the following areas: • Alcohol and other substances; • Falls across the lifespan; • Road and off-road safety; and may include • Other areas of public health importance for the prevention of injuries, as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓ Ø Ø Ø	↑ X ↑ X	↑ ↑ Ø Ø	↑ ↑ Ø Ø	↑ ↑ Ø Ø	**Injury Prevention** Completed a presentation on Car Seat Safety for the Teen Prenatal Supper Club. Completed a Lunch n' Learn at the Curve Lake Health Centre on Car Seat Safety. Met with a Trent University B.Ed student to create a preliminary work plan to align the Risk Watch Resource for Teachers with the new Ontario curriculum for the 2012/2013 school year. Provided information for a media release regarding safety tips for pedestrians and drivers. **Substance Misuse Prevention** Hosted YouthSpeak to have two youth share their stories of struggling with addiction

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🛈 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.						at a local high school assembly. Collaborated on a presentation regarding cannabis use and impacts on adolescent development to parents and professionals. Co-hosted an interactive session with youth to share information about cannabis use. Distributed brochures about the National Low Risk Drinking Guidelines to internal and external partners.
Health Protection						
5. The board of health shall use a comprehensive health promotion approach in collaboration with community partners, including enforcement agencies, to increase public awareness of and adoption of behaviours that are in accordance with current legislation related to the prevention of injury and substance misuse in the following areas: • Alcohol and other substances; • Falls across the lifespan; • Road and off-road safety; and may include • Other areas of public health importance for the prevention of injuries as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓ ✓ Ø Ø	↑ Ø ↑ X	Ø Ø ↑ Ø	Ø Ø Ø Ø	Ø Ø Ø Ø	Consulted via telephone with caregivers on their specific concerns and requests related to car seat safety.

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Public Health Emergency Preparedness Q4 2012 (Manager: Donna Churipuy)

Goal: To enable and ensure a consistent and effective response to public health emergencies and emergencies with public health impacts.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall identify and assess the relevant hazards and risks to the public's health in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	A Hazard Identification and Risk Assessment was completed and approved by the Medical Officer of Health.
Health Protection/Emergency Planning						
2. The board of health shall develop a continuity of operations plan to sustain the ongoing functioning of time-critical board of health services during business disruptions in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Draft recovery strategies were developed for various disasters that could affect the infrastructure and/or operations of the Health Unit.
3. The board of health shall develop its emergency response plan, in consultation with community partners and governmental bodies, to address the identified hazards for which the board of health and medical officer of health will	✓	↑	✓	✓	✓	

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
have a lead role in responding to, consistent with an Incident Management System and in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).						
Risk Communications and Public Awareness						
4. The board of health shall develop, implement, and document 24/7 notification protocols for communications with board of health staff, community partners, and governmental bodies to facilitate the sharing of information in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	The notification protocol was updated.
5. The board of health shall, in collaboration with community partners, increase public awareness regarding emergency preparedness activities.	✓	↑	↑	↑	✓	The public was notified that the Health Unit has activated the Extreme Cold Response Plan for the winter season.
Education, Training, and Exercises						
6. The board of health shall ensure the provision of emergency preparedness and response education and training for board of health staff in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Training sessions for all staff on the Hazard Identification and Risk Assessment, Incident Management System and the Continuity of Operations Plan were completed during the fourth quarter.
7. The board of health shall ensure that its officials are oriented on the board of health's emergency response plan in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	A presentation (with a voice over) of the Health Unit Emergency Response System was developed. It will be posted to the Health Unit intranet.

Status Legend: **✓ = Compliant ↑ = On Target Ø = Partially Compliant i = Compliant to Date × = Non Compliant**

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
8. The board of health shall exercise, in whole or in part, the continuity of operations plan, emergency response plan, and 24/7 notification procedures in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	As part of the staff training conducted in the fourth quarter, table top exercises were conducted to enhance understanding of the Incident Management System.

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Rabies Prevention and Control Q4 2012 (Manager: Atul Jain)

Goal: To prevent the occurrence of rabies in humans.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall liaise with the Canadian Food Inspection Agency to identify local cases of rabies in animal species.	✓	↑	↑	↑	✓	Year-to-date 2012: Four rabid bats were reported in the PCCHU's geographic area.
2. The board of health shall report rabies data elements in accordance with the Health Protection and Promotion Act and the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Information on eight incidents where post-exposure prophylaxis was provided was entered into the Ministry of Health and Long Term Care (MOHLTC) database. Year-to-date: 33.
3. The board of health shall conduct surveillance of rabies in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) and the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	The Fourth Quarter Animal Rabies Report for Ontario has not been published yet. Year-to-date: 27 (24 bats, 1 dog, 1 skunk and 1 cat).
4. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	There have been no cases of human rabies in this area. There was one human case reported in Toronto, with the virus being acquired in the Dominican Republic.
Health Promotion and Policy Development						
5. The board of health shall work with community partners to improve public knowledge of rabies and its prevention in the	✓	↑	✓	✓	✓	Year to date: a total of 1,821 animals were vaccinated at low-cost rabies clinics. Last year's total was 1,538 animals. This was an increase of 15%. More advertising of the clinic date was done this year with both local radio and television ads being purchased.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
community by supplementing national/provincial education/communications strategies and/or developing and implementing regional/local communications strategies[24] based on local epidemiology.						
Disease Prevention/ Health Protection						
6. The board of health shall annually remind those individuals specified in the Health Protection and Promotion Act of their duty to report suspected rabies exposure.	✓	↑	↑	✓	✓	Peterborough City and County veterinarians, hospital, and police services were reminded of their obligation to notify the Health Unit of any animal bites or other animal contact which may result in rabies in persons.
7. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to suspected rabies exposures in accordance with the Health Protection and Promotion Act; the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Fifty-one incidents of possible transmission of the rabies virus were investigated. Year-to-date 2012: 233 Year-to-date 2011: 252 Eight series of anti-rabies vaccine and globulin were distributed. Year-to-date 2012: 33 Year-to-date 2011: 26 In December, the Ministry of Health and Long-Term Care changed the rabies post-exposure prophylaxis vaccine schedule from 5 doses to 4.
8. The board of health shall address the prevention and control of rabies threats as per a local Rabies Contingency Plan, as outlined in the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	The MOHLTC has not requested development of a Rabies Contingency Plan.

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Reproductive Health and Healthy Babies Healthy Children; Q4 2012 (Manager: Karen Chomniak)

To enable individuals and families to achieve optimal preconception health, experience a healthy pregnancy, have the healthiest newborn(s) possible, and be prepared for parenthood.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) in the areas of: • Preconception health; • Healthy pregnancies; • Reproductive health outcomes; and • Preparation for parenting.	✓	↑	↑	↑	✓	
Health Promotion and Policy Development						
2. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and the creation or enhancement of supportive environments to address: • Preconception health; • Healthy pregnancies; and • Preparation for parenting. These efforts shall include: a. Conducting a situational assessment in accordance with the *Population Health Assessment and Surveillance Protocol,*	✓	↑	↑	↑	✓	Staff participated in one Ontario Public Health Association (OPHA) Reproductive Health (RH) Working Group and Supporting Normal Birth Task Group Task Group sessions. Staff contributed to the development of the Briefing Note: Supporting, Protecting, and Promoting Normal Birth in Ontario. With Dr Pellizzari, staff participated in a teleconference of the Provincial Council for Maternal and Child Health (PCMCH) to advocate for a reproductive health culture that supports and values normal birth as part of a healthy continuum from preconception to parenting. Situational assessments regarding healthy weights in pregnancy and smoking rates among pregnant and post-partum women were completed. Smoking cessation messaging has been incorporated into In TOUCH workshops and the Teen Prenatal Supper Club (TPSC).

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
2008 (or as current); and b. Reviewing, adapting, and/or providing behaviour change support resources and programs.						
3. The board of health shall increase public awareness of preconception health, healthy pregnancies, and preparation for parenting by: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑	↑	↑	✓	The Best Start Resource Centre launched its awareness campaign: Healthy Babies Healthy Brain. Evidence-based resources for parents to support early brain development were obtained and have been incorporated into adult prenatal classes. A Skin-to-Skin literature search and review was completed. The Skin-to-Skin Campaign was launched via the Health Unit website, radio, TV, bus ads, and posters.
4. The board of health shall provide, in collaboration with community partners, prenatal programs, services, and supports, which include: a. Consultation, assessment, and referral; and b. Group sessions.	✓	↑	↑	↑	✓	20 adult prenatal classes were taught in the fourth quarter and a total of 105 classes were taught in 2012. Breastfeeding class curriculum was reviewed with Child Health staff to ensure content is compliant with Baby Friendly (BFI) requirements. An overview was provided of local Perinatal Support Services to Dr McLaughlin (medical student). 157 "Your First Prenatal Visit" packages were distributed to local physicians and midwives.
5. The board of health shall provide advice and information to link people to community programs and services on the following topics: • Preconception health; • Healthy pregnancies; and • Preparation for parenting.	✓	↑	↑	↑	✓	The Skin-to-Skin Campaign was launched.
6. The board of health shall provide, in collaboration with community partners, outreach to priority populations to link them to information, programs, and services.	✓	↑	↑	↑	✓	A series of six TPSC classes were held with eight pregnant women and their support persons attending. Meetings were held with staff from the School for Young Moms and the Peterborough

Status Legend: **✓ = Compliant ↑ = On Target Ø = Partially Compliant 🄸 = Compliant to Date × = Non Compliant**

<table>
<tr><th rowspan="2">Requirement</th><th>Status 2011</th><th colspan="4">Status 2012</th><th rowspan="2">Comments</th></tr>
<tr><th>4th</th><th>1st</th><th>2nd</th><th>3rd</th><th>4th</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Alternative Continuing Education to facilitate Health Unit programming at both locations.</td></tr>
<tr><td colspan="7">Disease Prevention/ Health Protection</td></tr>
<tr><td>7. The board of health shall provide all the components of the Healthy Babies Healthy Children Program in accordance with the Healthy Babies Healthy Children Protocol, 2008 (or as current) (Ministry of Children and Youth Services).</td><td>Ø</td><td>Ø</td><td>Ø</td><td>Ø</td><td>Ø</td><td>
<table>
<tr><th>Healthy Babies, Healthy Children (HBHC) Program Activities</th><th>Q4 2012*</th><th>2012* Year to Date</th><th>2011 Year to Date</th></tr>
<tr><td>Number of prenatal screens received</td><td>122</td><td>583</td><td>492</td></tr>
<tr><td>Number of postpartum screens received</td><td>231</td><td>994</td><td>1053</td></tr>
<tr><td>Number of postpartum contacts</td><td>243</td><td>1014</td><td>1046</td></tr>
<tr><td>Number of families receiving postpartum home visits</td><td>21</td><td>99</td><td>168</td></tr>
<tr><td>Number of In Depth Assessments completed</td><td>30</td><td>123</td><td>152</td></tr>
<tr><td>Number of joint home visits provided</td><td>59</td><td>213</td><td>331</td></tr>
<tr><td>Number of home visits provided – PHNs</td><td>100</td><td>374</td><td>507</td></tr>
<tr><td>Number of home visits provided – FHVs</td><td>167</td><td>593</td><td>684</td></tr>
</table>
* Figures to December 31, 2012

From December 2011 to December 2012, all five Public Health Nurses (PHNs) assigned to HBHC have each commenced a maternity leave of absence. Over this period, significant time has been spent in the orientation of four new PHNs, resulting in the need to maintain a waiting list of new referrals to the high-risk home visiting component of HBHC; this has then affected the overall number of home visits provided in comparison to the same time last year. The HBHC program continued to gap a 1.0 full-time equivalent PHN position.
</td></tr>
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Safe Water Q4 2012 (Manager: Atul Jain)

Goals: To prevent or reduce the burden of water-borne illness related to drinking water. To prevent or reduce the burden of water-borne illness and injury related to recreational water use.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report Safe Water Program data elements in accordance with the *Beach Management Protocol, 2008* (or as current); the *Drinking Water Protocol, 2008* (or as current); and the *Recreational Water Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Monthly reports on Small Drinking Water Systems (SDWS) assessments were provided to the Ministry of Health and Long Term Care (MOHLTC). Phase I SDWS Inventory Wrap-Up Survey was completed in the fourth quarter. This survey involved an extensive review of all 314 SDWS to determine which assessments were phase 1 or phase 2 assessments and the resulting shift in risk levels during each phase. Adverse notifications were reported in the MOHLTC's database. To date the MOHLTC has requested completion rates for the number of Class A pool inspections for the period January 1- December 31, 2012 as part of the Accountability Agreements. We have a 100% completion rate.
2. The board of health shall conduct surveillance of drinking-water systems and of drinking water illnesses of public health importance, their associated risk factors, and emerging trends in accordance with the *Drinking Water Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	No clusters of illnesses related to drinking water were identified.
3. The board of health shall conduct surveillance of public beaches and public beach water illnesses of public health	✓	↑	↑	✓	✓	The Health Unit monitors 16 public beaches.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
importance, their associated risk factors, and emerging trends in accordance with the *Beach Management Protocol, 2008* (or as current).						
4. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	No clusters of illnesses related to drinking water, recreational water, or beach use were identified.
5. The board of health shall conduct surveillance of recreational water facilities in accordance with the *Recreational Water Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Twelve inspections of pools, spas, wading pools and splash pads were conducted. Year-to-date 2012: 212 Year-to-date 2011: 206
Health Promotion and Policy Development						
6. The board of health shall provide information to private citizens who operate their own wells, cisterns, rain or lake water system to promote their awareness of how to safely manage their own drinking-water systems.	✓	↑	↑	↑	✓	Inspectors provided 77 consultations with the public about sample result interpretation, and maintaining and improving well water quality. Year-to-date 2012: 525 Year-to-date 2011: 886
7. The board of health shall provide education and training for owners/operators of drinking-water systems in accordance with the *Drinking Water Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	A Public Health Inspector provided informal training and guidance to operators during SDWS inspections.
8. The board of health shall increase public awareness of water-borne illnesses and safe drinking water use by: a. Adapting and/or supplementing national and provincial safe drinking water communications strategies; and/or	✓	↑	↑	↑	✓	*How Well Is Your Well* and *Water Wells: Best Management Practices* were distributed through Municipal offices, the Public Health Lab, and the Health Unit.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
b. Developing and implementing regional/local communications strategies.						
9. The board of health shall provide education and training for owner/operators of recreational water facilities in accordance with the *Recreational Water Protocol, 2008* (or as current).	✓	↑	↑	✓	✓	The Health Unit provided replacement copies of the pool operator's manual and the pubic spa operator's manual to local operators and facilities.
Disease Prevention/ Health Protection						
10. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to: • Adverse events related to safe water, such as reports of adverse drinking water on drinking-water systems governed under the Health Protection and Promotion Act or the Safe Drinking Water Act; • Reports of water-borne illnesses or outbreaks; • Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and • Safe water issues relating to recreational water use including public beaches in accordance with the Health Protection and Promotion Act; the *Beach Management Protocol, 2008* (or as current); the *Drinking Water Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current);	✓	↑	↑	↑	✓	Staff responded to nine adverse drinking water reports. Year-to-date 2012: 58 Year-to-date 2011: 77

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
and the *Recreational Water Protocol, 2008* (or as current).						
11. The board of health shall provide all the components of the Safe Water Program in accordance with all applicable statutes and regulations, and the *Drinking Water Protocol, 2008* (or as current) to protect the public from exposure to unsafe drinking water.	✓	↑	↑	↑	✓	As reported to the Board of Health in February, the Health Unit is beginning the monitoring phase of the SDWS portion of the Safe Water program, and has conducted 20 risk assessments and re-assessments in the fourth quarter.
12. The board of health shall inform the public about unsafe drinking water conditions and provide the necessary information to respond appropriately in accordance with the *Drinking Water Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Six Boil Water Advisories were issued. Year-to-date 2012: 21 Year-to-date 2011: 21
13. The board of health shall reduce risks of public beach use by implementing a beach management program in accordance with the *Beach Management Protocol, 2008* (or as current).	✓	↑	✓	✓	✓	
14. The board of health shall reduce the risks of recreational water facility use by implementing a management program in accordance with the *Recreational Water Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	As noted above, there were 12 inspections of pools, spas, wading pools and splash pads. Year-to-date 2012: 212 Year-to-date 2011: 206

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Sexual Health, Sexually Transmitted Infections, and Blood Borne Infections (including HIV) Q4 2012 (Manager: Patti Fitzgerald)

Goals: To prevent or reduce the burden of sexually transmitted infections and blood borne infections and to promote healthy sexuality.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report data elements on sexually transmitted infections and blood-borne infections in accordance with the Health Protection and Promotion Act and the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	Reported cases of sexually-transmitted (STIs) and blood-borne infections (BBIs) are reported electronically, on a monthly basis, to the Ministry of Health and Long-Term Care (MOHLTC) via the Integrated Public Health Information Surveillance (iPHIS) system.
2. The board of health shall conduct surveillance of: • Sexually transmitted infections (STI); • Blood-borne infections (BBI); • Reproductive outcomes; • Risk behaviours; and • Distribution of harm reduction materials/equipment in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) and the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Staff provided case management for 124 cases of sexually transmitted (STI) and blood-borne (BBI) infections, and provided follow-up for 26 contacts of reported cases. Staff performed 652 clinical assessments related to STIs/BBIs.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	The Epidemiologist provides reports on reportable diseases quarterly.
Health Promotion and Policy Development						
4. The board of health shall increase public awareness of the epidemiology, associated risk behaviours, risk factors, and risk reduction strategies related to healthy sexuality, sexually transmitted infections, and blood-borne infections by: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑	↑	↑	✓	The *Use Condom Sense* campaign was further disseminated through the local media (radio), transit ads, promotional products (swag), and the promotional efforts of our community partners. Use Condom Sense posters were distributed to many locations throughout Peterborough.
5. The board of health shall use a comprehensive health promotion approach to increase the community capacity regarding the promotion of healthy sexuality, including the prevention of adolescent pregnancies, sexually transmitted infections, and blood-borne infections, by: a. Collaborating with and engaging community partners and priority populations; b. Mobilizing and promoting access to community resources;	✓	↑	↑	↑	✓	Public Health Nurses (PHN's) continue to provide consultation to health care professionals to ensure that cases of STIs/BBIs are managed and treated as per current guidelines. A Sexual Health PHN attended the following with our community partners: • Rainbow Coalition Meeting; • HIV conference ("Opening Doors); and • Transcultural Sensitivity Competence workshop.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
c. Providing skill-building opportunities; and d. Sharing best practices and evidence.						
6. The board of health shall collaborate with community partners, including school boards, to create supportive environments to promote healthy sexuality and access to sexual health services.	✓	↑	↑	↑	✓	PHNs provided maturation and sexuality classes to 16 grade eight classes (within both local school boards). A PHN attended the School for Young Moms to promote clinic services, education on sexual health, sexually transmitted infections and contraception. A PHN provided two education sessions for Alternatives Community Program Services (for adults with developmental disabilities). PHNs provided two In Touch facilitated workshops. Outreach clinic services were offered monthly at high schools in Lakefield and Norwood.
Disease Prevention/ Health Protection						
7. The board of health shall provide clinical services for priority populations to address contraception, comprehensive pregnancy counselling, sexually transmitted infections, and blood-borne infections. For further information, refer to the *Sexual Health Clinic Services Manual, 2002* (or as current).	✓	↑	↑	↑	✓	PHNs and physicians conducted 222 clinical assessments related to contraception and pregnancy and 652 clinical assessments related to testing and treatment for STI/BBIs. PHNs also investigated and followed-up all reported community cases of STI/BBIs (see # 2).
8. The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with the Health Protection and Promotion Act and the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	The Emergency Service Worker (ESW) Protocol /Mandatory Blood Testing Act provides for risk assessment, advice and follow-up following potential occupational exposures to blood-borne infections. There was no reported exposure reported this quarter. All STI reports for Health Care Providers were reviewed and revised.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
9. The board of health shall provide or ensure access to provincially funded drugs for the treatment of sexually transmitted infections, at no cost to clients, in accordance with the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Provincially-funded medications for the treatment of STIs are dispensed at the Sexual Health Clinic. Two more clinic offices were added to our Community STI Medication Distribution program.
10. The board of health shall communicate and coordinate care with health care providers to achieve a comprehensive and consistent approach to the management of sexually transmitted infections and blood-borne infections.	✓	↑	↑	↑	✓	PHNs continue to work collaboratively with community Medical Doctors/Nurse Practitioners to ensure cases of STI/BBIs are managed and treated appropriately as per current guidelines.
11. The board of health shall engage community partners and priority populations in the planning, development, and implementation of harm reduction programming.	✓	↑	↑	↑	✓	To increase awareness of the importance of access to and use of condoms in preventing transmission of STIs, 13,270 condoms were distributed through clinic, youth-serving agencies, and organizations that interface with priority populations. Harm Reduction Works, operated by PARN - Your Community AIDS Resource Network on behalf of the Peterborough County-City and the Haliburton, Kawartha, Pine Ridge Health Unit, has five fixed sites, two of which are in Peterborough: PARN and Four Counties Addictions Services Team (4CAST). **Needle Exchange Program Activity Report for 2012 not yet available from PARN
12. The board of health shall ensure access to a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance.	✓	↑	↑	↑	✓	Peterborough City and County residents have access to needles, syringes, condoms, and other harm reduction supplies through a number of venues.

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Tuberculosis Prevention and Control Q4 2012 (Manager: Edwina Dusome)

Goal: To prevent or reduce the burden of tuberculosis.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report TB data elements in accordance with the Health Protection and Promotion Act and the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	🗓	🗓	🗓	✓	Staff entered data into the Integrated Public Health Information System (iPHIS).
2. The board of health shall conduct surveillance of active tuberculosis as well as individuals with LTBI in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) and the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	🗓	🗓	🗓	✓	Staff investigated all reports of active or latent TB infections.
3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	🗓	🗓	🗓	✓	All suspected and confirmed cases were entered into iPHIS. Due to the few staff investigating and the few cases of active TB occurring, staff are cognizant of the mode of transmission and closely monitor for trend and priority populations.
Health Promotion and Policy Development						
4. The board of health shall engage in health promotion and policy development activities with community partners, policy-makers, and health care providers that have clients/contacts from priority populations based on local epidemiology.	✓	↑	✓	✓	✓	World TB Day funds were used to promote TB awareness to the community and health care providers.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Disease Prevention/ Health Protection						
5. The board of health shall facilitate timely identification of active cases of TB and referrals of persons with inactive TB through immigration medical surveillance in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Staff responded to reports of active TB and immigration medical surveillance reports, provided follow-up and made recommendations to minimize public health risk (i.e. isolation, medication, Mantoux testing).
6. The board of health shall provide management of cases to minimize the public health risk in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Staff distributed anti-tuberculosis medication to individuals and/or health care providers for distribution to appropriate clients. In some instances, directly observed therapy was required.
7. The board of health shall provide or ensure access to TB medication at no cost to clients or providers.	✓	↑	↑	↑	✓	14 clients are receiving anti-tuberculosis medication year to date and two clients were initiated this quarter.
8. The board of health shall provide or ensure the provision of the identification, assessment, and public health management of contacts of active cases in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Staff conducts follow-up of contacts of active TB.
9. The board of health shall provide or ensure the provision of the identification and effective public health management of individuals with LTBI in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current), with a particular focus on people at highest risk of progression to active TB.	✓	↑	↑	↑	✓	Year to date is 32 cases.
10. The board of health shall respond to local, provincial/territorial, federal, and international changes in disease epidemiology by adapting programs and services.	✓	↑	↑	↑	✓	No changes were required this quarter.

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Vaccine Preventable Diseases Q4 2012 (Manager: Edwina Dusome)

Goal: To reduce or eliminate the burden of vaccine preventable diseases.

Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall assess, maintain records and report, where applicable, on: • The immunization status of children enrolled in licensed child care programs as defined in the Day Nurseries Act; • The immunization status of children attending schools in accordance with the Immunization of School Pupils Act; and • Immunizations administered at board of health-based clinics as required In accordance with the *Immunization Management Protocol, 2008* (or as current) and the *Infectious Diseases Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	The percent of day nursery attendees adequately immunized for their age is 69%. The percent of students in elementary and secondary schools adequately immunized for their age is 91%. The number of immunizations administered at the PCCHU Immunization Clinic was 218.
2. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Infectious Diseases Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	🛈	🛈	🛈	✓	Staff reviewed monthly reports of communicable diseases and identified risk factors. The epidemiologist provided quarterly communicable disease reports.
Health Promotion and Policy Development						
3. The board of health shall work with community partners to improve public	✓	↑	↑	↑	✓	Staff offered telephone consultation on immunization to the general public and health care providers. Immunization information was posted on the PCCHU web site.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
knowledge and confidence in immunization programs by: a. Supplementing national and provincial health communications strategies, and/or b. Developing and implementing regional/local communications strategies. Topics to be addressed shall include: • The importance of immunization. • Diseases that vaccines prevent. • Recommended immunization schedules for children and adults and the importance of adhering to the schedules; • Introduction of new provincially funded vaccines; • Promotion of childhood and adult immunization, including high-risk programs; • The importance of maintaining a personal immunization record for all family members; • The importance of reporting adverse events following immunization; • Reporting immunization information to the board of health as required; • Vaccine safety; and • Legislation related to immunizations.						Immunization information on selected vaccines was distributed to parents of students in Grades 7 and 8. Staff visited health care providers to offer information on immunization and vaccine safety during cold chain inspections and sent information to parents of students and day care attendees. Information on immunization was included in the *For Your Information* newsletter for health care providers.
4. The board of health shall promote the reporting of adverse events following immunization by health care providers to the local board of health in accordance with the Health Protection and Promotion Act.	✓	↑	↑	↑	✓	Health care workers were reminded, via the *For Your Information* newsletter, to report adverse vaccine reactions.
5. The board of health shall provide a comprehensive information and education	Ø	↑	↑	↑	✓	The number of cold chain inspections conducted this year to date: 106.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
strategy to promote optimal vaccine management, including storage and handling practices, among health care providers in accordance with the *Vaccine Storage and Handling Protocol, 2008* (or as current). This shall include: • One-on-one training at the time of cold chain inspection; • Distributing information to new health care providers who handle vaccines; and • Providing ongoing support to existing health care providers who handle vaccines.						
6. The board of health shall provide consultation to community partners to develop immunization policies (e.g., workplace policies) based on local need and as requested.	✓	↑	↑	↑	✓	No requests were received this quarter.
Disease Prevention/ Health Protection						
7. The board of health shall promote and provide provincially funded immunization programs to any eligible person in the health unit, including: • Board of health-based clinics; • School-based clinics (including, but not limited to, hepatitis B and meningococcal immunization); • Community-based clinics, and • Outreach clinics to priority populations.	✓	↑	↑	↑	✓	NOTE: The data below is for the calendar year and not by school year: Staff immunized Grade 7 students with Hepatitis B: first dose 464; second dose 15; third dose 0 (note: the schedule was changed from three doses to two doses to complete the series). Staff immunized Grade 7 students with the Meningitis vaccine: 463 Staff immunized Grade 8 females with the human papilloma virus vaccine: first dose 435; second dose 235, and third dose 5 (to date, more to follow). Staff have conducted a partial cleansing of the Immunization Record Information System in preparation for the Panorama (new Ministry of Health immunization and reportable disease database).

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
8. The board of health shall, as part of the Public Health Emergency Preparedness Program Standard, have a contingency plan to deploy board of health staff capable of providing vaccine preventable disease outbreak management control such as mass immunization in the event of a community outbreak.	✓	↑	↑	↑	✓	The Health Unit mass vaccination plan (as part of the PCCHU Pandemic Plan) was updated in 2010 to include lessons learned from the pandemic response. It is available on the Health Unit website. The Peterborough Interagency Outbreak Planning Team conducted an information session on pandemic influenza in May 2012.
9. The board of health shall provide or ensure the availability of travel health clinics.	✓	↑	↑	↑	✓	Travel clinic services were offered on Tuesdays, Wednesdays and Thursdays by appointment. The following provides the statistics on the clinic (year-to-date): # of clients seen: 1,077 # of phone consults: 2,657 # of yellow fever immunizations: 97 # hep A and hep B high risk: 0 # immunizations covered by OGP: 388 # other immunizations: 1,690 Total immunizations administered: 2,078
Health Protection						
10. The board of health shall ensure the storage and distribution of provincially funded vaccines including to health care providers practicing within the health unit in accordance with the *Vaccine Storage and Handling Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Distributed vaccines to community partners and facilities. Total amount of doses of government funded vaccine distributed: 9,241 this quarter.
11. The board of health shall promote vaccine inventory management in all premises where provincially funded vaccines are stored in accordance with the *Vaccine Storage and Handling Protocol, 2008* (or as current).	✓	↑	↑	↑	✓	Promotion conducted during inspection of premises through telephone consultation, For Your Information newsletter, and through investigation of cold chain incidents. All premises storing these vaccines are inspected once yearly.
12. The board of health shall health shall monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial	✓	🗓	🗓	🗓	✓	The number of adverse events reported this year to date is: 29.

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Requirement	Status 2011	Status 2012				Comments
	4th	1st	2nd	3rd	4th	
reporting criteria and promptly report all cases						
13. The board of health shall comply with the Immunization Management Protocol, 2008 (or as current), that specifies the process for the assessment of the immunization status of children in licensed day nurseries as defined in the Day Nurseries Act and the enforcement of the Immunization of School Pupils Act.	✓	↑	↑	↑	✓	In January, staff initiated the collection of immunization information for children/ students in day nurseries and schools and suspended, if necessary, those with no or inadequate immunization information on file. During the summer, letters were sent to parents of students with no or inadequate immunization information on file requesting follow-up. The Immunization process for school-age students was initiated mid October.

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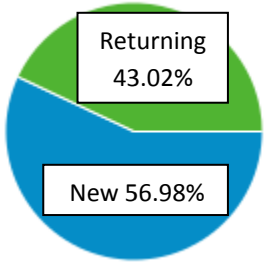
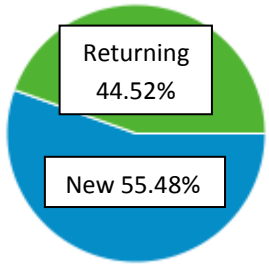
Communications 2012 Q4 (Supervisor, Communications Services: Brittany Cadence)

Media Relations:

Activity	Q4		Year To Date	
	2012	2011	2012	2011 (whole year)
Press releases issued	39	18	134	86
Media interviews	27	17	150	118
Number of media stories directly covering PCCHU activities (print and TV only, and some radio when stories posted online)	93	37	334	208

Website Statistics:

Q4 Comparisons	2012	2011	Year To Date	
			2012	2011
Website Traffic	**58,504** page views	**67,652** page views	240,252 page views	233,967 page views
% change in website traffic	-13.52%	--	+2.62%	--
New/Returning visitors				
Pages/Visit	3.01 (+18.53%)	2.54	N/A	N/A
Average Visit Time	2:28 (+18.53%)	2:54		
Visits from Mobile Phones	2460 (+87.93%)	1309		

PCCHU Website:

The website is continuously maintained to keep content fresh, increase interactivity and functionality. The focus of this quarter was enhancing security and training staff how to use the content management system.

Social Media:

In the fourth quarter, we became very active in our communications via social media networks, especially with regards to promoting our flu clinics. We utilized Twitter to update the public in real time on the status of our clinics wait times. We received very positive response and feedback on this from both the media and the public.

Activity	Q4		Year To Date	
	2012	2011	2012	2011 (whole year)
Twitter (@PCCHU):				
Tweets	126	N/A	167	N/A
Re-tweets (re-posting of content from those we follow i.e. Health Canada)	16		16	
Followers	146	N/A	340	N/A
Facebook (search: Peterborough County-City Health Unit):				
Likes	7	N/A	16	N/A
Events Promoted	0	N/A	3	N/A
Posts	45	N/A	47	N/A

Q4 Graphic Design Projects

PCCHU Corporate:
- Media Releases
- Alerts and Advisories
- Update IT Electronic Forms – IT New Employee Request, IT Employee Transfer Request, IT Employee Termination Request
- Media Banners (3)
- A Handbook for Personal Safety and Violence Prevention in the Workplace

Dental:
- Appointment Cards
- Dental Mobile Schedule (x2)

Family/Child Health:
- Skin-to-Skin Campaign – Final Materials (3 Posters, Brochure, Fact Sheet, 2 Bus Ads)
- Physician Nipissing Flowchart – Update
- BFI Plaque

Health Hazards
- Air Quality Index

Cancer Prevention
- Cervical Screening Grand Rounds – Poster
- Promotional Pencils (Be Sun Smart & Screen for Life)
- Cancer Screening Banners (x4)
- Cancer Screening – T-shirt
- Cancer Screening Day – Invitation & Evaluation

Nutrition
- NOURISH – Brochure
- Food For Kids Annual Report
- Food in Peterborough – Bookmark
- NTS Bookmark
- Healthy Toddler - Pamphlet

School Health
- Building Healthy Schools Display

Substance Misuse
- Overdose Poster

Tobacco
- Butt Out Your Way – Banner
- MUDS – Kijijii Ad
- Choose to Be – Brochure Update

Triple P
- Peterborough Kids Ad

Youth Engagement
- Intramural Peer Leader Workshop – Invitations & Binder Covers
- The Teen Brain - Poster

Sexual Health:
- Condom Sense Campaign – Pen, Stress Sperm, Water Bottle, Fling Ring
- Clinic Signs

Inspection Services
- How Well is Your Well

Injury Prevention
- Swim to Survive - Flyer
- Risk Watch Photo Contest - Poster

Genetics Q4 2012 (Manager: Patti Fitzgerald)

Program Activity	October 2012	November 2012	December 2012	2012 Year-to-Date	2011 Year-to-date
Total # referrals:	39	20	18	310	273
• Prenatal	7	2	3	43	40
• cancer	13	9	8	161	124
• other (general)	19	9	7	106	109
Total # counselling sessions	18	29	5	259	234
• # clients attending	16	32	5	277	250
• # others attending	8	6	1	77	98
Total # clinic attendance	-	16	10	104	95
• # clients	-	7	5	48	48
• # others	-	9	5	56	47
# Consultations to health care providers*	0	0	0	12	19
# Consultations to other individuals/agencies*	4	0	0	51	59
# Promotional activities	0	0	0	4	6

* does not include consultations on specific clients

Infant and Toddler Development Q4 2012 (Manager: Karen Chomniak)

Infant and Toddler Development (ITDP) Program Activities	Q4 2012	2012 Year-to-Date	2011 Year-to-Date
New referrals	37	124	102
Children discharged from program	38	125	93
Children on current caseload	93	93	102
Home/agency visits	207	799	825
Visits provided in group settings	0	22	58

The Infant and Toddler Development Program (ITDP) has continued with a steady stream of new referrals, ongoing home and agency visits, consultations to community programs, consultations with community agencies, and program planning for 2013.

Two Infant Development Workers (IDWs) attended the annual Ontario Association of Infant and Child Development conference in October. The IDWs attended concurrent sessions and returned with a wealth of relevant information on topics such as attachment, Fetal Alcohol Syndrome, sleep assessments, stress, and Autism Spectrum Disorder.

The IDWs met with two staff of the Family and Youth Clinic to discuss strategies to help IDWs work with families experiencing difficulties with attachment and/or feeding.

The IDWs met with representatives of Five Counties Children's Centre to facilitate coordinated referrals between their agency and the ITDP.

Sewage Disposal Program Q4 2012 (Manager: Atul Jain)

	Oct 2012	Nov 2012	Dec 2012	Total Q4 2012	2012 Year-to-Date	2011 Year-to-Date
Applications for Sewage System Permits	43	38	25	106	376	295
Permits Issued	40	35	20	95	343	277
Applications for Severance	4	7	12	23	85	76
Applications for Subdivision (# of Lots)	3	0	0	3	3	0
Existing Systems and Complaints	14	13	1	28	115	95

Staff Report

Q4 2012 Financial Report

Date:	February 13, 2013
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Bob Dubay, Accounting Supervisor

Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive the *Q4 (Fourth Quarter) 2012 Financial Report*, for information.

Financial Implications and Impact

This report provides a pre-audit look at results from 2012 financial operations. Most of the numbers provided to the Board will not change, but some may be adjusted slightly as more accurate information becomes available.

To this end, we have not reported on the Ontario Works Dental program administered by the Board. In this program, dental services are offered to Ontario Works clientele and most of the dental work is performed by private dentists and paid for by the program. Provincial rules allow dentists to bill the program up to 2 months after month end. Normally we would accrue a reasonable expense amount based on past history for reporting purposes. However, this year, we have a unique situation as clients are anticipating that services may not be continued into the future. As a result we have unprecedented and unpredictable levels of program usage. We will not have solid numbers until mid March, but by mid February's Board meeting there should be a better understanding of how much work has been done thus providing a reasonable basis for an accrual. We will report on the program at the February Board meeting.

On a whole all programs have operated within budget. Within the report some items have been bolded to draw attention to aspects that did or could have a financial impact.

Background

Previous quarterly reports have indicated that the Healthy Smiles Ontario program needed to be closely monitored to ensure that revenues required to balance the budget were achieved. The fourth quarter report reveals that that the necessary revenues were achieved and the program's budget is balanced at year end.

Strategic Direction

The financial operations for 2012 continued to allow the Health Unit to contribute to the strategic goal to Meet our Mandate by addressing the needs of identified priority populations and ensure access within both the City and County of Peterborough.

The successful financial operations allowed the Board of Health to meet its mandate to better achieve the Ontario Public Health Standards.

Contact:

Bob Dubay, Accounting Supervisor
Corporate Services
(705) 743-1003, ext. 286
bdubay@pcchu.ca

Attachments:

Attachment A – Financial Update December 31, 2012

Financial Update December 31, 2012 (Accounting Supervisor: Bob Dubay) - unaudited as of January 30th, 2013

ATTACHMENT A

Programs funded January 1 to December 31, 2012	Type	2012	Approved By board	Approved By Province	Expenditures to Dec. 31	% of Budget	Funding	Comments
Mandatory Public Health Programs	Cost Shared	6,944,590	14-Dec-11	6,944,590	6,928,240	99.8%	MOHLTC	Operated within budget for the year.
Vector- Borne Disease (West Nile Virus)	Cost Shared	76,101	14-Dec-11	76,101	38,103	50.1%	MOHLTC	Operated within budget for the year. Insecticide treatment costs controlled by City and County based on need.
One-time cost request	Cost Shared	401,033	14-Mar-12	0	0	0.0%	MOHLTC	**Capital requests not approved by province**
Infectious Disease Control	100%	222,233	14-Dec-11	222,233	222,233	100.0%	MOHLTC	Operated within budget for the year.
Infection Prevention and Control Nurses	100%	84,872	14-Dec-11	86,569	86,569	100.0%	MOHLTC	Operated within budget for the year.
Small Drinking Water Systems	Cost Shared	**96,127**	14-Dec-11	**90,800**	**90,800**	**100.0%**	MOHLTC	Operated within budget for the year.
Healthy Smiles Ontario	100%	**414,399**	09-May-12	**402,329**	**402,329**	**100.0%**	MOHLTC	Operated within budget for the year.
One-time cost - Facilities renewal	100%	1,500,000	14-Mar-12	0	0	0.0%	MOHLTC	**Capital requests not approved by province**
Enhanced Food Safety	100%	25,000	09-May-12	25,000	25,000	100.0%	MOHLTC	Operated within budget for the year.
Enhanced Safe Water	100%	15,500	09-May-12	15,500	15,500	100.0%	MOHLTC	Operated within budget for the year.
Needle Exchange Initiative	100%	21,121	09-May-12	21,121	21,121	100.0%	MOHLTC	Operated within budget for the year.
Infection Prevention and Control Week	100%	8,000	09-May-12	8,000	6,153	76.9%	MOHLTC	Operated within budget for the year.
Sexually Transmitted Infections Prevention week	100%	7,000	09-May-12	7,000	6,943	99.2%	MOHLTC	Operated within budget for the year.
Nurses Commitment	100%	170,040	14-Dec-11	173,441	173,441	100.0%	MOHLTC	Operated within budget for the year.

Programs funded January 1 to December 31, 2012	Type	2012	Approved By board	Approved By Province	Expenditures to Dec. 31	% of Budget	Funding	Comments
Smoke Free Ontario - Control	100%	100,000	11-Apr-12	100,000	98,106	98.1%	MHPS	Operated within budget for the year.
Smoke Free Ontario - Enforcement	100%	120,724	11-Apr-12	120,800	111,699	92.5%	MHPS	Operated within budget for the year.
Youth Engagement	100%	80,000	11-Apr-12	80,000	78,957	98.7%	MHPS	Operated within budget for the year.
CINOT Expansion	Cost Shared	**49,000**	14-Dec-11	**26,473**	**33,313**	**125.8%**	MHPS	**Budget was reduced by province. Health Unit is required to treat those that meet the provincially set criteria. Will ask the province to fund 75% of $6,840 excess cost**
Genetics Program	100%	237,266		NA	**252,903**	**106.6%**	PRHC	**Program transferred to PRHC January 1, 2013; $15,637 of the program's deferred revenue will be used to cover off overage.**
Healthy Babies, Healthy Children	100%	828,413	11-Apr-12	submitted	800,648	96.6%	MCYS	Operated within budget for the year. Under spent as there were a number of statutory leaves of absence during the year.
Chief Nursing Officer Initiative	100%	116,700	14-Dec-11	116,699	58,349	50.0%	MOHLTC	**Position not filled until July 2012. Unused funds were not available for other programs.**
One-Time Healthy Babies, Healthy Children	100%	41,684	09-May-12	submitted	0	0.0%	MCYS	One-time budget waiting for approval.

Programs funded April 1, 2012 to March 31, 2013	Type	2012 - 2013	Approved By Board	Approved By Province	Expenditures Apr 1 to Dec 31	% of Budget	Funding	Comments
Infant Toddler and Development Program	100%	242,423	14-Sep-11	242,423	182,809	75.4%	MCSS	Operating within budget.
Medical Officer of Health Compensation	100%	70,259			52,701	75.0%	MOHLTC	**The province does not have a current service agreement with Physicians. The Ministry is continuing to cash flow based on the last year's approved M.O.H. compensation agreement. There has been no correspondence from the province with regards to budget or funding.**
Speech		13,084	NA	NA	9,813	75.0%	FCCC	Operating within budget.

Funded Entirely by User Fees January 1 to December 31, 2012	Type	2012	Approved By Board	Approved By Province	Expenditures to Dec 31	% of Budget	Funding	Comments
Sewage Program		343,388	13-Apr-11	NA	266,639	77.6%	FEES	**The program has accumulated a small surplus of just over $40,000 which should allow the operations of the program through the spring when traditionally little money is coming into the program. Currently there is only one PHI working in the program. Historically the Health Unit has employed two PHIs in the program.**

Staff Report

Student Nutrition Programs:
Best Practices, Actions for Sustainability and Call to Action

Date:	February 13, 2013	
To:	Board of Health	
From:	Dr. Rosana Pellizzari, Medical Officer of Health	
Original approved by		***Original approved by***
Rosana Pellizzari, M.D.		Carolyn Doris, RD, Public Health Nutritionist

Recommendations

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

1. Endorse the background report, *Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action for Food For Kids Peterborough and County*
2. Endorse the vision of Student Nutrition Programs (SNP), delivered in Peterborough County and City schools by Food For Kids Peterborough and County so that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.
3. Send a letter to the provincial Ministers of Children and Youth Services, Health and Long-term Care and Education to request continued and increased support and funding for SNPs.

Financial Implications and Impact

There are no direct financial implications for the Board of Health arising from this report.

Decision History

At the December 12, 2012 Board of Health Meeting, a motion was made as a result of the Staff Report: Food Security Recommendations, requesting a presentation from staff about a

proactive strategy to address the long-term funding situation for the Food for Kids Peterborough and County Student Nutrition Programs (breakfast clubs and snack programs).

The Board of Health has not previously made a decision with regards to this matter.

Background

Student Nutrition Programs (SNP), also known as Breakfast Clubs or Programs, are school community based initiatives, coordinated by school staff or volunteers within local elementary and secondary schools. The goal is to provide nutritious breakfasts and snacks to all students, based on Canada's Food Guide, in a welcoming environment.

SNPs play a major role in encouraging healthy eating practices and improving the learning capabilities of elementary and secondary school children.[1] Locally, SNPs are supported by the local coalition, Food For Kids Peterborough and County (FFK). The Peterborough County-City Health Unit has supported the development of SNPs since 1992 and continues to act as the host agency for Food For Kids Peterborough and County.

Childhood is a critical time for developing healthy eating habits, which in turn are maintained into adulthood. Research indicates that Peterborough children have significant room for improvement when it comes to healthy eating recommendations made in the Canada's Food Guide. Canada's Food Guide is based on extensive scientific evidence and is designed to help people get enough vitamins, minerals and nutrients for optimal growth and disease prevention. Universal Student Nutrition Programs offered in elementary and secondary schools can make a positive impact on the eating habits of students.

A 2012 Toronto Public Health report entitled "Nourishing Young Minds" included a literature review of SNPs as they exist throughout the industrialized world and examined the administrative and funding models utilized, program goals, participation rates and program challenges. The literature review revealed that:

1. The desire to have a positive impact on students' health is the most common goal for programs in other jurisdictions;
2. The majority of international programs are administered through an education arm of the government;
3. Most programs operate on a cost-shared basis, and most federal governments contribute to the funding model;
4. Where programs have restrictive individual means test, stigmatization negatively impacts participation by needy students.[2]

This review helps to confirm that Food For Kids Peterborough and County has many of the components considered as best practices such as the need to be flexible with program set-up according to the school community's needs, cost-shared funding models that include contributions from different levels of governments, and the need for both capital and operating funds. It is clear that because of FFK long-term commitment to universality of all programs, that locally we have overcome the hurdle of stigmatization faced in other

jurisdictions. The community relationships that FFK has built over the past 20 years are a critical key to success of local SNPs. This foundation needs to be further enhanced.

Rationale

In 2012-13, Food For Kids Peterborough and County finds itself at a financial crossroads. Funding from the Ontario Ministry of Children and Youth Services (MCYS) has been maintained at the same level across the province even though the number of programs offered has increased and the programs are providing access to nutritious food choices to more children daily. Breakfast For Learning Foundation, a traditional funding partner of both FFK and local school programs since 1996 has communicated that due to changes in management, policies and procedures, funding will decrease by 83% to local programs in the 2012-13 school year. It is not anticipated that this funding will increase in the near future. Increasing numbers of students accessing SNPs; increasing food costs, along with reduction in traditional funding requires FFK to develop a sustainable plan for the future.

To move forward with sustainable funding to allow for quality programs that universally allow all students in Peterborough and County to be well nourished and perform to the best of their ability, Food For Kids Peterborough and County Steering Committee, requests the endorsement of the Peterborough County-City Board of Health, as the host agency, to support a new strategy that addresses program growth, sustainability and long-term support.

The basis for moving forward is based upon 6 pillars:

1. Provincial Government Commitment
2. School Board Partnership
3. Foundations supporting Student Nutrition Programs
4. Municipal Partnerships
5. Community and Parent Support
6. Local Farming and Agriculture.

Strategic Direction

Support for the Food For Kids Peterborough and County Steering Committee and implementation of Student Nutrition Programs in local elementary and secondary schools supports the following Board of Health strategic directions:

- Continue to Meet Our Mandate
- Build on Our Leadership Role
- Expand Existing and Build New Strategic Partnerships

Contact:

Carolyn Doris, RD, Public Health Nutritionist
Nutrition Promotion Program
(705) 743-1000, ext. 251
cdoris@pcchu.ca

References:

1. Call to Action: Creating a Healthy School Nutrition Environment, Ontario Society of Nutrition Professionals in Public Health, School Nutrition Workgroup Steering Committee, March 2004.

2. Toronto Public Health: Nourishing Young Minds, June 2012.

Attachments:

Attachment A – Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action

Food for Kids
PETERBOROUGH AND COUNTY
Student Nutrition Programs

Ensuring that every student in every Peterborough county and city school can attend class well-nourished and ready to learn.

Student Nutrition Programs:
Best Practices, Actions for Sustainability and Call to Action for Food For Kids Peterborough and County

Carolyn Doris
Public Health Nutritionist
Peterborough County-City Health Unit
February 13, 2013

Table of Contents

Call to Action: Supporting Student Nutrition Programs in Peterborough and County

This Call to Action proposes actions to support the sustainability and future growth of universal Student Nutrition Programs, including breakfast and snack programs, in Peterborough City and County. Student Nutrition Programs (SNP) allow all students to attend school well-nourished and ready to learn and support the creation of healthy school nutrition environments.

Recommended Actions:

Local School Communities

That local school communities continue to show commitment to Student Nutrition Programs by:

1. promoting their school SNP to students and provide a welcoming and inclusive environment;
2. providing space, utilities and administrative support;
3. providing donations of money, food, supplies and equipment with support of Food For Kids Peterborough and County;
4. requesting funds annual from School Councils;
5. requesting and organizing volunteers;
6. working with Food For Kids Peterborough and County; and,
7. continuing to implement identified Best Practices for SNPs

Food For Kids Peterborough and County Steering Committee

In order to support the sustainability of Student Nutrition Programs, the Food For Kids Peterborough and County Steering Committee will:

1. Endorse the report, *Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action for Food For Kids Peterborough and County.*
2. Advocate to the Trustees and Directors of Education of KPRDSB and PVNCCDSB to continue support of SNPs within their schools as outlined in School Board Nutrition Polices and maximize current resources by considering:
    a. optimizing the allocation of space and equipment for SNPs in schools;
    b. supporting staff time and involvement in local school-based SNPs in light of the growth of programs;
    c. exploring education opportunities to teach cooking, food skills and nutrition to students;

    d. ongoing integration of innovative and creative food-related school activities with local SNPs; and,
    e. funding to support SNPs in local schools that positively impact student health and ability to learn.
3. Advocate for ongoing support of school boards with School principal representation on the Food For Kids Peterborough and County Steering Committee.
4. Request consideration of appointing Trustees to FFK Steering Committee.
5. Investigate new school partnerships with Breakfast Clubs of Canada.
6. Continue advocacy with Breakfast for Learning for adequate funding and support of local programs.
7. Develop relationships with other funders for SNPs.
8. Advocate to the City of Peterborough and County municipalities and townships for base budget support. This could be based on the numbers of school aged children and youth in their communities.
9. Implement a long-term fund development plan.
10. Continue to raise awareness of SNPs in Peterborough County and City schools and the need for parental and community support program operating costs (including equipment).
11. Support school communities in raising donations.
12. Continue to investigate partnerships that will benefit SNPs including local businesses, service clubs and faith groups.
13. Continue to increase volunteer capacity of FFK programs including using community capacity building approaches that allow for a collaborative partnership for SNP program delivery and planning (i.e., School SNP Committees).
14. Strengthen relationships with Nourish Peterborough, Sustainable Peterborough and Sustain Ontario to encourage local food partnerships.
15. Investigate funding opportunities that would result in more use of local food in schools.

Peterborough County-City Board of Health

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

1. Endorse the report, *Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action for Food For Kids Peterborough and County.*
2. Endorse the vision of SNPs, delivered in Peterborough County and City schools by Food For Kids Peterborough and County so that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.
3. Send a letter to the Ministers of Health and Long-Term Care, Education and Children and Youth Services requesting continued and increased support and funding for SNPs.

Student Nutrition Programs

Student Nutrition Programs (SNP), also known as Breakfast Clubs or Programs, are school community based initiatives, coordinated by school staff or volunteers within local elementary and secondary schools. The goal is to provide nutritious breakfasts and snacks to all students, based on Canada's Food Guide, in a welcoming environment.

SNPs play a major role in encouraging healthy eating practices and improving the learning capabilities of elementary and secondary school children.[1] Locally, SNPs are supported by the local coalition, Food For Kids Peterborough and County (FFK).

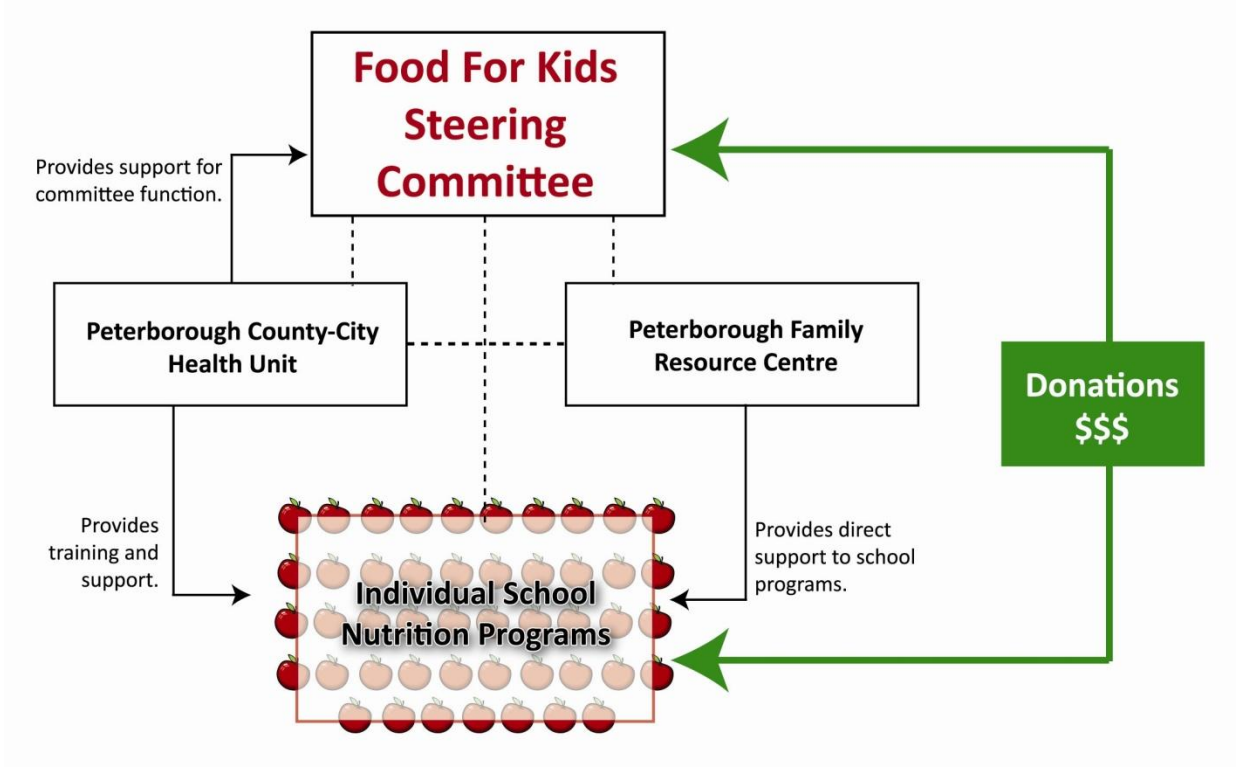
Food For Kids Peterborough and County History

The Peterborough County-City Health Unit has supported universal breakfast programs in the City and County of Peterborough since 1992. Support began with two local schools and has now grown to 46 school programs within the county and city.

In 1996, the Breakfast Program model was expanded with a Community Partners Grant from Breakfast of Learning which supported the expansion of programs in Peterborough City and County. The FFK Peterborough and County Steering Committee was founded in 1997. Since then the Steering Committee has continued to support breakfast programs with fundraising, training and education, and advocacy.

Food For Kids Peterborough and County is a community partnership with members representing education, media, health, social services, volunteers and interested community members. We are committed to improving child nutrition, well-being and learning capacity of all students through the provision of healthy and vital Student Nutrition Programs (SNPs) in local schools. Dedicated volunteers at the school and community level are integral to the success of SNPs. Peterborough County-City Health Unit Nutrition Promotion Program, specifically Public Health Nutritionists and a Health Promoter, have played a critical role in supporting local SNPs, as well as chairing and supporting the FFK Steering committee since its inception.

Figure 1: Food For Kids Steering Committee Structure and Relationship to School Programs



In 2004 the Ministry of Children and Youth Services (MCYS) began supporting Student Nutrition Programs across Ontario with a regional model that saw an original investment of $8.5 million. In 2008, as part of the Poverty Reduction plan of the Ontario government, an additional investment of $32 million over three years supported SNPs. This investment has been stable since. MCYS reports that across Ontario in 2010-11, Student Nutrition Programs provided over 660,000 students with nutritious breakfasts, snacks and lunches.[2]

The Peterborough Family Resource Centre was named the Lead Agency for Central East Ontario SNP administration for MCYS. Current and new FFK programs apply for provincially based funding each year. Applications are reviewed by FFK program staff and forwarded to PFRC (local lead agency). Funding is determined using a formula and is dispersed according to policies set by a Central East SNP Chairs Committee, coordinated by PFRC and of which FFK is a member. This dedicated funding from MCYS has allowed for expansion in FFK programs. Since MCYS funding was introduced, SNPs have been able to reach more students through new and expanded programs.

In 2011-12, FFK provided 1.8 million healthy breakfasts and snacks at 47 local schools that were accessed by over 17,000 students. Currently 86% (43 of the 50) of the elementary and secondary schools within three Boards of Education (Kawartha Pine Ridge District School Board (KPRDSB), Peterborough Victoria Northumberland Clarington Catholic District School Board (PVNCCDSB) and Conseil scolaire de distrique Catholique Centre-Sud) have SNPs. As well, three alternative schools, Centre for Individual Studies at Peterborough Alternative Education Centre

(PACE), School for Young Moms at PACE and Kinark's STRIVE! program at Thomas A. Stewart Secondary School also house FFK Programs.

Local School Board Nutrition Policies support the use of healthy foods in schools in a comprehensive manner that ensures the healthy choice is the easy choice. Breakfast Programs and Student Nutrition Programs are specifically named as a program that all principals should encourage the development of in local schools so that all children have access to healthy food in schools.[3,4] School nutrition policies provide a framework by which schools can plan, implement and evaluate nutrition-related actions using a coordinated approach that reflects current dietary guidance.[5] The work of FFK and Nutrition Promotion staff supports implementation of Ontario Public Health Standards (Chronic Disease Prevention, 3).[6]

Both KPRDSB and PVNCCDSB are long-term partners in supporting access to SNP in school. SNP are universal in that breakfast or snack is available for any student who wishes to participate. Regular breakfast consumption and the provision of early morning SNPs, result in positive health, learning and behaviour outcomes among children and youth. Universal SNPs recognize that all students should have access to healthy foods regardless of need so they can achieve to the best of their abilities and respond to the Social Determinants of Health.

SNPs depend on financial and in-kind donations to operate. FFK programs must operate a minimum of 3 days a week and follow SNP Nutrition Guidelines to receive provincial funding. In the 2011-12 school year, food costs, on a cash basis, equaled $258,721.17. Cost per meal average, including the value of food donations was $0.23.

As programs have grown, so has the need for sustainable funding. In addition to MCYS funding, SNPs access funding and in-kind support through their school boards, parents, and community groups. As well, FFK does broader based fund raising, donor and volunteer recognition at a community and provincial level. In the 2012-13 school year, it is anticipated that FFK, along with school communities must raise $100,000 to cover food costs for SNPs. This amount needs to be raised annually to maintain current program levels. Growth to additional school communities would necessitate additional fund development.

Eating Habits of Children and Youth

The following section will discuss the eating habits of children and youth according to Eating Well with Canada's Food Guide, sodium, breakfast consumption rates and the impact of Student Nutrition Programs.[7]

Childhood is a critical time for developing healthy eating habits, which in turn are maintained into adulthood. Research indicates that Peterborough children have significant room for improvement when it comes to healthy eating recommendations made in the Canada's Food

Guide. Canada's Food Guide is based on extensive scientific evidence and is designed to help people get enough vitamins, minerals and nutrients for optimal growth and disease prevention.

Vegetable and Fruit Consumption

Vegetable and fruit consumption is an independent risk modifier for chronic disease and a good marker of overall diet quality.[8] Sufficient daily consumption of fruit and vegetables in childhood and adolescence is associated with healthy body weight, prevention of certain types of cancer, continued healthy eating patterns in adulthood, reduced risk for cardiovascular disease and improved growth and development during a time when nutrient needs are especially high.

Canada's Food Guide recommends 5 servings of vegetables and fruit each day for children 4 to 8 years of age and 6-8 servings for children aged 9-18 years.[9] National sources report that 59% of Canadian children, aged 2 to 17 years of age, are consuming vegetables and fruit less than 5 times a day.[10] A recent study of Peterborough youth in secondary schools found that 48% of male youth and 56% of female youth reported consuming 3 to 5 servings of vegetables and fruit daily.[11] Only 14% of males and females reported consuming 6 or more servings of vegetables and fruit a day. The 2009-10 Canadian Community Health Survey found that 80% of Ontario teens (14 to 18 years), are consuming less than the recommended seven servings per day.[12]

Other Food Groups

Recent reports based on interviews held during Cycle 2.2 of Canadian Community Health Survey show that overall children and youth are falling short of healthy eating goals.

Canadian teens do not consume the daily recommended servings of milk products from Canada's Food Guide.[13] Canadians in general are also not meeting recommendations for grain products from the Food Guide.[14]

Other Foods

In 2004, 22% of calories consumed by Ontarians were from foods designated as "Foods to Limit" in *Eating Well with Canada's Food Guide*. Consuming these foods on a regular basis either means that nutritious foods are being displaced from the diet or that individuals are eating too many foods high in calories, salt, sugar or fat, which can contribute to the development of chronic disease.

Along with vegetable and fruit consumption, another key concern for PCCHU Public Health Nutritionists is higher sodium food choices. Seventy-seven per cent of 1-3 year olds and 93% of 4-8 year olds had usual intakes of sodium exceeding the Tolerable Upper Intake Level (UL) set for their age group (1500 mg and 1900 mg/d, respectively).[15] When looking at the youth population, among Canadian girls, the median sodium intake was 2885 mg/d for 9 to 13 year olds and 2962 mg/d for 14-18 year-olds; among boys the median sodium intake was 3510 mg/d for 9-13 year olds and 4151 mg/d for 14-18 year-olds.[16] These findings suggest that since Canadian children and youth have sodium intakes above the UL, they are at an increased risk of adverse health effects due to their sodium intake.

Breakfast Consumption

Eating a regular and healthy breakfast in childhood and adolescence is associated with:

- Healthy body weight and decreased obesity
- Improved academic performance
- Better memory functioning
- Increased school attendance[17]

The influence of breakfast on various learning outcomes including cognition, alertness, attention, memory, processing of complex visual displays, problem solving and mathematics along with reduction in absenteeism and positive mental health including connectedness with teachers and peers, lessened mental distress and fewer psychosocial problems have been well documented for over a decade.[18]

Breakfast skippers are reported to have higher daily intakes of fat, cholesterol, and energy and lower intakes of fibre, vitamins and minerals than breakfast eaters.[19] Breakfast is different from other meals in that it is consumed after a short fast during sleep. It is important to "break the fast" and is critical for brain function.

Breakfast skipping is more prevalent among female students and, children from lower socio-economic backgrounds. It is also more common during the transition from childhood to adolescence. There are many reasons why children do not eat breakfast including busy lifestyles. In some households it may be based on food insecurity, lack of time in the morning, children's lack of appetite, parents leaving for work before children need to be at school, long bus rides to school and insufficient role modeling by parents since many do not eat breakfast at home and instead purchase their breakfast on the way to work.

Canadian research shows that more children and youth skip breakfast as they get older. Approximately 5% of young children skip breakfast; by grade 4, an average of 24% students skip breakfast and 41% of eighth graders miss the morning meal. Breakfast skipping is known to become a habit for teenagers.[20] In the local sample of the Youth Smoking Survey , youth were asked how many times they ate breakfast within the last 7 days.[21] Only 47% of females and 55% of males eat breakfast on a daily basis; 26% of females and 23% of males reported only eating breakfast 0-2 days in the previous week.

Healthy Eating Opportunities at SNPs

MCYS has Nutrition Guidelines for all Ontario SNPs that are based on Canada's Food Guide. Breakfast and morning meal programs must offer foods from at least three of the four food groups and snack programs must offer 2 food groups. In order to receive provincial funding, all school-based programs are mandated to offer a vegetable or fruit choice daily in all meals and snacks.[22] Access to vegetables and fruit in SNPs encourages students to eat with their peers and to come closer to eating according to Canada's Food Guide. This is a supportive policy that directs what should be served and can impact healthier choices of local students.

Along with vegetable and fruit options, milk and alternatives and grain products most often round out the menus at local SNPs. Due to nut-safe environments in the majority of local elementary schools, schools focus on providing a vegetable/fruit, a milk or alternative (i.e., milk, cheese, yogurt) and grain products (i.e., bagels, toast, muffins, cereal, crackers, granola bars). These options mirror the choices that research shows children are most lacking in their diets. Healthy options that are lower in sodium are encouraged.

Local data suggests that high school students are not skipping breakfast as often as other Canadian youth; this can be reasoned as FFK has worked closely with both elementary and secondary schools to make SNPs a regular part of the school day. The universal approach taken by FFK appears to have positively affected breakfast consumption. This speaks to the need to continue quality programming considering increasing rates of food insecurity, potential cuts to discretionary benefits and increasing food costs that may impact food choices at home.

SNPs provide an opportunity to promote healthy food choices based on Canada's Food Guide and to role model healthy eating in the school environment that is taught in the Ontario Health and Physical Education Curriculum. As well, breakfast can economically provide lower fat, lower sodium highly nutritious foods for all children and youth. Nutritious food helps students to learn and get the most out of their school day.[23]

Best Practices for Student Nutrition Programs

The following section will include findings of a recent report of Toronto Public Health entitled "Nourishing Young Minds". The report included an international literature review on SNPs in 19 countries and outlined five key reasons for child nutrition programs in schools. These include:

1. **Health**: Improving health and nutrition is the most common goal (France, Italy, Brazil, the United Kingdom and the United States) and some programs specifically mention the prevention of obesity as a goal.
2. **Education**: Improving educational outcomes through school attendance is one of the most common targets of international school meal programs (Jamaica, Australia, Chile and India all cite attendance; improving school performance is cited by programs in Ireland, South Africa and Wales)
3. **Child Hunger and Poverty:** Few programs have specific objectives related to preventing hunger; although historically, many programs were initiated on this basis. Today, programs in India, the UK and Jamaica include hunger prevention as a program objective.
4. **Social Development**: France and Finland consider school meals to be an opportunity for students to learn good manners and eating habits, and to interact with other students in a relaxing and pleasant atmosphere; the French also see school meals as a time of discovery and pleasure related to food experiences

5. **Local Food and Employment:** SNPs in a small number of countries incorporate objectives not directly related to children and/or nutrition. These objectives include the use of local food, preservation of local food habits, support for local food production (Brazil, United States) and the creation of employment opportunities (indigenous people in Australia).[24]

The Nourishing Young Minds report quotes a 2010 issue brief regarding the Child Nutrition Reauthorization in the United States that succinctly states, *"The School Breakfast Program is a miracle of good public policy. It not only reduces hunger, but it has a range of other positive outcomes that advance key national priorities. The positive impact of the program on student achievement, health and well-being is well documented in an extensive body of research."*[25]

Currently, Canada is one of the few G8 countries that does not provide federal funding to SNP.[26] In fact, while the United States subsidizes school meals at a rate of US $1.24 per day, per student (a total of US $12 billion annually), Canada's provincial/territorial governments average less than four cents per day, per student.[27]

The report also shows that worldwide, social stigmatization is cited as the most significant program challenge. The National Assembly of Wales demonstrates the severity of this issue by stating in its report on child poverty that "*for the children and young people, who would rather forgo a meal than risk derision from their peers, stigma is more than just an issue for discussion – it is the reason for their hunger.*"[28]

Next to stigmatization, the challenges most commonly facing SNPs, regardless of their funding models, include:

- inadequate funding,
- food quality issues,
- lack of facilities or inadequate facilities,
- presence of competitive foods in the schools (through vending machines, school stores, cafeterias, and near-by off-site stores), and
- student food preferences.[29]

The Nourishing Young Minds report outlines, based on documented best practices, the review of international programs and input from subject matter experts, characteristics of a "gold standard" SNP. The following table compares Food For Kids Peterborough and County SNP programs to the gold standard or best practice.[30]

Table 1: SNP Best Practices

Gold Standard SNP	Food For Kids Peterborough and County
Offered to all students within a school who can benefit from the program (since schools offer key opportunity for intervention), or in a nearby community-based environment	All programs are universal and open to all students

Gold Standard SNP	Food For Kids Peterborough and County
Integrated into the school environment as a component of a comprehensive school nutrition environment (seen as an integral, seamless component, and not as a separate entity)	SNPs are recognized in School Board Nutrition Policy and are encouraged
Has a high participation rate among student population (i.e., students want to be a part of the program)	Universal approach means that programs can be accessed by all students; many elementary programs offer a "grab 'n' go" or bin program served to all students in classrooms; these programs allow for participation of all students including those bused or walking to school
Students are actively involved in the program (food preparation, delivery etc)	FFK encourages involvement of students
Breakfast or morning meal programs (served before 10:30 am) consisting of 3-4 food groups	Yes
Offers a variety of culturally appropriate, nutritious foods meeting a Nutrition Standard	Yes – School board policies and MCYS Guidelines
Integrates food and nutrition knowledge into the school program	Yes – FFK continues to build on this component
Financially sustainable: • Receives an adequate level of funding from government • Receives funding from diverse sources • Receives parental contributions • Successfully raises funds within the school environment (increases commitment and awareness) • Receives adequate local donations, and • Receives consistent, reliable funding sources (e.g., corporate, NGOS, other)	Needs to be further addressed through long-term fund development
Meal supervisors who have a positive relations with the students and provide adequate supervision in gymnasiums or cafeterias	Encouraged by FFK
Strong Local SNP Committee which assists with providing program support, fundraising and engaging the local community	20 year history of FFK is a strength; currently increasing membership
Engages a knowledgeable, well-trained and committed Local Program Coordinator	FFK is fortunate to have dedicated SNP coordinators in each school; coordinators are supported by the FFK SNP Coordinator (funded by PFRC) and health unit staff

Gold Standard SNP	Food For Kids Peterborough and County
Sufficient volunteers to share the workload to avoid "volunteer burnout"	Relying on volunteers and workload can be onerous; FFK recently had a Trillium Grant that supported volunteer recruitment; radio ads running Jan-March 2013
Adequate kitchen facilities and equipment including the food preparation area, food serving area, food storage area, and commercial food preparation equipment and storage capability	Wide range of facilities in schools; FFK supports with equipment purchases
Strong partnerships between students, parents, school administration, teachers, the local program coordinator, volunteers, local community groups (businesses, religious institutions etc), foundations, the community development workers (animators), school board level staff and public health	Yes but need to continually build partnerships
Where feasible: • Offers fresh fruits and vegetables • Uses local, sustainable food products, and • Reduces reliance of pre-package, prepared foods	Yes Packaged/processed grain products often used in programs
Includes program budgeting, monitoring and evaluation on a regular basis	Yes – support provided by FFK staff and schools

This international review helps to confirm that Food For Kids Peterborough and County has many of the components considered as best practices such as the need to be flexible with program set-up according to the school community's needs, cost-shared funding models that include contributions from different levels of governments, and the need for both capital and operating funds. It is clear that because of FFK long-term commitment to universality, that locally we have overcome the hurdle of stigmatization faced in other jurisdictions. The community relationships that FFK has built over the past 20 years are a critical key to success of local SNPs. This foundation needs to be further enhanced.

Future Direction

In 2012-13, Food For Kids Peterborough and County finds itself at a financial crossroads. MCYS funding has been maintained at the same level across the province even though the number of programs offered has increased and the programs are providing access to nutritious food choices to more children daily. Breakfast For Learning Foundation, a traditional funding partner of both FFK and local school programs since 1996 has communicated that due to changes in management, policies and procedures, funding will decrease by 83% to local programs in the

2012-13 school year. It is not anticipated that this funding will increase in the near future. Increasing numbers of students accessing SNPs; increasing food costs, along with reduction in traditional funding requires FFK to develop a sustainable plan for the future.

SNPs help create healthier eating habits. The nutritious meals offered provide students with nutrients and energy they need to be ready to learn and participate in school. When offered as part of the school day, student nutrition programs can change the school culture and result in reduced absenteeism, less aggressive behaviour and fewer violent incidents. The programs are also a catalyst for community capacity building, community development and job skills training.[31] It is also widely recognized that SNPs should be viewed as integral parts of school policy rather than a supplemental program.

To move forward with sustainable funding to allow for quality programs that universally allow all students in Peterborough and County to be well nourished and perform to the best of their ability, Food For Kids Peterborough and County Steering Committee, requests the endorsement of the Peterborough County-City Board of Health, as the host agency, to support a new strategy that addresses program growth, sustainability and long-term support.

The basis for moving forward is based upon 6 pillars:

1. Provincial Government Commitment
2. School Board Partnership
3. Foundations supporting Student Nutrition Programs
4. Municipal Partnerships
5. Community and Parent Support
6. Local Farming and Agriculture

Pillar 1: Provincial Government Commitment

The Ministry of Children and Youth Services provides leadership, establishes policies, standards and guidelines and allocates budgets to lead agencies. Funding flows from MCYS to the lead agencies, who then allocate the provincial funds to the local programs through a granting process. Peterborough Family Resource Centre, the lead agency for Central East Region, uses an agreed upon formula and regional policies for equitable distribution of funds. Food For Kids Peterborough and County has had the opportunity to input these decisions through a Regional Chairs committee that meets biannually.

SNPs locally depend upon the funding that they have received from MCYS since 2004. It is a critical time for the Board of Health and FFK to advocate for long-term funding of SNPs from the Ontario government because of cross ministerial benefits (Ministry of Health and Long Term Care, Ministry of Education, Ministry of Children and Youth Services, Ministry of Agriculture, Food and Rural Affairs) Interestingly, international literature review indicates that in most countries (12 of 19 reviewed) fund their SNPs through the governing body responsible for education. Most federal governments also contribute to the funding model that is cost-shared.

As well, the funding amount has not increased since 2008 despite program growth and number of students being positively impacted. Increase of funding to better reflect current state is encouraged.

Action Items for Pillar 1

1. Advocate to the to the provincial Ministers of Children and Youth Services, Health and Long-Term Care, and Education to request continued and increased support and funding for SNPs.

Pillar 2: School Board Partnerships

As noted earlier, both KPRDSB and PVNCCSDB have been long term supporters of Food For Kids Peterborough and County. In April 2012, FFK recognized both school boards for supporting local breakfast programs over the past 20 years.

Both boards support in school programs in a variety of ways including:

- Use of facilities
- Access to cleaning supplies
- Support from administration (as outlined in Nutrition Polices notation)
- Secretarial support for accounting and reporting purposes
- In some cases, staff resources to coordinate or volunteer at programs.

In 2010, FFK in partnership with community partnerships in City of Kawartha Lakes, Durham Region and Northumberland that all support SNPs within the PVNCCDSB, made a presentation to the trustees of the PVNCCDSB. The request was based on a similar model used by Trillium Lakelands District School Board that provides $1,500 in base funding to each SNP in school. As a result, for both the 2011-12 and 2012-13 school years, PVNCCDSB has set aside $20,000 in funds that are distributed on a per student basis directly to school principals. Principals are encouraged to use the funding to support SNP within their school. In Peterborough, four local schools receive a share of funding without a FFK supported program.

Considering the current funding situation, it is important for SNP Community Partnerships that support schools in the KPRDSB area (Northumberland, Durham Region, Hastings Prince Edward and Peterborough), to meet with KPRDSB representatives to review the evidence for universal SNPS and to discuss future support and school board partnerships.

FFK staff also intend to meet with l'école Monsigneur Jâmot to determine interest. Staff attempt to meet yearly with school communities without SNPs to gauge interest. Since programs are community led, if there is not interest or capacity, programs are not forced.

KPRDSB and PVNCCDSB have Principal representatives on the FFK Steering Committee. This involvement and support is critical in understanding school needs.

Action Items for Pillar 2

1. Advocate to the Trustees and Directors of Education of KPRDSB and PVNCCDSB to continue support of SNPs within their schools as outlined in School Board Nutrition Polices and maximize current resources by considering:

    a) optimizing the allocation of space and equipment for SNPs in schools;
    b) supporting staff time and involvement in local school-based SNPs in light of the growth of programs;
    c) exploring education opportunities to teach cooking, food skills and nutrition to students;
    d) ongoing integration of innovative and creative food-related school activities with local SNPs; and,
    e) funding to support SNPs in local schools that positively impact student health and ability to learn.

2. Request ongoing support of school boards with School principal representation on the FFK Steering Committee.

3. Request consideration of appointing Trustees to FFK Steering Committee.

Pillar 3: Foundations Supporting Student Nutrition Programs

FFK has support from Breakfast For Learning Foundation (BFL) since 1996 when a grant allowed for initial expansion of local programming. Over the years, FFK has applied for group funding on behalf of local schools or schools have applied directly by completing an application form, with FFK support, to BFL. In 2011-12 school year, 41 programs received a total of $96,000 from BFL through cheques and gift cards to the Loblaws chain of stores. Over the summer of 2012, BFL had changes in management, policies and direction. As a result, schools are assigned funding based on a funding formula. Peterborough City and County schools will only receive a total of $18,000 in gift cards/ grants and $3,413.58 for the purchase of appliances.

Breakfast Clubs of Canada (BCC) is a relatively new partner with FFK programs. Currently four local schools have entered a partnership agreement with BCC. BCC considers sustainability of programs key so when a school becomes a BCC school, it is considered a long-term partnership. In 2011-12, a total of $5,000 was divided between new BCC schools; an additional school with a three year grant received additional funding. These four schools also receive vouchers for free food supplies donated by national BCC partners such as Minute Maid and Dempsters Bread.

There are a number of other community and provincial/national foundations with an interest in childhood issues and child nutrition. As part of the Fund Development plan, PCCHU staff will investigate and submit applications to these foundations and groups that meet the ethics review of PCCHU and FFK.

Action Items for Pillar 3

1. Investigate new school partnerships with Breakfasts Clubs of Canada.
2. Continued advocacy with Breakfast for Learning for adequate funding and support of local programs.
3. Develop relationships with other funders for SNPs.

Pillar 4: Municipal Partnerships

In many parts of Ontario areas, municipal and regional government funding is a critical investment in SNP. Financial support in 2010 from municipalities ranged from $4.90 per student per year in York Region to $28.69 in the City of Toronto. In September, 2012, City of Toronto Board of Health passed an amendment requesting an increase in municipal funding and a five year plan for stabilization of existing SNP in Toronto, with an incremental increase in municipal investment to provide up to 20% of estimated program costs.[32]

In the past, FFK has applied to various municipal grants for support of local SNPs. Funding has not always been granted and ongoing proposal writing rather than base budget contributions impact overall sustainability of programs.

Local First Nation Councils show leadership when considering the educational and health benefits of student participation in SNPs. Yearly, both Curve Lake First Nation and Hiawatha First Nation make direct financial donations to the SNPs that students from the First Nation attend. In 2011-12, Curve Lake First Nation donated $2,000 to Ridpath Junior Public School in Lakefield, and Hiawatha First Nation donated $1,750 to North Shore Public School in Keene. Based on 2011-12 costs of SNPs in those schools, Curve Lake First Nation's donation covered ($2,000 of $4,491.85) 45 % and Hiawatha covered ($1,750 of $6,986.04) 25 % of total food costs (note: does not include in-kind or donated food).

Due to the specialization of schools and students attending schools within three boards of education, it is important to recognize that students in a municipality may attend schools in other areas of the City and County.

Action Items for Pillar 4

1. Advocate to the City of Peterborough and County municipalities and townships for base budget support. This could be based on the numbers of school aged children and youth in their communities

Pillar 5: Community and Parental Support

It has always been a philosophy of FFK that local school communities and families would support Student Nutrition Programs. This philosophy was reiterated when the Ontario Funding Model from MCYS was developed in that provincial funding was to lever other funds at the local program/community level. Provincial funding was not intended to replace contributions from parents, corporate sponsors, farmers, local charities or municipal governments.[33]

FFK and PCCHU support local schools in raising funds through a variety of means:

- Donations to PCCHU directed to FFK are eligible for charitable receipts
- Donation forms are distributed to local schools and coordinators (with approval of school boards)
- Form letters are available on request

FFK also supports community fundraising and involvement including:

- Preparing applications for local funding sources
- Maintaining partnerships with long-term donors
- Yearly donor recognition event and production of Annual Report highlighting generous sponsors to schools and FFK
- Development of a Fund Development Plan for 2013 and beyond based on the pillars outlined in this report
- Increasing capacity of FFK Steering committee including increasing membership to a variety of sectors interested in child nutrition and education

PCCHU staff coordinate FFK budget requests from schools based on need and expenditures. For the past 2 years, a separate amount ($4,000) from FFK funding has been set aside for emergency large equipment purchases such as refrigerators and stoves.

Volunteers are a key to local FFK programs. Community and school volunteers including parents and caregivers, members of service groups, organizations, businesses, faith groups, seniors, teachers, students and school staff organize and operate local SNP. FFK support volunteer recruitment through media, contacts with local organizations and schools etc. In the 2011-12 school year, more than 960 volunteers helped to organize programs, shop for nutritious food and supplies, prepare food and help at SNPs in Peterborough County and City. FFK coordinates volunteer recognition including organizing an event with funding from a MCYS Special Projects Fund and submissions to the Ontario Volunteer Service Awards coordinated by the Ministry of Citizenship and Culture.

A review of Best Practices for Child Nutrition Programs, states that parental involvement contributes to successful in-school programs. This includes the involvement of parents as volunteers and their participation on program committees.[34] Parents who are involved with SNPs exemplify positive regard to nutrition, volunteerism and act as role models of attitudes and behaviour toward food and can reinforce healthy eating behaviours at home. However, parent's work schedules can act as a barrier to their participation as volunteers in programs.

Schools secure local donations but it must be recognized that fundraising, especially in some school communities, is difficult. A request to parents for food donations was introduced in some schools in the 2012-13 school year. Fundraising can be unreliable especially since schools fundraise for many causes including sports equipment, field trips, curriculum programs and library improvements. "Fundraising burnout" in local schools is recognized. As well, schools are limited to one major fundraising campaign per year (usually organized by the School Council) and may fundraise for social justice and community organizations where the funds raised are donated.[35]

Action Items for Pillar 5

1. Continue with implementation of a long-term fund development plan including recommendations from this report.

2. Continue to raise awareness of SNPs in Peterborough County and City schools and the need for parental and community support program operating costs (including equipment).

3. Support school communities in raising donations.

4. Continue to investigate partnerships that will benefit SNPs including local businesses, service clubs and faith groups.

5. Continue to increase volunteer capacity of FFK programs including using community capacity building approaches that allow for a collaborative partnership for SNP program delivery and planning (i.e., School SNP Committees).

Pillar 6: Local Farming and Agriculture

In 2006, the City of Kawartha Lakes and Great Peterborough Area Agricultural Economic Impact and Development Study found that agriculture in the Peterborough/Kawartha Lakes generated more than $155 Million in gross farm receipts in 2001. Using this as a benchmark for current activity in the region, it was concluded that agricultural activities will generate the following impacts on an annual basis:

- a total impact in excess of $353 million ($85 million in direct impacts, $207 million in indirect impacts and $62 million in induced impacts); and,
- a labour income impact in excess of $56 million.[36]

Local farming and agriculture have positive connections to FFK SNPs. MCYS Nutrition Guidelines (July 2008 – reference) outline Guiding Principles that are encouraged in all SNPs. One of these principles is that SNPs should choose Ontario food first by offering Ontario grown and/or produced foods when available and practical and to purchase food locally where possible (e.g., local farmers markets and local grocery stores).

SNPs in Peterborough City and County do make efforts to purchase and use local foods when possible. A number of local grocery stores and wholesalers offer strong partnerships to schools that include discounts for purchases, pre-ordering sale items and allowing for charge accounts. FFK intends to further explore local retailer partnerships. Ontario grown apples, cucumbers, carrots, peppers, pears, milk, cheese are staples on menus throughout the school year.

Many SNPs also purchase locally produced food benefiting farmers. Some SNPs have made connections with local farmers at Peterborough City and County farmers markets. A unique partnership began in fall 2012 through a grant from the Ontario Farm to School Challenge funded by the Greenbelt Foundation and organized by Sustain Ontario and Food Share Toronto. As a Regional partner, FFK received a grant to allow for purchase and delivery of locally grown carrots to local SNPs. In partnership with the YWCA Just Food Box program, 560 lb of local carrots were delivered to City schools in November and an additional 920 lb was delivered in January 2013. The "Carrots for Kids" project was highlighted in local media and schools were supported with curriculum materials produced by Ontario Agri-Food Education Inc. to make local food connections in class easier for teachers. This project has been a positive way to model healthy eating and raise awareness of local agriculture.

Sustain Ontario: The Alliance for Healthy Food and Farming notes that provincial funding for SNPs and the development of School Nutrition Policies are steps in the right direction for making healthier foods available to Ontario children and youth.[37] They outline a number of Good Food Policies for Education. These include:

1. **Teach Kids About Food:** Integrate education about food and agriculture into the Ontario curriculum at all levels.

2. **Fund Student Nutrition:** Renew and increase the Ontario Student Nutrition Program to ensure that all children have access to a healthy breakfast and snack every day.

3. **Build Food Into Schools:** Provide infrastructure grants for schools to enable them to build kitchens, buy food processing equipment and create school gardens.

4. **Support Healthy and Local Food:** Provide incentives to encourage schools to provide healthy and local food options, such as salad bars and local ingredients.

5. **Advocate for Federal Funding:** Advocate for federal funding of student nutrition.

6. **Find New Opportunities:** Bring all ministries that relate to food together along with community members to identify opportunities to create a stronger economy and a healthier province through food. Create a Provincial Food Secretariat or Food Policy Council.[38]

Food For Kids Peterborough and County along with Nutrition staff from PCCHU advocate for many of these components through SNPs and Nutrition Promotion programs related to food security, and comprehensive school health.

Action Items for Pillar 6

1. Strengthen relationships with Nourish Peterborough, Sustainable Peterborough and Sustain Ontario to encourage local food partnerships.

2. Investigate funding opportunities that would result in more use of local food in schools.

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http://www.breakfastforlearning.ca/images/pdfs/Services_and_Information/backgrounder%20-%20national%20nutrition%20program.pdf

[27] Breakfast For Learning Foundation website, accessed Dec. 17, 2012. http://www.breakfastforlearning.ca/en/how-to-help/canadas-children-need-a-national-nutrition-program

[28] Toronto Public Health: Nourishing Young Minds, June 2012.

[29] Ibid.

[30] Ibid.

[31] Ibid.

[32] Student Nutrition Program 2013 Operating Budget Request and Proposed Five Year Plan, City of Toronto, accessed Dec. 13, 2012. http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2012.HL16.5

[33] Toronto Public Health: Nourishing Young Minds, June 2012.

[34]Russell, J., Best Practices for Child Nutrition Programs: A review of the Literature; Breakfast for Learning, Canadian Living Foundation 2004.

[35] Communication with Principals representing local school boards on Food For Kids Peterborough and County Steering Committee.

[36] City of Kawartha Lakes and the Greater Peterborough Area Agricultural Economic Impact & Development Study: Executive Summary, October 27, 2006. http://gpaedc.on.ca/pdf/locate/AgImpactStudy.pdf

[37] Good Food Policies for Education, Sustain Ontario: The Alliance for Healthy Food and Farming. http://sustainontario.com/initiatives/policies/gfpps-sector/good-food-policies-for-health

[38] Ibid.

Staff Report

Audit Letter of Engagement

Date:	February 13, 2013	
To:	Board of Health	
From:	Dr. Rosana Pellizzari, Medical Officer of Health	
Original approved by		***Original approved by***
Rosana Pellizzari, M.D.		Brent Woodford, Director Corporate Services

Recommendations

That the Board of Health for the Peterborough County-City Health Unit engage the auditing services of Collins Barrow Kawarthas LLP and authorize the Chair and Vice-Chair to sign the Letter of Engagement.

Financial Implications and Impact

Agreement will result in the annual audit fees. If the Letter of Engagement is not signed, the auditor will not be able to carry out the annual audit. Audit expenses are part of the approved budget.

Decision History

Approval of the Letter of Engagement is required annually.

Background

Before the turn of this century auditors required their clients to sign a "Letter of Engagement" appointing the auditor, directing the auditor to audit the books of account and committing the organization to pay for the audit once the work was done. Then due accounting scandals (such

as Worldcom or Encon) the audit societies increased the responsibilities and requirements of auditors, including reporting to the Board any relationships they may have with the Board. These relationships include:

- Holding a financial interest, directly or indirectly, in the Board;
- Holding a position, directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of the Board;
- A personal or business relationship with immediate family, close relatives, partners or retired partners of the Board;
- Having an economic dependence on the work of the Board;
- Providing services to the Board other than auditing (for example: consulting services).

The auditors have not identified any relationship.

The auditors have committed to expressing an opinion on whether our Financial Statements fairly represent, in a material way, the financial position of the Board.

The auditors note that their obligation is to obtain reasonable, but not absolute assurance that the financial statements are free of material misstatement. That is: the auditor will examine our records but will not guarantee they will find a misstatement, if one is present. This also means that there may be small misstatements but the misstatement will not have a significant bearing on our Financial Statements.

The auditors will:

- Assess the risk that the financial statements contain misstatement(s) that are material to the Financial Statements;
- Examine on a test basis the evidence supporting amounts and disclosures to the financial statements (for example: compare invoices to cheque amounts, lease commitments, etc);
- Assess the accounting principles used and their application;
- Assess the estimates made;
- Examine internal controls in place.

The Board is required to:

- Meet with the auditors prior to the release and approval of the financial statements to review audit, disclosure and compliance issues;
- If necessary, review matters raised by the auditors with management, and if necessary report back to the auditors on the Board's findings;
- Make known to the auditors any issues of fraud or illegal acts or non-compliance with any laws or regulatory requirements known to the Board that may affect the financial statements;

- Provide direction to the auditor on any additional work the auditor feels should be undertaken in response to issued raised or concerns expressed;
- Make enquiries into the findings of the auditor with respect to corporate governance, management conduct, management cooperation, information flow and systems of internal control;
- Review the draft financial statements; and
- Pre-approve all professional and consulting services to be provided by the auditors. In our case, there are none.

Rationale

This is a standard letter as required by the Canadian Institute of Chartered Accountants (CICA). An annual audit by external auditors is required by legislation and under Board Policy 2-130.

Contact:

Brent Woodford
Director Corporate Services
(705) 743-1000, ext. 231
bwoodford@pcchu.ca

Attachments:

Attachment A: Collins Barrow Kawarthas LLP Letter of Engagement

Collins Barrow
Chartered Accountants

Collins Barrow Kawarthas LLP
272 Charlotte Street
Peterborough, Ontario
K9J 2V4

T. 705.742.3418
F. 705.742.9775

www.collinsbarrowkawarthas.com

January 17, 2013

Members of the Board of Health
Peterborough County - City Health Unit
10 Hospital Drive
Peterborough, Ontario
K9J 8M1

Re: Audit of the Consolidated Financial Statements of the Peterborough County - City Health Unit

Dear Members of the Board of Health:

This report is intended solely for the use of the Board of Health and should not be distributed without our prior consent. We accept no responsibility to a third party who uses this communication.

We have been engaged to express an audit opinion on the consolidated financial statements of the Peterborough County - City Health Unit ("the Health Unit") for the year ended December 31, 2012. Canadian Auditing Standards ("CAS") require that we communicate the following information with you in relation to your audit.

Management is responsible for establishing and maintaining an adequate internal control structure and procedures for financial reporting. This includes the design and maintenance of accounting records, recording transactions, selecting and applying accounting policies, safeguarding of assets and preventing and detecting fraud and error.

Auditor Independence

CAS require communications with audit committees, or other appropriate parties responsible for governance, at least annually, regarding all relationships between the Health Unit and our firm that, in our professional judgment, may reasonably be thought to bear on our independence.

We will, through our planning process, identify any potential independence threats and will communicate any concerns we identify. The Health Unit, management and the Board of Health have a proactive role in this process, and are responsible for understanding the independence requirements applicable to the Health Unit and its auditors. You must also bring to our attention any concerns you may have, or any knowledge of situations or relationships between the Health Unit, management, personnel (acting in an oversight or financial reporting role) and our firm, its partners and audit team personnel that may reasonably be thought to bear on our independence.

In determining which relationships to report, these standards require us to consider relevant rules and related interpretations prescribed by the Institute of Chartered Accountants of Ontario and applicable legislation, covering such matters as:

(a) holding a financial interest, either directly or indirectly, in a client;

(b) holding a position, either directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of a client;

(c) personal or business relationships of immediate family, close relatives, partners or retired partners, either directly or indirectly, with a client;

(d) economic dependence on a client; and

(e) provision of services in addition to the audit engagement.

In accordance with our professional requirements, we advise you that we are not aware of any relationships between the Health Unit and our firm that, in our professional judgment, may reasonably be thought to bear on our independence.

Accordingly, we hereby confirm that our audit engagement team, our firm and the other Collins Barrow offices are independent with respect to the Health Unit within the meaning of the Rules of Professional Conduct Rule 204 of the Institute of Chartered Accountants of Ontario.

Our Responsibilities as Auditors

As stated in the engagement letter, our responsibility as auditors of the Health Unit is to express an opinion on whether the consolidated financial statements present fairly, in all material respects, the financial position, results of operations and cash flows of the Health Unit in accordance with Canadian Public Sector Accounting Standards.

An audit is performed to obtain reasonable but not absolute assurance as to whether the financial statements are free of material misstatement. Due to the inherent limitations of an audit, there is an unavoidable risk that some misstatements of the financial statements will not be detected (particularly intentional misstatements concealed through collusion), even though the audit is properly planned and performed.

Our audit includes:

- Assessing the risk that the financial statements may contain material misstatements that, individually or in the aggregate, are material to the financial statements taken as a whole;
- Examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements;
- Assessing the accounting principles used, and their application; and
- Assessing the significant estimates made by management.

As part of our audit, we will obtain a sufficient understanding of the business and internal control structure of the Health Unit to plan the audit. This will include management's assessment of:

- The risk that the financial statements may be materially misstated as a result of fraud and error; and

- The internal controls put in place by management to address such risks.

The engagement team must undertake a documented planning process prior to commencement of the audit to identify concerns, address independence considerations, assess the engagement team requirements, and plan the audit work and timing. It may be necessary to contact members of the Board of Health if significant matters arise from planning procedures.

An audit does not relieve management or those responsible for governance of their responsibilities for the preparation of the Health Unit's financial statements.

Board of Health Members' Responsibilities

The Board of Health's role is to act in an objective, independent capacity as a liaison between the auditors and management to ensure the auditors have a facility to consider and discuss governance and audit issues with parties not directly responsible for operations.

The Board of Health's responsibilities include:

- Being available to assist and provide direction in the audit planning process when and where appropriate;
- Meeting with the auditors as necessary and prior to release and approval of financial statements to review audit, disclosure and compliance issues;
- Where necessary, reviewing matters raised by the auditors with appropriate levels of management, and reporting back to the auditors their findings;
- Making known to the auditors any issues of disclosure, corporate governance, fraud or illegal acts, non-compliance with laws or regulatory requirements that are known to them, where such matters may impact the financial statements or the Independent Auditors' Report;
- Providing guidance and direction to the auditors on any additional work the auditors feel should be undertaken in response to issues raised or concerns expressed;
- Making such enquiries as appropriate into the findings of the auditors with respect to corporate governance, management conduct, cooperation, information flow and systems of internal controls;
- Reviewing the draft financial statements prepared by management, including the presentation, disclosures and supporting notes and schedules, for accuracy, completeness and appropriateness, and recommend same to be passed to Council for approval; and
- Pre-approving all professional services and allowable consulting services to be provided by the auditors.

Audit Approach

Outlined below are certain aspects of our audit approach which are intended to help you in discharging your oversight responsibilities. Our general approach to the audit of the Peterborough County - City Health Unit is to assess the risks of material misstatement in the financial statements and then respond by designing audit procedures.

Illegal Acts, Fraud, Intentional Misstatements and Errors

Our auditing procedures, including tests of your accounting records, will be limited to those considered necessary in the circumstances and will not necessarily disclose all illegal acts, fraud, intentional misstatements or errors should any exist. We will conduct the audit under CAS, which include procedures to consider (based on the control environment, governance structure and circumstances encountered during the audit), the potential likelihood of fraud and illegal acts occurring.

These procedures are not designed to test for fraudulent or illegal acts, nor will they necessarily detect such acts or recognize them as such, even if the effect of its consequences on the financial statements is material. However, should we become aware that an illegal or possible illegal act or an act of fraud may have occurred, we will communicate this information directly to the Board of Health.

It is management's responsibility to detect and prevent illegal actions. If such acts are discovered or the Board of Health becomes aware of circumstances under which the Health Unit may have been involved in fraudulent, illegal or regulatory non-compliance situations, such circumstances must be disclosed to us.

Related Party Transactions

During our audit, we conduct various tests and procedures to identify transactions considered to involve related parties. Related parties exist when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control or common significant influence. Related parties also include management, members of the Board of Health and their immediate family members and companies with which these individuals have an economic interest.

We will ensure that any related party transactions that are identified during the audit have been represented by management to have been disclosed in the notes to financial statements, recorded in accordance with Canadian Public Sector Accounting Standards, and have been reviewed with you. Management is required to advise us if any related party transactions have occurred that have not been disclosed to us. The Board of Health is required to advise us if they are aware of or suspect any other related party transactions have occurred which have not been disclosed in the financial statements.

Significant Accounting Principles and Policies

The Health Unit's financial statements will be prepared by management using various accounting principles, which have been incorporated into the Health Unit's accounting policies and disclosed in the notes to the financial statements. Where accounting policies have changed from one period to the next, such changes will be noted and the effect of these changes will be disclosed.

The accounting policies adopted may be acceptable policies under Canadian Public Sector Accounting Standards; however, alternative policies may also be acceptable under Canadian Public Sector Accounting Standards. The Health Unit and the Board of Health have a responsibility to not adopt extreme or inappropriate interpretations of Canadian Public Sector Accounting Standards that may have inappropriate or misleading results. Alternative policies, if adopted, may produce significant changes in the reported results of the operations, financial position and disclosures of the Health Unit.

The Board of Health has a responsibility to review the accounting policies adopted by the Health Unit, and where alternative policies are available, make determinations as to the most appropriate policies to be adopted in the circumstances. If members of the Board of Health are concerned that the adoption or change of an accounting policy may produce an inappropriate or misleading result in financial reporting or disclosure, this concern must be discussed with management and the auditors. If the Board of Health believes that a policy or policies adopted are inappropriate or produce a misleading result in the circumstances, these concerns should be discussed with us directly, either privately or in Board of Health meetings.

Risk-based

Our risk-based approach focuses on obtaining sufficient appropriate audit evidence to reduce the risk of material misstatement in the financial statements to an appropriately low level. This means that we focus our audit work on higher risk areas that have a higher risk of being materially misstated.

Based on our knowledge of the Health Unit's business and our past experience, we have identified the following areas that have a potentially higher risk of a material misstatement.

(a) Year-end cut-off for accounts receivable and accounts payable;

(b) Useful life estimates for tangible capital assets; and

(c) Year-end cut-off of environmental program deferred revenue.

Materiality

Materiality is defined as:

Materiality is the term used to describe the significance of financial statement information to decision makers. An item of information, or an aggregate of items, is material if it is probable that its omission or misstatement would influence or change a decision. Materiality is a matter of professional judgment in the particular circumstances.

We plan to use an overall materiality of $350,000 and a performance materiality of $297,500. Performance materiality is the level of materiality that will be used in performing the audit procedures and determining sample sizes.

Materiality is used throughout the audit and in particular when:

a) Identifying and assessing risk of material misstatement;

b) Determining the nature, timing and extent of further audit procedures; and

c) Evaluating the effect of uncorrected misstatements, if any, on the financial statements and in forming an opinion on the auditors' report.

Audit Procedures

In responding to our risk assessment, we will use a combination of tests of controls, tests of details and substantive analytical procedures. The objective of the tests of controls is to evaluate whether certain controls operated effectively. The objective of the tests of details is to detect material misstatements in the account balances and transaction streams. Substantive analytical procedures are used to identify differences between recorded amounts and predictable expectations in larger volumes of transactions over time.

To ensure there is a clear understanding and record of the matters discussed, we ask that two members of the Board of Health sign their acknowledgement in the spaces provided below. Should any member of the Board of Health wish to discuss or review any matter addressed in this letter or any other matters related to financial reporting, please do not hesitate to contact us at any time.

Yours very truly,

Collins Barrow Kawarthas LLP

per: Richard Steiginga, CA

Acknowledgement of the Board of Health:

We have read and reviewed the above disclosures and understand and agree with the comments therein:

Peterborough County - City Health Unit

Are you aware of any frauds, illegal acts or management override of internal controls at the Health Unit?

Yes / No (please circle one)

If yes, please contact our office immediately

_____	_____
Name	Position
_____	_____
Name	Position

To: All Members
Board of Health

From: Mr. David Watton, Chair, Board of Health

Subject: **Committee Report: Governance**

Date: February 13, 2013

Recommendation:

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

- receive for information, meeting minutes of the Governance Committee for November 26, 2012, approved by the Committee on February 1, 2013; and

- approve the designation of Chief Phyllis Williams as Chairperson of the Committee; and,

- approve the following documents referred by the Committee at the February 1, 2013 meeting:

    - Revised Policy #2-348, Committee, Governance, Terms of Reference
    - New Policy #2-374, Contractor Performance and Litigation

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Please refer to the attached.

Original approved by

_____

Mr. David Watton
Chair, Board of Health

Board of Health
for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
November 26, 2012 – 9:00 a.m. to 12:00 p.m.
(Board Room - 10 Hospital Drive, Peterborough)

Present: Dr. Rosana Pellizzari
Deputy Mayor Andy Sharpe
Mayor Mary Smith
Mrs. Alida Tanna, Recorder
Mr. David Watton, Chair
Mr. Brent Woodford, Director, Corporate Services

Regrets: Mr. Jim Embrey

1. Call To Order

Mr. Watton called the meeting to order at 3:02 p.m.

2. Declaration of Pecuniary Interest

Nil.

3. Delegations

Nil.

4. Approval of the Agenda

Moved by Mayor Smith — Seconded by Deputy Mayor Sharpe

That the agenda be approved with the following changes:

- addition of item 7.4, Recruitment of New Board Provincial Appointee
- addition of item 7.5, Interest in Continuing on Governance Committee; and,
- move item 7.1, Non Union Discussions, to the Closed Session due to confidential personnel matters.

Carried

5. Approval of the Minutes

5.1 September 5, 2012

Moved by	Seconded by
Mayor Smith	Deputy Mayor Sharpe

That the minutes of September 5, 2012 be approved as written, and brought forward to the next Board of Health meeting.

Carried

6. Business Arising from the Minutes

6.1 Board of Health Liability Presentation to the Board (Woodford)

Mr. Woodford confirmed that this presentation was made to the Board at its November 14, 2012 meeting.

7. New Business

7.1 **Non Union Discussions**

Moved to closed session, please refer to item 4 for details.

7.2 **Ontario Public Health Operational Requirements - Management Operations**

Within the Ontario Public Health Organizational Standards, Part 2/Section 6 outlines Management Operations which requires boards of health "to ensure that the administration of the board of health uses a proactive, problem solving approach to establishing its operational directions, demonstrates its organizational priorities and objectives through its actions on program delivery, and functions in an efficient and effective manner." It is noted that "requirements within this section require that the board delegate tasks to the senior staff of the health unit, or 'administration'".

Dr. Pellizzari advised that it was expected that the Ministry of Health and Long-Term Care would audit two Health Units per year to ensure compliance with these standards.

The Executive Committee, which consists of Dr. Pellizzari, Larry Stinson and Brent Woodford, met earlier this month and provided the Governance Committee with a report on the status of the requirements within the Management Operations section. The Health Unit has achieved compliance for the majority of the requirements, and in areas where it is partially compliant, Executive will ensure these requirements are met in 2013.

Comments were noted for the following items:

6.1, Operational Plan – Dr. Pellizzari noted that as part of the Committee's agenda package, changes have been recommended to the performance review policy and procedure for the Medical Officer of Health (MOH). The Association of Local Public Health Agencies (alPHa) is starting work on MOH performance tools for boards of health (BOH) and expects to have an update for the BOH Section at the Winter Symposium in February 2013. alPHa anticipates having these tools ready for distribution by the end of March 2013.

6.9, Capital Funding Plan - The Health Unit is currently developing a capital replacement list, Mayor Smith enquired whether we should adopt a similar format as the municipalities by using Public Sector Accounting Principles. **ACTION: Brent to follow up with John Butler, Treasurer, County of Peterborough.**

With respect to capital funding, the Ministry does not allow Boards to maintain a surplus – all capital funding must be applied for. Advocacy is under way through alPHa and PCCHU to have a capital budget allocated. Advocacy is also underway to allow health units to retain surpluses or some other method of developing capital funding.

6.1.2, Information Management – The Health Unit has established a Privacy Working Group, members include Dr. Pellizzari, Brent Woodford (MFIPPA lead), Patti Fitzgerald (Chief Nursing Officer and PHIPA lead), as well as Brittany Cadence and Mamdouh Mina from Communications Services. This group meets on an ad hoc basis to address these issues. It was identified that the Health Unit requires a procedure for remediation in the event an error is made. **ACTION: Dr. Pellizzari to ensure this procedure is developed in 2013.** It was suggested that a presentation could be made to the Board in 2013 on information security and how it relates to the Board.

Under this section, boards of health must be compliant with all applicable legislation, including the Health Protection and Promotion Act (HPPA). **ACTION: Dr. Pellizzari offered to prepare a presentation to the Board in 2013 which would outline our compliance with the HPPA.**

6.1.4, Human Resources Strategy - The Health Unit is in the midst of producing a code of conduct. Dr. Pellizzari noted this ranked high at the October 2012 Health Unit All Staff Day where staff reviewed results of an internal Organizational Culture survey and identified priorities for the Health Unit to pursue. Governance Committee members agreed this policy would not require Board approval and could exist at the organizational level. Brent advised that new processes are in place to ensure staff and unions are included in a consultation process for all Health Unit policies and procedures.

Moved by Seconded by
Mayor Smith Deputy Mayor Sharpe
That the Board of Health Governance Committee:

- accept the Management Operations Status Report for information;
- direct Executive Committee members to provide an annual update to the Committee at the end of each calendar year; and
- request a presentation from the Medical Officer of Health on Compliance with Obligations under the Health Protection and Promotion Act in 2013.

Carried.

7.3 By-Law, Policy and Procedure Review

The following by-laws, policies and procedures were reviewed by the Committee. Revisions were captured as discussed.

Moved by Seconded by
Deputy Mayor Sharpe Mayor Smith
That the following revised documents be forwarded for approval to the Board of Health at its next meeting:

- 2-100, By-Law Number 1, Management of Property
- 2-180, By-Law Number 9, Procurement of Goods and Services *(attachment)*
- 2-340 – Policy, Medical Officer of Health, Performance Appraisal
- 2-341 – Procedure, Medical Officer of Health, Performance Appraisal
- 2-400 – Policy, Naming Rights
- 2-401 – Procedure, Naming Rights
- 2-802 – Access to the Board of Health

Carried.

With respect to By-Law Number 9, Brent advised that while not mandatory, he recommended that the Health Unit tender for insurance and banking in 2013. Committee members supported this decision. **ACTION: Brent to proceed with tendering process in 2013.**

7.4 Recruitment of New Provincial Appointee

The Committee discussed avenues for recruitment for the upcoming vacancy of Mr. Jobe in March, 2013. It was noted the duties and responsibilities of board members (as outlined in Board policy #2-200) should be included in the advertisement for this position. An advertisement will be placed in a local paper in January, in addition, the vacancy will be included as a news alert on the Health Unit's website which is featured on the main page at www.pcchu.ca. **ACTION: Alida to follow up on this item.**

It was also noted that Mr. Embrey's term would be completed in April 2013. Deputy Mayor Sharpe confirmed Mr. Embrey's desire to continue serving the Board, the Board Chair and the Committee supported his reapplication to the province. **ACTION: Dr. Pellizzari will draft a letter of support to MPP Jeff Leal for the Board Chair. She will also follow up with Mr. Embrey on submitting his reappointment application.**

7.5 Interest in Continuing on Governance Committee

Committee members were advised that Alida would be contacting all Board members to enquire about interest in serving on Board Committees in 2013. This information will be provided to the Chair at the January meeting to assist in determining Committee membership for the year.

8. 2013+ Strategic Plan

8.1 General Discussion (All)

Unfortunately, due to a lack of turnout at the City and County open house sessions, the Norwood session (which was originally rescheduled due to inclement weather) was cancelled.

This lack of interest and/or response has not been the case for the consultation sessions with partners, which have been very well attended. Nor has it been the case with respect to surveys which are being completed by staff and the general public. The survey remains open, and the numbers to date that have been received are positive.

9. In Camera/Closed Session for Personal Matters

Brittany Cadence and Hallie Atter joined the meeting for this item.

Moved by	Seconded by
Mayor Smith	Deputy Mayor Sharpe

That the Board of Health Governance Committee go in camera to discuss confidential personal matters.

Carried.

Moved by	Seconded by
Deputy Mayor Sharpe	Mayor Smith

That the Board of Health Governance Committee rise from in camera.

Carried.

Moved by Seconded by
Mayor Smith Deputy Mayor Sharpe
That the Governance Committee forward revised policy 2-800, *Forum for Governance Committee and Non-Union Staff Discussions (Terms of Reference)* to the Board of Health for approval at its next meeting.

Carried.

10. Items to be referred to:

10.1 Board of Health

- Governance Committee Minutes, September 5, 2012
- 2-100, By-Law Number 1, Management of Property
- 2-180, By-Law Number 9, Procurement of Goods and Services *(attachment)*
- 2-340 – Policy, Medical Officer of Health, Performance Appraisal
- 2-341 – Procedure, Medical Officer of Health, Performance Appraisal
- 2-400 – Policy, Naming Rights
- 2-401 – Procedure, Naming Rights
- 2-800 - Forum for Governance Committee and Non-Union Staff Discussions, Terms of Reference
- 2-802 – Access to the Board of Health

10.2 Other

Please refer to action items as noted in the minutes.

11. Agenda Items for Next Meeting

- Provincial Appointee Recruitment
- Review of By-Laws, Policies and Procedures as Required

12. Date, Time and Place of Next Meeting

The next meeting will be scheduled in late January 2013, or at the call of the Chair.

13. Adjournment

Moved by Seconded by
Mayor Smith Mr. Embrey
That the meeting be adjourned.

Carried

The meeting adjourned at 12:10 p.m.

c: Mr. Jim Embrey
Dr. Rosana Pellizzari
Mayor Mary Smith
Mr. David Watton
Chief Phyllis Williams
Mr. Brent Woodford

Board of Health
Policy

Section:	Number:	Title:	Page:
Board of Health	**2-348**	**Committee, Governance** *Terms of Reference*	**1 of 3**

Approved by: Board of Health **Date:** September 14, 2011 **Housekeeping Revision** **Approved by:** **On:**	**Original** **Approved by: Board of Health** **On: May 12, 2010** **Revision** **Approved by: Board of Health** **On: September 14, 2011** **Reviewed** **By: Governance Committee** **On: June 9, 2011** **Next Review Date: January 2013**
Reference:	

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' ~~performance~~ 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;

5. establish and administer a process for assessing the effectiveness of the Board, its Committees~~, and each member~~; and,

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

Membership

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

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.

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 Director, Corporate Services~~ The Administrative 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. ~~of the Director, Corporate Services.~~

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.

~~The agenda will follow a standard format at each meeting.~~

~~1. Call to Order~~
~~2. Declaration of Pecuniary Interest~~
~~3. Delegations~~
~~4. Approval of the Agenda~~
~~5. Approval of the Minutes~~
~~6. Business Arising from the Minutes~~
~~7. New Business~~
~~8. In Camera/Closed Session~~
~~9. Items to be Referred to:~~
~~9.1. Board of Health~~
~~9.2. Other~~
~~10. Agenda Items for Next Meeting~~

~~11. Date, Time, and Place of Next Meeting~~
~~12. Adjournment~~

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.

Board of Health
Policy

Section: **Board of Health**	Number: **2-374**	Title: **Contractor Performance and Litigation**	**Page: 1 of 2**
Approved by: Board of Health **Housekeeping Revision** **Approved by:** **On:**		**Original** **Approved By:** **On:** **Revision** **Approved by:** **On:** **Reviewed** **By:** **On:**	
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.

Purpose:

To ensure the work of contractors meets the requirements of the tender or contract.

Definitions:

a) "award" means the authorization to proceed with the purchase of goods, services or construction;

b) "bid" means an offer or submission from a vendor received in response to a request for quotation, tender, proposal or call for bids, which is subject to acceptance or rejection;

c) "bidder" means any legal entity that submits a bid in response to a call for bids;

d) "call for bids" means a formal request for bids and includes a request for quotations, a request for tenders and a request for proposals;

e) “contract” means any form of binding agreement between two or more legal entities, awarded under purchasing policies;

f) “contractor” means any legal entity to whom a contract is awarded;

g) “litigation” means any dispute between the Region and any other party or related party adverse in interest, including third party and cross-claims, where either a legal proceeding has been commenced for an injunction, a mandatory order, a declaration or the recovery of money, or a threat of legal action has been made in writing;

Policy:

The Director of Corporate Services shall be responsible for monitoring the performance of contractors and documenting evidence of such performance and shall advise the Medical Officer of Health where the performance of a contractor has failed to comply with a contract or other requirements.

The Medical Officer of Health in consultation with the Board may prohibit a contractor whose performance has been unsatisfactory from submitting a bid in response to a call for bids in accordance with policies adopted by the Board.

Unless otherwise permitted, no bid or proposal shall be accepted from, nor shall any contract be awarded or extended to any contractor or related party as determined in the discretion of the Medical Officer of Health, or any other party with whom the Board is engaged in unresolved litigation.

To: All Members
Board of Health

From: Mr. David Watton, Chair, Board of Health

Subject: **Property Committee**

Date: February 13, 2013

Recommendation:

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

- approve the designation of Deputy Mayor Sharpe as Chairperson of the Committee; and,

- approve the following documents referred by the Committee at the February 1, 2013 meeting:

    - Revised Policy #2-350, Committee, Property, Terms of Reference

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Please refer to the attached.

Original approved by

Mr. David Watton
Chair, Board of Health

Board of Health
Policy

Section:	Number:	Title:	Page:
Board of Health	**2-350**	**Committee, Property** *Terms of Reference*	**1 of 3**

Approved by: Board of Health **Date:** May 9, 2012 **Housekeeping Revision** **Approved by:** **On:**	**Original** **Approved by: Board of Health** **On: May 9, 2012** **Revision** **Approved by:** **On:** **Reviewed** **By:** **On:** **Next Review Date: May 2014**
Reference:	

Goal

1. To ensure that the Peterborough County-City Health Unit has adequate facilities to carry out its functions.

Objectives

The Property Committee will:

1. Review, prepare and recommend options for the Board of Health to consider regarding its facilities.

2. Undertake a process to implement Board of Health decisions regarding facilities.

3. Oversee any capital projects undertaken by the Board of Health.

4. Ensure that all facilities meet accessibility standards and requirements (e.g,. Building Code).

Membership

The Committee will be composed of a minimum of three Board members including the Chair. Community Members with specific expertise may be invited in on an as-needed basis.

~~The Board of Health will elect the Chair for the Committee, the Committee will elect its own Vice-Chair.~~

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.

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 Property Committee.

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

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

Minutes

The Administrative 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.

~~The agenda will follow a standard format at each meeting.~~

1. ~~Call to Order~~
2. ~~Declaration of Pecuniary Interest~~
3. ~~Approval of the Agenda~~
4. ~~Approval of the Minutes~~
5. ~~Business Arising from the Minutes~~
6. ~~New Business~~
7. ~~In Camera/Closed Session~~
8. ~~Items for Referral:~~
    - 8.1. ~~Board of Health~~
    - 8.2. ~~Other~~
9. ~~Agenda Items for Next Meeting~~
10. ~~Date, Time, and Place of Next Meeting~~
11. ~~Adjournment~~

Terms of Reference

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