Board of Health for the
Peterborough County-City Health Unit
AGENDA
Governance Committee Meeting
Tuesday, December 3, 2013 – 2:00 – 5:00 p.m.
(City and County Rooms, 150 O'Carroll Avenue, Peterborough)

1. Call To Order

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1 August 29, 2013

6. Business Arising from the Minutes

6.1 2013-17 Strategic Plan – Implementation – Oral Update (Pellizzari)

6.2 Provincial Appointee Update (Pellizzari)

7. Correspondence

8. New Business

8.1 Organizational Standards – Management Operations (Pellizzari)

8.2 BOH Policies and Procedures for Review
- a. 2-120 - Calling of and Proceedings at Meetings (By-Law 6)
- b. 2-150 - Remuneration of Members (Policy)
- c. MOH Performance Review Documents (Policy, Procedure and Forms)

8.3 Article of Interest: Public Health Governance and Population Health (Pellizzari)

8.4 Staff Report – Board Remuneration Review (Woodford)

9. In Camera to Discuss Confidential Personal Matters

10. Date, Time and Place of Next Meeting

11. Adjournment

Parked Items

- *Trillium Funding Eligibility (Woodford, from Aug. 29/13)*

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
Thursday, August 29, 2013 – 1:00 – 3:00 p.m.
(City and County Rooms, 150 O'Carroll Avenue, Peterborough)

Present: Mr. Jim Embrey
Brittany Cadence, Communications Supervisor
Dr. Rosana Pellizzari, Medical Officer of Health
Mayor Mary Smith
Mrs. Alida Tanna, Administrative Assistant (Recorder)
Mr. David Watton
Chief Phyllis Williams, Chair
Mr. Brent Woodford, Director, Corporate Services

1. Call To Order

Chief Williams called the meeting to order at 1:05 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved by: Mr. Embrey
Seconded by: Mr. Watton
Motion carried. (M-13-22-GV)

3. Declaration of Pecuniary Interest

None.

4. Delegations and Presentations

None.

5. Confirmation of the Minutes of the Previous Meeting

5.1 May 30, 2013

MOTION:
That the minutes of May 30, 2013 be approved as written, and brought forward to the next Board of Health meeting.
Moved by: Mr. Watton
Seconded by: Mr. Embrey
Motion carried. (M-13-23-GV)

6. Business Arising from the Minutes

Dr. Pellizzari advised that M.P.P. Leal visited the Health Unit earlier in the week on another matter. At that meeting, she provided him with a copy of the letter sent to his office in March regarding the recommended applicants for the Provincial Appointee position. Alida Tanna has also sent an e-mail inquiry to the Public Appointments Unit at the Ministry of Health and Long-Term Care to follow up on the status of the appointment process.

7. Correspondence

None.

8. New Business

8.1 **2013-17 Strategic Plan – Implementation Plan**
Reference Document: 2013-17 Strategic Plan

Dr. Pellizzari reviewed the implementation plan for the Board of Health's new Strategic Plan which will run over the course of the next five years.

The following items were discussed in relation to that report:

- *Fundraising* – Potential options/ideas for fundraising could be to fund the new building, additional services and programs, or create a bursary for professional development for staff. Members discussed options on how to proceed with this work, which would likely start in 2014. Mayor Smith noted that Andrea Dicks, Executive Director for the Greater Peterborough Community Foundation, would be a useful resource in determining how to proceed with this. **ACTION: Mayor Smith will schedule an initial information gathering meeting with Ms. Dicks and Mr. Watton.**
- *Dissemination of the Strategic Plan* – Dr. Pellizzari advised that a presentation would be created for staff, and that Managers have been directed to have discussions with their teams, preferably with a member of the Strategic Planning Working Group in attendance. Future staff reports to the Board will also link to the relevant strategic direction, and in addition, operational planning for 2014

will also begin to incorporate the new plan. Committee Members determined that semi-annual reporting to the Board would be sufficient. **ACTION: Dr. Pellizzari will discuss this with the Executive Committee for 2014. An update will be provided to the Board at the next Board of Health meeting.**

- ***Sponsorship –*** Committee members discussed the ongoing issue of the Health Unit's exclusion from applying for Trillium funding. **ACTION: Mr. Woodford will confirm the reason for this exclusion and update the Committee at a future meeting.** It was also noted that the Health Unit should approach the Community Futures Development Corporation.

MOTION:
That the 2013-17 Strategic Plan – Implementation Plan be received for information.
Moved by: Mayor Smith
Seconded by: Mr. Watton
Motion carried. (M-13-24-GV)

8.2 BOH Policies and Procedures for Review

a. 2-240, Honourariums and Allowances (Policy)

ACTION: Staff were directed to combine this Policy with By-Law 6, Remuneration of Members, and bring this forward to the next Committee meeting for consideration.

b. 2-261, Appointments, Provincial Representatives (Procedure)

DECISION: Changes approved. ACTION: This item will be brought forward to the next Board meeting

c. 2-190, Sponsorship (Policy)

No changes.

d. 2-191, Sponsorship, EthicScan (Procedure)

ACTION: Mrs. Tanna will confirm the fee schedule for the EthicScan report order. If this has changed, this will be updated as a housekeeping revision.

MOTION:
That Procedure 2-261, Appointments, Provincial Representatives, be brought forward to the next Board of Health meeting for approval.
Moved by: Mr. Embrey
Seconded by: Mayor Smith
Motion carried. (M-13-25-GV)

8.3 Health Unit Branding

Brittany Cadence joined the meeting for this item.

Dr. Pellizzari and Mrs. Cadence presented information on the rebranding of the Health Unit. Should the Health Unit change its name (e.g., Peterborough Public Health), this would not require a legal change of name, so any legal documents, contracts, etc., would still remain status quo. Financial implications would be staff time to implement this, or costs associated with a consultant should the Board wish to utilize the services of a consultant for this process. A number of Health Units have recently rebranded, and rebranding is currently being considered at the provincial level as well.

Mayor Smith suggested that staff should speak with Tania Goncalves, Deputy Clerk Township of Selwyn, since she recently led the Township through its renaming and rebranding process. **ACTION: Staff were directed to prepare a report for the Board once additional information becomes available, including a potential schedule and costing.**

9. In Camera to Discuss Confidential Personal Matters

MOTION:
That the Committee go In Camera to discuss confidential personal matters.
Moved by: Mr. Watton
Seconded by: Mr. Embrey
Motion carried. (M-13-26-GV)

MOTION:
That the Committee rise from In Camera.
Moved by: Mr. Embrey
Seconded by: Mayor Smith
Motion carried. (M-13-27-GV)

10. Date, Time and Place of Next Meeting

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

11. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Mayor Smith
Seconded by: Mr. Embrey
Motion carried. (M-13-28-GV)

The meeting adjourned at 3:00 p.m.

Chair

Recorder

Ontario Public Health Organizational Standards
Management Operations – 2014 (Update – November 2013)

Requirements	Details	Lead	Comments
6.1 Operational plan	The board of health shall ensure that the administration establishes an operational plan for the organization which:	Rosana Pellizzari (RP)	
	• Describes the composition, responsibilities and function of the public health unit;		An organizational chart is maintained by the MOH Administrative Assistant.
	• Documents the internal processes for managing day-to-day operations of programs and services to achieve the required board of health outcomes as per OPHS;		• Organizational and program policies and procedures • Committee minutes • Reports to the Ministry and Board of Health
	• Demonstrates that the operational activities of the public health unit are aligned with the board of health's goals, objectives and priorities, as described in the strategic plan;		The MOH performance planner and those of the management team incorporate elements of the strategic plan. Reports to the Board of Health acknowledge relevant strategic directions. Operational Plans and Logic Models are reviewed and Operational Plans are developed on an annual basis. These are informed by BOH strategic directions and based on the outcomes and requirements set out in the Ontario Public Health Standards. Logic model components include: Population Health Assessment and Surveillance; Education and Awareness; Skill Building; Environmental Support; and Healthy Public Policy as the Program Areas of Focus. Operational Plans include activities that are linked to OPHS Requirements and detail the activities, staff responsibilities, resource requirements and timing. Quarterly reports on implementation of the planned activities are provided to the Medical Officer of Health and Board of Health.
	• Includes objectives, activities, timeframes, responsibilities, intended results, monitoring processes, an organizational chart and internal reporting requirements;		
	• Contains planned activities based on an assessment of its communities' needs;		The PCCHU planning process includes a Situational Assessment that determines local need, potential impact, capacity and opportunities for partnership.
	• Demonstrates efforts to minimize barriers to access; and		A Health Equity Mapping tool is used to assess programs and activities and identify opportunities for addressing disparities and improving access by priority populations. Each program reviews priority populations on an annual basis and planning discussions are framed to ensure coordination, and where appropriate integration of strategies. The Medical Officer of Health has begun work on a policy and procedure to ensure that all programs and services are accessible to vulnerable and priority populations.
	• Describes the monitoring of key performance indicators to support continuous quality improvement		In addition to Quarterly Compliance Reports, Accountability Agreement Indicators are reported to the Ministry of Health and Long-

Requirements	Details	Lead	Comments
	and evidence-informed public health practice.		Term Care as required. New strategies and activities that have been modified are evaluated to ensure short-term outcomes are achieved. Executive Committee will be launching a CQI strategy as part of the new strategic plan.
	The development of the operational plan shall involve staff at all levels of the organization and include input from community partners and shall be reviewed and updated at least annually, or more often as required by local circumstances, with the date of the most recent revisions noted.		All staff are engaged in operational plan development and through Program Meetings bring ideas and solutions to program challenges forward on an ongoing basis. Community partners and other stakeholders provide input into operational planning through coalitions, partnerships and community needs assessments at the program or issue-based level. A new engagement strategy is part of the BOH 2013-15 strategic plan.
	Achievement of the operational plan shall be monitored and reported in status reports on a quarterly basis to board members and staff.		Operational plans are reviewed annually. BOH receives quarterly reports based on the OPHS requirements, which are actualized through the operational plans.
6.2 Risk management	The board of health shall ensure that the administration monitors and responds to emerging issues and potential threats to the organization, from both internal and external sources, in a timely and effective manner. Risk management is expected to include but is not limited to: financial risks, HR succession and surge capacity planning, operational risks, and legal issues.	Brent Woodford	The Board is provided briefing notes and updates on emerging and potential threats from all levels of staff at each meeting. Staff presentations are made regarding contingency planning, liabilities and other areas of Board development. The Board is provided quarterly financial summaries, including an analysis of any areas of financial concern. The Board has developed policies, procedures and by-laws and these are reviewed by Governance then affirmed by the Board every two years on an ongoing basis. A succession plan was developed and updated annually
6.3 Medical Officer of Health provides direction to staff	The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programs or services under this or any other Act. (HPPA, s.67(2))	Rosana Pellizzari	Compliant.
6.4 Eligibility for appointment as a Medical Officer Of Health	No person is eligible for appointment as a medical officer of health or an associate medical officer of health unless (a) he or she is a physician; (b) he or she possesses the qualifications and requirements prescribed by the regulations for the position; and (c) the Minister approves the proposed appointment. (HPPA, s.64)	Rosana Pellizzari	Compliant.
6.5 Educational requirements for public health professionals	The educational and experiential qualifications of boards of health staff are specified for the positions of business administrator, public health dentist, dental hygienist, public health inspector, public health nurse, and public health nutritionist. (HPPA, Reg.566)8	Larry Stinson, Rosana Pellizzari	Job Descriptions for all classifications identify minimum requirements including education and/or equivalent experience. Successful applicants are required to provide proof of degrees attained and where appropriate current college registration.

Requirements	Details	Lead	Comments
6.6 Financial records	The board of health shall keep or cause to be kept (a) books, records and accounts of its financial affairs; (b) the invoices, receipts and other documents in its possession that relate to the financial affairs of the board.	Brent Woodford	An annual audit is conducted by an external, unaffiliated, independent auditor. Policies, procedures and by-laws have been developed and are reviewed every two years by Governance Committee and the Board every two years.
	The board of health shall cause to be prepared statements of its financial affairs in each year including but not limited to (a) an annual statement of income and expenses; (b) an annual statement of assets and liabilities; and (c) an annual estimate of expenses for the next year. (HPPA, s.59(1) and (2))		Budgets showing revenues and expenses are prepared for Board approval on an annual basis and the Board conducts quarterly reviews of financial performance.
6.7 Financial policies and procedures	The board of health shall ensure that the administration implements appropriate financial management and oversight which ensures that the following are in place:	Brent Woodford	
	• A plan for the management of physical and financial resources;		The Board has approved Purchasing and Management of Property By-Laws. The new strategic plan includes the development of an asset management policy.
	• A process for internal financial controls, which is based on generally accepted accounting principles;		There are organizational Policies and Procedures on purchasing and internal controls. PCCHU is a member of a purchasing co-op Accounting follows GAAP and external audit reports on performance.
	• A process to ensure that areas of variance are addressed and corrected;		Accounting produced monthly financial reports by manager. Managers are expected to address variances. Quarterly presentations made to Board outlining variances.
	• A procedure to ensure that the procurement policy is followed across all programs/services areas;		There are organizational Policies and Procedures on purchasing and internal controls.
	• A process to ensure the regular evaluation of the quality of service provided by contracted services, in accordance with contract standards;		There are external service contracts at this time and a process will be developed in 2014.
	• A process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity; and		The Board approves an annual budget. There are quarterly reports to Board including performance to budget and performance to operating plan. Areas of concern are brought to the Board's attention and staff present recommendations to address areas of significant variance for Board approval.
	• A budget forecast for the current fiscal year that does not project a deficit.		A balanced annual budget is presented to the Board for approval.
6.8 Procurement	The board of health shall comply with Section 270(2) of the *Municipal Act, 2001,* which requires that the board of health ensures that the administration adopts policies	Brent Woodford	

Requirements	Details	Lead	Comments
	with respect to its procurement of goods and services. Such policies shall include:		
	• The types of procurement processes that shall be used;		The Board has approved a Purchasing By-Law and there are policies and procedures on purchasing.
	• The goals to be achieved by using each type of procurement process;		There are organizational Policies and Procedures on purchasing and procedures on types of requests that are available to address needs.
	• The circumstances under which each type of procurement process shall be used;		Policies and Procedures specify type of procurement process to be followed by procurement type and by dollar amount
	• The circumstances under which a tendering process is not required;		The policy and procedure outlines when tendering is not required.
	• The circumstances under which in-house bids will be encouraged as part of the tendering process;		Addressing in-house bids is not applicable.
	• How the integrity of each procurement process will be maintained;		Tenders are prepared and reviewed by internal stakeholders. Stakeholders participate in proposal evaluations.
	• How the interests of the board, the public and persons participating in the procurement process will be protected; and,		Major tenders widely circulated through online procurement portals (e.g., MERX or Bidingo). Tenders are evaluated considering quality, vendor reputation and price.
	• How and when the procurement processes will be reviewed to evaluate their effectiveness.		Procurement processes will be reviewed at each new procurement cycle (i.e., each time procurement is re-tendered).
	• The board of health is expected to implement procurement policies and practices that align with those of the relevant municipality as appropriate.		Policies and procedures align with municipal, BPS and Ministry requirements.
6.9 Capital funding plan	A board of health may acquire and hold real property for the purpose of carrying out the functions of the board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it. HPPA, s.52(3) does not apply unless the board of health has first obtained the consent of the councils of the majority of the municipalities within the public health unit served by the board of health. (HPPA, s.52(3) and (4))	Brent Woodford	Approval to acquire and hold property was given when the Board formed. A capital replacement list being developed.
	The board of health that owns its own building(s) shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported.		Ministry policy <u>does not</u> allow Boards to maintain surplus – all capital funding must be applied for. Advocacy is under way through the provincial association and PCCHU to have capital budget allocated. Advocacy also under way to allow health units to retain surpluses or some other method of developing capital funding.
6.10 Service level agreements	Where a board of health functions as part of a municipal or regional government and is required to contribute financially to the corporate provision of services (e.g., IT, HR, financial management services), the board of health	n/a	n/a

Requirements	Details	Lead	Comments
	shall ensure that the administration negotiates a service level agreement with its local government which includes a description of the scope, volume and timeliness of services to be provided for a specific cost.		
6.11 Communications strategies	The board of health shall ensure that the administration develops an overall communication strategy that is complementary to the program specific communication strategies required in the OPHS and its Protocols, and addresses both external and internal audiences. The communication strategy shall include:	Rosana Pellizzari	Policies and procedures have been approved for media relations, graphic design, social media management, online communities, and healthcare provider communications. Communications guidelines have been developed for other external audiences including schools, and post-secondary institutions. Internal audiences and guidelines for research project dissemination will be developed in the fourth quarter so an overall communications strategy for the Health Unit is drafted by the fourth quarter.
	• Guidelines for sharing information with community partners and staff;		Specific guidelines have been created to address communications to healthcare providers and schools.
	• A plan to ensure consistency in messaging at all levels, to all audiences;		A graphic design policy and procedure have been created to ensure consistency in messaging. Webpage templates are in place and some program staff have been trained on updating and managing content. Almost all publicly issued material is vetted by the Communications Supervisor. Identity Standards guidelines will be drafted by Q1 2014 and rolled out to staff in Q2 2014.
	• Dissemination plans to disseminate relevant research findings for each approved research project proposal;		Knowledge Exchange plan is being embedded into new research approval template (Research and Education Committee, to be completed by Spring 2014)
	• Guidelines for use of relationships with media channels (e.g., print, radio, television, web) to share health information with general public and targeted populations or audiences;		Guidelines for use of relationships with media channels (e.g., print, radio, television, web) to share health information with general public and targeted populations or audiences is covered in our media relations policy and procedure; a social media policy and procedure is in draft and currently under review.
	• Plan for use of multiple modalities to ensure accessibility;		The organization has TTY. Print materials for public use include an accessibility line offering to provide the information in alternative
	• Strategies for educating community partners and the public about key public health issues; and		• MOH regularly presents on various PH topics in the community. • Monthly Examiner column. • Presentations have been offered to municipal councils and service clubs to educate partners and the public on what we do and relevant issues to public health (Annual Reports, Strategic Plan) • Public health issues are routinely monitored (e.g. fluoride, wifi, TCE, etc.) and fact sheets, web pages, and online resources are created as necessary. Public meetings are held to present information if required.

Requirements	Details	Lead	Comments
	• An internal communication strategy, including the posting of minutes of senior management team meetings, which informs staff of significant management decisions.		An internal communication strategy, including the posting of minutes of senior management team meetings, which informs staff of significant management decisions needs to be fully developed.
6.12 Information management	The board of health shall ensure that the Medical Officer of Health, as the designated health information custodian under the Personal Health Information Protection Act, maintains information systems that support the organization's mission and workforce by providing infrastructure for data collection/analysis, program management, administration and communications.	Executive Committee	IT maintains the security of all databases and ensures back-up to prevent data loss. Corporate Services provides infrastructure and seeks funding opportunities.
	The board of health shall ensure that the Medical Officer of Health establishes, maintains and implements policies and procedures related to data collection and records management, which ensure:		
	• Compliance with all applicable legislation, regulations and policies, including the HPPA, Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), and Personal Health Information Protection Act (PHIPA) to the management of all personal information and personal health information in board of health records;		The health unit is in compliance with MFIPPA and PHIPA legislation. All privacy breaches and MFIPPA/PHIPA access requests are tracked. Several new and revised PHIPA policies & procedures in final approval process.
	• Data quality in the creation and collection of data;		Documentation policy and procedure exist. CQI initiative will address data quality.
	• Confidentiality in how records are used and accessed;		Confidentiality is described in the records policy and all staff sign annual Confidentiality Agreements at the time of their performance review. All records are either password protected and/or locked. New procedure drafted on handling personal health information off premise. Privacy Impact Assessments are completed for remote clinic connectivity as required.
	• Use of current and appropriate security features, including strong encryption of personal health information during transfers and when stored on mobile devices;		Encryption is in place.

Requirements	Details	Lead	Comments
	• A records maintenance process that includes remediation of errors;		Not addressed. Current records policy requires accurate records but no procedure for remediation exists. Documentation procedure outlines process for staff if a correction to a record is needed. PHIPA procedure outlines process if a client requests a correction to his /her record.
	• Appropriate records retention process that varies by type of record;		Follow current records policy and retention/disposal schedule. This policy is being updated.
	• Secure disposal of records; and		See above. Secure shredding is available at all three sites.
	• That the purposes and appropriate uses of data being created are communicated to and respected by staff and management who collect, enter, store, analyze, use and/or destroy the data.		Staff receive PHIPA training. Also covered in the new/revised PHIPA policies and procedures.
	This requirement applies to all information that the board of health has in its control, including personal information and personal health information.		Policies and procedures apply to all records and information
6.13 Research ethics	The board of health shall ensure that the administration establishes, maintains and implements policies and procedures related to research ethics that reflect accepted standards of practice.	Rosana Pellizzari	The Research and Education Committee reviews all research and there are policies and procedures, and terms of reference for ethics review.
6.14 Human resources strategy	The board of health shall ensure that the administration establishes a human resources strategy, based on a workforce assessment which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development and leadership development of the public health unit workforce. The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision. Written policies and procedures shall be maintained concerning:	Brent Woodford	A Succession Plan policy and procedure has been implemented. Key positions are identified on an annual basis. Job descriptions are currently being reviewed for currency and accuracy. New policies to support professional development, training and education have been developed. An HR Strategy is included as one of the new 2013-17 Strategic objectives.
	• Orientation of public health unit staff;		There is a policy and procedure on orientation as well as an orientation checklist and modules.

Requirements	Details	Lead	Comments
	• The availability of job standards and position descriptions for staff;		Job descriptions are posted to the Health Unit intranet site which is accessible by all staff.
	• A process to ensure that staff meet qualifications for their positions, job classifications and licensure (as required);23 Ontario Public Health Organizational Standards		The CNO has developed and implemented a policy and procedure on verification of qualifications for professional (regulated) staff.
	• Contents of a personnel file and provisions for access; complete personnel files shall be maintained for each staff member, with appropriate policies and practices regarding the confidentiality of personnel information;		All staff have personnel file and there are P&P on access to files. HR, Labour, employment, disciplinary and other Policies and Procedures being reviewed, developed and approved. The Policy and Procedure on P&P now states 1/3 of all P&P will be reviewed annually – part of review is having MOH sign off.
	• Occupational health and safety policies;		Policies, procedures, checklists, forms and other documents available on the Intranet for all staff access. An OH&S committee meets quarterly or as required. OH&S committee has terms of reference. OH&S Policies and Procedures are reviewed by PP&F committee and OH&S committee
	• Recruitment and retention strategies, including workplace health practices;		All positions have job descriptions to assist in recruiting HR is reviewing job interview questions Employee survey conducted every two years (CMHA workplace survey) Joint Occupational Health and Safety Committee surveys, recommendations and oversight
	• A code of conduct;		The management team has developed a Management Framework to guide management conduct. A code of ethical conduct is being developed collaboratively as part of the Organizational Culture work.
	• Compensation policy;		Unionized staff wages and hours are negotiated through collective bargaining and the Collective Agreements is ratified by the Board. Policies have been approved for non-union benefits. A proposed compensation policy has been drafted and waiting Board direction on review to finalize.
	• Reporting relationships;		There is an organizational chart showing reporting relationships. A presentation module is being created to explore committee structures and decision making
	• Discipline and labour relation policies;		Discipline and labour relations policies are in place.
	• Staff performance evaluation processes; and		Staff performance appraisals done annually, including re-signing confidentiality agreement.
	• Succession planning.		Succession planning policy and procedure are covered above.
6.15 Staff development	The board of health shall ensure that the administration develops a workforce development plan which identifies	Management Team	The Research and Education Committee assists with the delivery of prioritized organization-wide training and education. Each supervisor

Requirements	Details	Lead	Comments
	the training needs of staff, including discipline specific and management training, and encourages opportunities for the development of core competencies and partnerships with academic institutions.		develops a professional development plan with his or her employee and then seeks opportunities to have these needs met. Ongoing discussions with Trent Nursing to develop a Masters of Nursing program.
	The board of health shall ensure that the administration provides formal and informal opportunities for leadership development, such as educational programs, membership in professional associations, coaching and mentoring, for staff at all organizational levels and with consideration to equity and fairness.		Leadership development is being pursued by the Executive Committee as part of our succession planning. Acting management positions are offered when possible. Incentives are offered for staff to take online PHAC modules in epidemiology. Workshop and conference policies and procedures have been updated. A new fund is being established to assist employees with education. A mentorship program is being developed in 2014. Placements will be supported. PEAK Leadership training is being offered and supported for staff.
	The board of health shall ensure that the administration fosters an interest in public health practice for future health professionals by supporting student placements.		Compliant. We offer a variety of student placements. Several educational agreements are in place.
6. 16 Professional practice support	The board of health shall support a culture of excellence in professional practice for all regulated and unregulated health professions that ensures inter-professional collaboration and learning, and that staff are able to comply with professional regulatory body requirements where applicable. A range of models could be used, including the designation of professional practice leads.	Patti Fitzgerald	CNO has established a Nursing Council and will develop a Professional Practice Council.
	Effective January 2013, boards of health are required to designate a Chief Nursing Officer (CNO) to be responsible for nursing quality assurance and nursing practice leadership.*		Compliant. The Health Unit recruited a CNO in July 2012.

TO: **BOH Governance Committee Members**

FROM: **Alida Tanna, Administrative Assistant**

DATE: **December 3, 2013**

RE: **Background Information for Policy and Procedure Review**

With respect to the policies and procedures included in this package, the following has been included for your reference:

1. **Changes to By-Law 6 – Remuneration of Members**

- At the last Governance Committee meeting, Members suggested combining By-Law 6, Remuneration of Members and Policy 2-240, Honorarium and Allowances.

- The Health Protection and Promotion Act notes that Boards must have certain by-laws in place (see below), remuneration is suggested for inclusion as a supplementary by-law however it is not mandatory. Staff propose that this By-Law be retired in favour of a Board of Health Policy.

- The enclosed Policy 2-150 has combined the two documents verbatim. Definitions and items 1 – 3 are taken from By-Law 6, items 4 – 11 are taken from Policy 2-240, no other changes to content have been made other than those identified.

HPPA – Board of Health Section

By-laws

56. (1) A board of health shall pass by-laws respecting,

(a) the management of its property;

(b) banking and finance;

(c) the calling of and proceedings at meetings; and

(d) the appointment of an auditor. R.S.O. 1990, c. H.7, s. 56 (1).

Idem

(2) A board of health may pass by-laws respecting,

(a) the appointment, duties and removal of officers (other than the medical officer of health or an associate medical officer of health) and employees, and the remuneration, pensions and other benefits of officers and employees; and

(b) any other matter necessary or advisable for the management of the affairs of the board of health. R.S.O. 1990, c. H.7, s. 56 (2).

2. **Medical Officer of Health Performance Review Documents**

The documents relating to the performance review for the Medical Officer of Health have been included as Members who recently participated in the review noted the following issues:

- some of the forms require improvement;
- conducting the 360^{o} component every two years may be too often; and
- the process of obtaining feedback from internal and external stakeholders could be staggered rather than occur at the same time.

Deputy Mayor Sharpe who recently took part in this review has been invited to the meeting to discuss this item.

Respectfully Submitted,

Alida Tanna
Administrative Assistant

Board of Health
POLICY

Section: Board of Health	**Number: 2-120**	**Title: By-Law Number 3, Calling of and Proceedings at Meetings**
Approved by: Board of Health **Signature:** **Date** (YYYY-MM-DD)**:** 2013-04-10 **Housekeeping Revision** **Approved by:** **On** (YYYY-MM-DD)**:**		**Original Approved by Board of Health** **On** (YYYY-MM-DD)**: 1989-10-11** **Revision** **Approved by:** Board of Health **On** (YYYY-MM-DD)**:** 2013-04-10 **Reviewed by:** Governance Committee **On** (YYYY-MM-DD)**:** 2013-03-13
Reference:		

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

By-Law Number 3
Calling of and Proceedings at Meetings

Section 1 - Interpretation

In this By-law:

1.1. "Act" means the Health Protection and Promotion Act;

1.2. "Board" means the Board of Health for the Peterborough County-City Health Unit;

1.3. "Director, Corporate Services" means the business administrator of the Board as defined in the Regulations under the Act;

1.4. "Chairperson" means the presiding officer at a meeting;

1.5. "Chairperson of the Board" means the Chairperson elected under the Act;

1.6. "Committee" means an assembly of two or more members that must meet together to transact business;

1.7. "Councils" means the municipal ~~c~~Councils of the Corporations of the County of Peterborough and the City of Peterborough, and the ~~Band~~ Councils of Curve Lake and Hiawatha First Nations;

1.8. "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations;

1.9. “Meeting" means an official gathering of members of the Board or a committee in one place to transact business;

1.10. "Member" means a person who is appointed to the Board by a ~~c~~Council or the Lieutenant Governor-in-Council or a person who is appointed to a committee by the Board;

1.11. "Motion" means a formal proposal by a member in a meeting that the Board or a committee take certain action;

1.12. "Resolution" means a motion that is carried at a meeting by a majority vote in the affirmative of the members present; and

1.13. "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act.

Section 2 – General

2.1. The rules in this By-law shall be observed in the calling of and the proceedings at all meetings of the Board and committees.

2.2. Except as herein provided, the most recent edition of Robert's Rules of Order shall be followed for governing the calling of and proceedings of meetings of the Board and committees.

2.3. No persons shall consume alcohol or tobacco products at a meeting.

2.4. In exceptional circumstances, and with the approval of the Chairperson of the Board or committee, members of the Board of Health can attend meetings by teleconference.

Section 3 - Convening of Meetings

3.1 The Medical Officer of Health shall call the first meeting of each calendar year.

3.2 The first meeting shall be held after the municipal members, appointed to the Board by their respective councils, are confirmed, and shall be held no later than the 1st day of February.

3.3 At the first meeting of each calendar year, the Board shall:

3.3.1 elect the Chairperson and the Vice-Chairperson of the Board for the year;

3.3.2 appoint members to its committees;

3.3.3 fix, by resolution, the date and time of regular meetings; and,

3.3.4 establish the honourarium paid to each member eligible for compensation in accordance with the Health Protection and Promotion Act.

3.4 ~~The Board may alter, by resolution, the day, time or place of any regular meeting.~~

A meeting may be rescheduled or cancelled due to the following circumstances:

3.4.1 in the event that an emergency has been declared by the Medical Officer of Health;

3.4.2 if there is indication from members in advance of the meeting that quorum will not be achievable; or

3.4.3 if upon consultation with the Medical Officer of Health, the Chairperson determines there is insufficient business to be considered.

In all instances, the Chairperson will poll members to obtain consensus to proceed with a cancellation. If approval is obtained through a majority vote, members will be notified and a public notice will be issued.

3.5 The Chairperson of the Board can call a special meeting and shall call a special meeting at the written request of a majority of the members.

3.6 The Medical Officer of Health shall:

3.6.1 give notice of the first and each regular and special meeting;

3.6.2 ensure that the notice accompany the agenda and any other matter, so far as known, to be brought before such meeting;

3.6.3 cause the notice to be delivered to the residence or place of business of each member or by e-mail or telephone so as to be received not later than two clear days in advance of the meeting.

3.7 The lack of receipt of the notice shall not affect the validity of the holding of the meeting or any action taken thereat.

3.8 No business other than that stated in the notice of a special meeting shall be considered at such meeting except with the unanimous consent of the members present.

3.9 Special meetings can be held by teleconference.

Section 4 - Agenda and Order of Business

4.1 The Medical Officer of Health shall have prepared for the use of each member at the first and regular meetings an agenda of the following items.

4.1.1 Call To Order

4.1.2 Confirmation of the Agenda

4.1.3 Declaration of Pecuniary Interest

4.1.4 Delegations and Presentations

4.1.5 Confirmation of the Minutes of the Previous Meeting

4.1.6 Business Arising from the Minutes

4.1.7 Correspondence

4.1.8 New Business

4.1.9 In Camera to Discuss Confidential Matters

4.1.10 Date, Time and Place of the Next Meeting

4.1.11 Adjournment

4.2 Any items not included on the prepared agenda may be added by resolution.

4.3 Agenda packages will be posted on the Health Unit's website on the same day that agendas are distributed to Board of Health members.

4.4 On the day following Board of Health meetings, Board members will be contacted and advised of the date, time, and location of the next meeting, and asked about their availability for the next meeting.

4.5 The business of each regular meeting shall be taken up in the order described in section 4.1 of this By-law unless otherwise decided by the members.

4.6 The Chairperson of the Board shall direct the preparation of an agenda for a special meeting.

4.7 The business of each special meeting shall be taken up in the order as listed on the agenda of such meeting unless otherwise decided by the members.

Section 5 - Commencement of Meetings

5.1 As soon as there is a quorum after the time fixed for the meeting, the Chairperson or Vice-Chairperson of the Board or the person appointed to act in their place and stead, shall take the chair and call the members to order.

5.2 A quorum for any meeting of the Board or a committee shall be a majority of the appointed members.

5.3 If the Chairperson or Vice-Chairperson of the Board or the Chairperson of a committee does not attend a meeting by the time a quorum is present, the Medical Officer of Health shall call the members to order and a presiding officer shall be appointed to preside during the meeting or until the arrival of the person who ought to preside.

5.4 Upon any members directing the attention of the Chairperson to the fact that a quorum is not present, the Medical Officer of Health, at the request of the Chairperson, shall record the names

of those members present and advise the chairperson if a quorum is or is not present. If there is no quorum within thirty minutes after the time fixed for the meeting, the Chairperson shall then adjourn until the day and time fixed for the next meeting.

Section 6 - Delegations and Debate

6.1 The Chairperson shall preside over the conduct of the meeting, including preserving good order and decorum, ruling on points of order and deciding all questions relating to the orderly proceedings of the meeting.

6.2 Any individual or group who wishes to make a presentation to the Board shall make a written request to the Chairperson of the Board up to a minimum of twenty-four hours before the start of the meeting.

6.3 The Chairperson of the Board (in consultation with the Medical Officer of Health) shall decide whether the delegation may make a presentation at a meeting and accordingly, shall inform the individual or group whether their request has been approved or denied.

6.4 The Chairperson shall give due consideration to the length of the agenda and the number of delegation requests received, and may limit the number of delegations to a maximum of five (5) per meeting.

6.5 All delegations appearing before the Board shall be permitted to speak only once on an item, unless new information is being brought forward, and/or unless permission is given by the Chairperson of the Board, in consultation with the Medical Officer of Health.

6.6 Delegations and presentations of general interest shall not exceed ten minutes except when answering questions posed by the Chairperson for clarification.

6.7 Unless otherwise directed by resolution, no action respecting a delegation will be taken until the Board has had an opportunity to discuss the delegation and to receive advice from the Medical Officer of Health.

6.8 The Board will be informed of all requests from delegations and the disposition of such requests and, upon review, the Board may reverse the decision of the Chairperson of the Board by resolution.

6.9 Every member shall address the Chairperson respectfully previous to speaking to any motion.

6.10 When two or more members ask to speak, the Chairperson shall name the member who, in their opinion, first asked to speak.

6.11 If the Chairperson desires to leave the Chair to participate in a debate or otherwise, they shall call on the Vice-Chairperson to fill their place until they resume the Chair.

6.12 A member may speak more than once to a motion, but after speaking, shall be placed at the foot of the list of members wishing to speak.

6.13 No member shall speak to the same motion at any one time for longer than ten minutes except that extensions for speaking for up to five minutes for each time extended may be granted by resolution.

6.14 6.14.1 A member may ask a question of the previous speaker and then only to clarify any part of their remarks.

6.14.2 When it is a member's turn to speak, before speaking, they may ask questions of the Medical Officer of Health or staff present, to obtain information relating to the matter in question and with the consent of the speaker, or other members may ask a question of the same persons.

6.14.3 All questions shall be stated concisely and shall not be used as a means of making statements or assertions.

6.14.4 Any question shall not be ironical, offensive, rhetorical, trivial, vague or meaningless or shall not contain epithet, innuendo, ridicule, or satire.

6.15 Any member who has the floor may require the motion under discussion to be read.

Section 7 - Decorum and Discipline

7.1 A member shall not:

7.1.1 speak disrespectfully of Her Majesty the Queen or any member of the Royal Family, the Governor-General, a Lieutenant Governor, the Board or any member thereof;

7.1.2 use offensive words or unparliamentary language;

7.1.3 disobey the rules of the Board or a decision of the Chairperson or the Board on questions of order, practice or an interpretation of the rules;

7.1.4 speak other than to the matter in debate;

7.1.5 leave their seat or make any disturbance when the Chairperson is putting a question and while a vote is being taken and until the result is declared; and

7.1.6 interrupt a member while speaking except to raise a point of order.

7.2 If a member commits an offense, the Chairperson shall interrupt and correct the member.

7.3 If an offense is serious or repeated, the Board may decide, by resolution, not to permit the member to resume speaking.

7.4 If a member ignores or disregards a decision of the Chairperson or the Board, the Chairperson shall not recognize the member except to receive an apology by the member and until it has been accepted by the Board.

7.5 If a member persists in committing an offense, the Board may order, by resolution, the member to leave the meeting and not resume their seat until they have tendered an apology and it has been accepted by the Board.

Section 8 - Questions of Privilege and Points of Order

8.1 The Chairperson shall permit any member to raise a question relating to the rights and benefits of the Board or one or more of the members thereof and questions of privilege shall take precedence over all other motions except to adjourn and to recess.

8.2 When a member desires to assert that a rule has been violated, they shall ask leave of the Chairperson to raise a point of order with a concise explanation and then shall not speak until the Chairperson has decided on the point of order.

8.3 The decision of the Chairperson shall be final unless a member appeals immediately to the Board.

8.4 If the decision is appealed, the Board shall decide the question "Shall the decision of the chair be sustained?" by majority vote without debate and its decision shall be final.

8.5 When the Chairperson calls a member to order, the member shall cease speaking immediately until the point of order is dealt with and they shall not speak again without the permission of the Chairperson unless to appeal the ruling of the Chairperson.

Section 9 - By-laws

9.1 No motion to pass a By-law shall be considered unless written notice has been received by the members in the manner set out in section 3.6 of this By-law.

9.2 A motion to pass a By-law shall be carried by a two-thirds vote in the affirmative of the members present at that meeting.

9.3 A By-law shall come in to force on the date of passing thereof unless otherwise specified by the Board.

9.4 No motion for the amendment or repeal of the By-laws, or any part thereof, shall be considered unless written notice has been received by the members in the manner set out in section 3.6 of this By-law.

9.5 A motion to amend or repeal the By-laws, or any part thereof, shall be carried by a two-thirds vote in the affirmative of the members present at the meeting at which the amendment or repeal is to be considered.

Section 10 - Motions

10.1 Every motion shall be verbal unless the Chairperson requests that the motion be submitted in writing.

10.2 Debate on a debatable motion shall not proceed unless it has been seconded.

10.3 Every motion shall be deemed to be in possession of the Board for debate after it has been presented by the Chairperson, but may, with permission of the members who moved and seconded a motion, be withdrawn at any time before amendment or decision.

10.4 A main motion before the Board shall receive disposition before another main motion can be received except a motion:

10.4.1 to adjourn;

10.4.2 to recess;

10.4.3 to raise a question of privilege;

10.4.4 to lay on the table;

10.4.5 to order the previous question (close debate);

10.4.6 to limit or extend limits of debate;

10.4.7 to postpone definitely (defer);

10.4.8 to commit or refer;

10.4.9 to postpone indefinitely (withdraw); or

10.4.10 to amend;

which have been listed in order of precedence.

10.5 When a motion that the vote be taken is presented, it shall be put to a vote without debate, and if carried by resolution, the motion and any amendments under debate shall be put forthwith without further debate.

10.6 A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

10.7 A motion to adjourn a meeting or debate shall be in order, except:

10.7.1 when a member has the floor;

10.7.2 when it has been decided that the vote be now taken; or

10.7.3 during the taking of a vote;

and when rejected, shall not be moved again on the same item.

Section 11 - Voting

11.1 Only one primary amendment at a time can be presented to a main motion and only one secondary amendment can be presented to a primary amendment, but when the secondary amendment has been disposed of, another may be introduced, and when a primary amendment has been decided, another may be introduced.

11.2 A secondary amendment, if any, shall be voted on first, and, if no other secondary amendment is presented, the primary amendment shall be voted on next, and if no other primary amendment is presented, or if any amendment has been carried, the main motion as amended shall be put to a vote.

11.3 A main motion may be divided by resolution and each division thereof shall be voted on separately.

11.4 After the Chairperson commences to take a vote, no member shall speak or present another motion until the vote has been taken on such motion.

11.5 Every member present at a meeting shall vote when a vote is taken unless prohibited by statute and if any member present refuses or fails to vote, he shall be deemed as voting in the negative.

11.6 Any member may require that a vote be recorded.

11.7 If a member disagrees with the declaration by the Chairperson of the result of any vote, the member may object immediately and require that the vote be retaken and recorded.

11.8 After any matter has been decided, any member may move for reconsideration of the matter at a subsequent meeting in the same year but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried by two-thirds of the members, and no matter shall be reconsidered more than once in the same calendar year.

Section 12 - Committees

12.1 The Board may strike committees and appoint members to such committees to consider such matters as directed by the Board.

12.2 The Medical Officer of Health shall preside over the first meeting of each calendar year until a Chairperson and Vice-Chairperson of the committee are elected by its members.

12.3 The Chairperson of a committee shall:

12.3.1 preside over all meetings of the committee;

12.3.2 report on the deliberations and recommendations of the committee to the Board; and

12.3.3 perform such other duties as may be determined from time to time by the Board or the committee.

12.4 The Chairperson of a committee may appoint non-Board members to the committee.

12.5 The number of non-Board members of a committee shall not exceed the number of Board members of the same committee at any time.

12.6 The number of Board members on a committee shall not be a majority of the members of the Board of Health.

12.7 It shall be the duty of a committee:

12.7.1 to report to the Board on all matters referred to it and to recommend such action as it deems necessary;

12.7.2 to forward to an incoming committee for the following year any matters not disposed of; and

12.7.3 to provide to the Board any information relating to the committee that is requested by the Board.

12.8 All committees shall be dissolved no later than immediately preceding the first meeting as set out in section 3 of this By-law.

12.9 The Board may dissolve, by resolution, any committee at any time.

Section 13 - Minutes

The Medical Officer of Health shall ensure that full and accurate minutes are kept of the proceedings of all meetings including a text of the By-laws and the resolutions passed by the Board.

Historical Record
Revisions:

Board of Health, October 13, 2010
Board of Health, October 11, 2007
Board of Health, January 12, 2005
Board of Health, July 3, 2003
Board of Health, October 28, 1998
Board of Health, October 14, 1992

Review:
Governance Committee, January 27, 2012
By-Laws, Policies and Procedures Committee, October 13, 2010
Governance Committee, September 27, 2010

Board of Health
POLICY

Section: Board of Health	**Number: 2-150**	**Title: ~~By-Law Number 6,~~ Remuneration of Members**
Approved by: Board of Health **Signature:** **Date** (YYYY-MM-DD)**:** 2013-06-12 **Housekeeping Revision** **Approved by:** **On** (YYYY-MM-DD)**:**		**Original Approved by Board of Health** **On** (YYYY-MM-DD)**: 1989-10-11** **Revision** **Approved by:** Board of Health **On** (YYYY-MM-DD)**:** 2013-06-12 **Reviewed by:** Governance Committee **On** (YYYY-MM-DD)**:** 2013-05-30
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.

Definitions

"Board" means the Board of Health for the Peterborough County-City Health Unit;

"Council" means the municipal ~~c~~Councils of the Corporations of the County of Peterborough and the City of Peterborough, and Councils for Curve Lake First Nation and Hiawatha First Nation;

“Committee” means an assembly of two or more members appointed by the Board of Health”;

"Meeting" means an official gathering of members of the Board or its committees in one place to transact business; and

"Member" means a person who is appointed to the board by a ~~c~~Council or the Lieutenant Governor-in-Council or a person who is appointed to a committee by the Board.

Policy

1. At its first meeting, the Board shall confirm which members shall be remunerated for attending meetings and shall determine the amount of the remuneration. The Board shall be provided with a

recommendation from the Governance Committee on proposed adjustments or increases to support their decision.

2. The Board shall reimburse each member for all reasonable expenses incurred as a result of acting in his/her capacity as a member in accordance with the policies of the Board.

3. The Board shall reimburse each member for all reasonable expenses incurred by the attendance at conventions, conferences, seminars, etc. in accordance with the policies of the Board.

4. An honorarium will be paid to each member of the Board of Health who is eligible for compensation in accordance with the Health Promotion and Protection Act.

5. The amount of the honorarium will be established by the Board of Health at the first regular meeting of the Board of Health each year.

6. The honorarium will be paid to each eligible Board member who attends:
   (a) a regular meeting of the Board;
   (b) a committee meeting;
   (c) a conference or convention; or
   (d) a business meeting on behalf of the Board.

7. A Board member who attends one meeting (or consecutive meetings) that extend over six hours, will receive one and one half times the regular honorarium.

8. A Board member will be paid one half of the regular honorarium when required to attend to Board business not covered ~~in paragraph one~~ under item 6. This will include cheque signing when not carried out at regular meetings.

9. Board members will not be compensated for attendance at community events unless representing the Chair of the Board of Health.

10. The quarterly financial report presented to the Board of Health will provide details of the Board of Health's section of the report.

11. Meeting attendance by County representatives on the Board of Health will be forwarded to the County Clerk's office on a biannual basis.

Historical Record

Revisions:
Board of Health, October 13, 2010
Board of Health, March 17, 2006

Review:
By-Laws, Policies and Procedures Committee, October 13, 2010

Board of Health
Policy

Section:	Number:	Title:	Page:
Board of Health	**2-340**	**Medical Officer of Health (MOH) Performance Appraisal**	**1 of 2**

Approved by: Board of Health **Date:** **Housekeeping Revision** **Approved by:** **On:**	**Original** **Approved By:** Board of Health **On:** February 11, 2009 **Revision** **Approved By:** Board of Health **On:** December 12, 2012 **Reviewed** **By:** Governance Committee **On:** November 26, 2012 **Next Review Date:** November 2014

Reference:
Medical Officer of Health Performance Appraisal Procedure – 2-341

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.

The Board of Health facilitates performance by creating an environment where the MOH and all employees of the PCCHU achieve their best. A written appraisal system will be used to provide an objective and uniform way to evaluate employees on the job. It is a constructive process to build on strengths, correct weaknesses, and maximize performance.

1. The Medical Officer of Health's (MOH) performance is to be appraised before the end of the probationary period, in order to recommend to the Board of Health appointment to regular appointment status, extension of probationary period, or termination of employment.

2. The Medical Officer of Health's appraisal will be conducted by a committee of the Board of Health chaired by the Chair of the Board of Health.

3. Annual reviews of performance will include the setting and review of objectives; and

professional development plan with a 360º component at least every two years.

4. On alternate years, this review is to be conducted by the current Chair, Vice Chair, and a past Chair of the Board, when possible.

5. The MOH is responsible for completing a self appraisal.

6. The Board will incorporate a feedback form from internal and external stakeholders as part of the 360° component. If relevant, the MOH may incorporate any such processes from their professional college into the appraisal process. If the 360° component corresponds with a municipal election, the component should be postponed to the beginning of the next calendar year.

7. External stakeholders will be approached for feedback by the Board where appropriate.

8. The MOH is to receive a full copy of the completed appraisal document. The Director, Corporate Services will retain the original including the self assessment in the MOH's personnel file.

9. Formal performance appraisals do not take the place of ongoing evaluation and feedback. If the MOH's work is not adequate, the matter is to be dealt with while details and facts are fresh and will not wait for the formal review. The MOH's performance must return to the required standard within a specified time period or further action may be taken by the Board.

Historical Record

Revisions:
Board of Health, November 10, 2010

Review:
By-Laws, Policies and Procedures Committee, October 27, 2010

Board of Health
Procedure

Section:	Number:	Title:	Page:
Board of Health	**2-341**	**Medical Officer of Health (MOH) Performance Appraisal**	**1 of 2**

Approved by: Board of Health **Date:** **Housekeeping Revision** **Approved by:** **On:**	**Original** **Approved by:** Board of Health **On:** February 11, 2009 **Revision** **Approved by:** Board of Health **On:** December 12, 2012 **Reviewed** **By:** Governance Committee **On:** November 26, 2012 **Next Review Date:** November 2014

Reference:
Medical Officer of Health Performance Appraisal Policy – 2-340

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.

The Board of Health will:

1. Schedule the performance appraisal before the end of the probationary period and then at least every year, preferably around the Medical Officer of Health's (MOH) anniversary date.

2. Provide the MOH with copies of the following documents in advance of the interview:
   - A copy of the previous MOH Performance Appraisal Form (Performance Planner)
   - A blank copy of the MOH Performance Appraisal Form
   - A blank copy of the Self Appraisal Form
   - A blank copy of the Confidentiality Agreement

3. When a 360° component is planned as part of the review:
   - request from the Medical Officer of Health in advance of the interview, a list of staff and potential external stakeholders for potential feedback; and
   - request feedback prior to the performance review using the Feedback Agreement and Appraisal Form. (A meeting to discuss the completed form may be requested by the Board or appraiser. They may elect to remain anonymous.).

4. Consult with any other persons they feel could provide relevant input to the performance appraisal. Review the job description, operational plans, significant events and any other pertinent items from the period under review. (This will include external stakeholders).

5. Complete the Performance Appraisal Form. Grade each factor using the definitions included in the performance appraisal form and support the decision with comments and examples wherever possible. The appraisal should also include an assessment of performance relative to the Learning and Development Objectives and overall program objectives set in the previous performance appraisal. In the Board's comments, clearly indicate whether the overall performance is satisfactory or not. For probationary MOHs indicate if probation has been completed satisfactorily.

6. Conduct the interview. This part may require more than one meeting. Genuinely consider the MOH's input and make changes/additions to the factor comments, examples and even grading where warranted. Determine with the MOH the Learning and Development Objectives as well as overall program objectives for the coming year structured according to the headings in the PCCHU Strategic Plan.

7. Sign and date the Performance Appraisal Form and have the MOH do the same. The MOH's signature means that they have read and understood the review. Ensure that a signed version of the Confidentiality Agreement is received.

8. Provide the MOH a full copy of the completed Performance Appraisal Form. The Director, Corporate Services is to retain the original including the self assessment in the MOH's personnel file.

Historical Record

Revisions:
Board of Health, November 10, 2010

Review:
By-Laws, Policies and Procedures Committee, October 27, 2010

PERFORMANCE PLANNER *(for management use only)*

Employee Name: _____	**Date:** _____
Title: _____	
Directorate: _____	
Reporting to: Name _____	**Title:** _____
Review Period Covered:	

Objectives

- ***Develop objectives that are in line with the Strategic Direction of the Board of Health. Make sure your objectives are SMART specific, measurable, achievable, realistic, time specific/observable (Five objectives are considered to be a manageable number for most employees)***
- ***Write objectives that answer these questions: What will happen? By what date?***

Area of responsibility	**Objectives** At the start of the performance review period, develop objectives.	**Achievements** At the end of the annual review period, describe the achievements for each objective and any obstacles or challenges faced.
Community-Centred Focus		

Area of responsibility	Objectives At the start of the performance review period, develop objectives.	Achievements At the end of the annual review period, describe the achievements for each objective and any obstacles or challenges faced.
Determinants of Health and Health Equity		
Capacity and Infrastructure		

Area of responsibility	Objectives At the start of the performance review period, develop objectives.	Achievements At the end of the annual review period, describe the achievements for each objective and any obstacles or challenges faced.
Quality and Performance		

If additional space is needed, please use the table provided below.

Area of responsibility	Objectives	Achievements

Professional Development Plan

- ***Describe the competencies needed to achieve objectives.***
- ***Include activities such as special assignments, courses, working with someone who has the skills that you need to develop, special projects……***

Competencies/skills to be developed	Development activities that took place

There are three categories for performance ratings: met objectives, developmental, did not meet objectives.

Please indicate overall performance rating:

☐ **Met Objectives**

☐ **Developmental**

☐ **Did not meet objectives**

Supervisor's comments (include signature and title)

Employee's comments (include signature and title)

Next steps:

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

SELF APPRAISAL FORM

Name: _____

Performance Appraisal Scheduled for: _____

This form is an essential part of the Performance Appraisal Process. Take time to complete it and bring it to your review, to provide the two way communications necessary to enable a productive discussion.

1. What have been your major contributions or special achievements since your last appraisal? What particular skills and abilities did you bring to these?

2. What progress have you made on your previous learning and developmental objectives?

3. Are there areas of your work in the past review period with which you are unhappy or wished you had done differently? What contributed to this? What will help you in these areas?

4. Describe two or three things you would like to improve, change or learn in the coming year. What can you do about it and how can we help?

5. If you wish to make any further comments, please feel free to include them below.

10 Hospital Drive
Peterborough, ON K9J 8M1
705-743-1000

FEEDBACK AGREEMENT

DATE: _____

TO: _____

FROM: _____

RE: Agreement to Provide Feedback on _____

As you may be aware, our Performance Appraisal process involves getting feedback from key working relationships. I would like to ask for your help in providing feedback.

Please complete the feedback form found on the reverse and ensure that you provide examples wherever possible. If you require additional space for your comments, please attach them on a separate sheet and include it with your response. Although the process is confidential, your comments may be paraphrased or quoted. An option is offered at the end of the feedback form to indicate your preference regarding the disclosure of your identity to the individual being reviewed. **These documents will be destroyed upon completion of the appraisal process.**

Please return these documents to me in the envelope provided, sealed and marked confidential by _____.
(date)

I hope that you can take the time to do this. If you feel that you will be unable to provide satisfactory feedback or cannot accommodate this request, please let me know as soon as possible.

Please feel free to book some time to discuss the form with me if you prefer. Your feedback is important to the evaluation process.

Thank you for your participation.

FEEDBACK FORM

1. What actions or accomplishments has this employee taken that have had a positive impact (e.g., job function, behaviour, attitude, your own working relationship)?

2. Please identify two or three of the following, which are strengths for this individual:

☐ Job knowledge	☐ Problem solving, judgement & decision making
☐ Productivity	☐ Interpersonal skills/communication
☐ Quality of work	☐ Leadership
☐ Initiative	☐ Attendance and punctuality
☐ Planning and organization	☐ Other
☐ Staff management (*management staff only)*	☐ Overall management (*management staff only)*

   List an example for each factor that you have chosen.

3. Are there any learning and development goals that you would suggest for this employee?

4. Do you have any other comments?

Reviewer: _____ Date: _____

I give permission for my identity to be disclosed to the individual being reviewed: ☐ YES ☐ NO
I give permission for you to attribute these comments to me: ☐ YES ☐ NO

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Public Health Governance and Population Health Outcomes

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Abstract
Research reviews have identified a gap in understanding the diversity of health department governance structures and in understanding how the variations in governing relates to health outcomes. This report details the categorization of local public health governance and reveals that certain governance types may be better suited to achieve better population health outcomes. State systems achieve the poorest health outcomes, but the best health outcomes are achieved when the political branches have a key role in local public health governance. Public health systems should consider greater local control and involvement in governance; but local governance should include the political branches -- and even the state -- to achieve more positive health outcomes.

Keywords
public health, governance, local boards of health, health outcomes

Cover Page Footnote
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Introduction*

Recently, reviews have identified a need for studies that explore the structures and governance of public health and how that relates to improved health outcomes [1,2]. Current research has identified some intriguing findings, one of which is that a Board of Health is not directly associated with LHD "effectiveness" or with improved health system performance [3,4]. Bhandari found that scores for the performance of the ten essential public health services were lower where there was an LBOH than where there was not, but having a policy-making board was positively associated with overall system performance of the ten essential services[5]. However, none of this work directly examined health boards and health outcomes and only accounted for the presence or absence of a board of health, when in fact boards of health vary in their range of authority. This study examined existing governance structures to identify nine different types of governance structures in 164 purposefully selected counties from 41 states and compared health outcomes for the different governing types. Our results showed that a county's type of public health governance relates to its population health outcomes. These findings can guide states and local public health agencies in making the most effective choices about optimally structuring public health governance to face the challenges ahead.

Methods

Due to our focus on health outcomes at the county level, nine states were eliminated from the study because the jurisdictional boundary of the health department is not the same as the jurisdictional boundary of the county or counties it serves†. To test our findings in as many different states as possible, and under very different conditions of social and economic factors that impact health, we purposefully selected four counties from each state that represented different relationships between health outcomes and socio-economic factors. The four counties were selected using the within-state rankings on "Health Outcomes" as reported in the 2011 County Health Rankings study[6]: the healthiest county at the highest SES level, the healthiest county at the lowest SES level, the least healthy county at the highest SES level, and the least healthy county at the lowest SES level.

Next, we examined the operative state law for each county in the study and the county level responses to survey questions regarding local governance on the National Profile of Local Health Departments. Lastly, county level websites were checked and in rare cases phone calls to particular counties were made to verify and reconcile operative structures and authority. Based on these data, we created numerical codes for each county to represent the presence of a board of health, the size of the board, and the required composition of the board of health. Next, we identified the level of government (i.e., board of health, county, or state) with the statutory authority for each of four authorized powers: hiring and firing, budgeting, adopting regulations, and setting fines and fees.

Based on these data, we identified nine unique governance types relying on three concepts of governing: The locus of primary authority for public health in the county (the state, the county government, a local board of health, or various levels of sharing among them), the extent of

*This work was funded by the Public Health Law Research Program, a national program of the Robert Wood Johnson Foundation.

†The nine excluded states (CT, DE, HI, MA, NH, NJ, NM, RI, and SD) were states where within-state health jurisdictions were too few (i.e., Delaware with two), too many (i.e., Massachusetts with 353) or non-existent (Hawaii and Rhode Island).

empowerment of the local board of health where it exists (fully empowered, shared authority with another level, advisory, or no local board of health), and the composition of the local board of health. These three components were combined to create the Composite Governance Index, which is a taxonomy dividing the governance of these counties into nine types. Two types of ANOVA were used to compare the values for health outcomes across these nine governance types. For the Kruskal-Wallis mean rank comparisons, a Monte Carlo correction method was used to correct for low sample sizes.

Health outcomes were measured with a "Proximal Health Outcomes Index." This index, comprised of indicators derived from the County Health Rankings data set, is based on factors that local health departments would most likely affect. These include the percent of adult smokers, the percent of babies born at low birth weight, the rate of chlamydia cases per 100,000 people, the rate of babies born to teens per 1000 females ages 15-19, the diabetic screening rate, and the mammography screening rate. All scores were recoded so that positive values indicated a healthier county.

Results

The governance coding and the ANOVA results are shown in Table 1. Even with the variation in the number of counties within each type, the table shows that the rankings on proximal health outcomes are significantly different across the nine different governance types. In itself, this finding shows the utility of considering governance type when examining health outcomes.

The analysis, however, provides evidence for several interesting findings. First, the bad news: State-run systems achieve the lowest mean ranking and are the furthest below the overall mean on Proximal Health outcomes than any other governance type. Perhaps more interesting is that the second poorest performing health governance type is empowered boards of health that are comprised of health professionals. In contrast, the relatively healthiest governance type is an empowered board comprised of a combination of health professionals and political office-holders, but where neither group has a majority. The second best performing governance type is one that shares responsibility among a board of health, the county government and the state. Finally, another surprising finding from the perspective of health outcomes, is that empowered boards of health comprised of a majority of political office-holders are related to better health outcomes.

Implications

One of the most basic implications of these findings is the creation of a useful means of distinguishing among local health governance types. Categorizing local health governance can be quite challenging given the variations and exceptions among counties. We believe that identifying specific and distinctive governance types is a significant contribution of this endeavor, and putting this categorization to use by examining health outcomes across the different governance types is potentially even more powerful. One limitation of the study is the limited number of counties in the analysis. These findings should be replicated with much larger numbers of counties and in more comprehensive models of county health outcomes; but, the findings presented here -- while far from the end of this story -- provide some profound implications.

First, we begin to see the problems of state-centralized systems. Having limited local control and buy-in would seem to have negative ramifications for county level health outcomes. We might

have expected empowered local health boards, comprised of trained health professionals, to correct this; but surprisingly, this, too, could be a mistake from the perspective of achieving population health outcomes.

Health governance that yields the best health outcomes turns out to be a more nuanced undertaking. This, however, is perhaps understandable from a broader perspective of public health. The system that governs best (from the perspective of health outcomes) includes the political branches on an empowered health board. Another relatively strong governance structure is a local board that shares authority with the local county government and the state. This may not be surprising considering the contemporary challenges that health departments face, and the important role that having multiple stakeholders, including those with political power and even those with a statewide perspective, can have for achieving population health.

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Table 1 : Governance coding and ANOVA results

Composite Governance				Proximal Health	
Name	**Description**	**N**	**%**	**Mean Rank ****	**Z**
State	State is fully empowered to run LHD	54	32.93	101.44	-0.382073
State w/County	State and County share power to run LHD	17	10.37	77.88	-0.018161
State w/ LBOH	State and LBOH share power to run LHD	8	4.88	85.62	-0.015179
County	County is fully empowered to run LHD	38	23.17	74.87	0.171168
County w/ LBOH	County and LBOH share power to run LHD	6	3.66	81.83	0.086388
Shared Governance	LBOH and County and State all have some power	12	7.32	56.92	0.500562
Pol BOH	Empowered LBOH, with a majority of political designees	13	7.93	72	0.216619
Pol and Health	Empowered LBOH, with some political designees and some health professionals, but not a majority of either.	6	3.66	30.83	1.005837
Health BOH	Empowered LBOH, with a majority of health professionals	10	6.10	90.3	-0.081846

Staff Report

Board Remuneration Review

Date:	December 3, 2013
To:	BOH Governance Committee
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 Governance Committee for the Board of Health for the Peterborough County-City Health Unit:

- receive the staff report, *Board Remuneration Review*, for information;
- forward the staff report to the Board for its consideration at the January 9, 2014 meeting; and
- recommend no increase to the current honourarium for 2014.

Financial Implications and Impact

City councillors are not entitled to receive the honourarium, however County councillors, First Nation Council Appointees and Provincial Appointees receive an hounourarium while on Health Unit business. The current honourarium is $145.61 so every 1% increase would amount to $1.46.

Decision History

With respect to honourarium increases, on March 13, 2013, the Board approved the following motion (M-13-43):

That the Board of Health for the Peterborough County-City Health Unit, starting this year, establish board member compensation in the future that is equal to staff increases or to the Consumer Price Index, whichever is lower.

On June 12, 2013, the Board approved a revision to the By-Law on remuneration requesting that:

The Board shall be provided with a recommendation from the Governance Committee on proposed adjustments or increases to support their decision.

Background

Policy requires the Board to confirm, at its first meeting of the year, which members shall be remunerated for attending meetings and determine the amount of the remuneration. Policy also requires Governance to review the Board honourarium rate at the end of each calendar year and that the Committee considers the increase granted to staff during the current year and to consider the Consumer Price Index (CPI) increase in making a recommendation.

For 2013 management was given no increase. The OPSEU collective agreement expired April 2013 and we are negotiating for two years of zero increase. ONA and CUPE will receive a 2% increase as they are in the final year of a three year contract.

Statistics Canada indicates the CPI increased less than 1%.

A survey was conducted of other Health Units to ascertain what honourariums were paid to their Board members. Fourteen of thirty-six health units responded. Please refer to Attachment "A" for the results.

All responding Health Units noted Board members are provided expenses (mileage, meal allowance, etc.) per the staff policy.

Rationale

The Board approved motion reads "*board member compensation in the future that is equal to staff increases or to the Consumer Price Index, whichever is lower."* Management wages have been frozen for the current year, therefore no increase is recommended.

Strategic Direction

This will allow the Board to pursue its strategic direction of Quality and Performance.

Contact:

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Attachments:

Attachment A – Board Honourarium Survey Results

Board Per Diem Survey Results

A survey of Boards of Health was conducted to ascertain the per diems allowed. Fourteen of sixteen Health Units Responded.

Health Unit	**Per Diem 2013**
Brant	$66.65
Chatham Kent	All councilors - no per diems paid
Grey Bruce	$150 full day, $75 half day
Haldimand-Norfolk	All councilors - no per diems paid
Hamilton	All councilors - no per diems paid
HKPR	$110 - meeting or full day conference
Kingston Frontenac	$100 per day, $50 for meeting
Leeds Grenville	$89.88 for meeting, $179.76 for all day conference
Perth	$159.56 full day, $105.40 for half day
Porcupine	$100 per half day
Hastings	$100 per day
Sudbury	$81.25 for meeting, $162.50 for full day
Timiskeming	$140 if more than 4 hours, $80 if less than 4 hours
Wellington Dufferin	$85 for meeting/half day, $150 for full day
Peterborough	**$145.61**