Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, November 13, 2024 – 5:30 p.m.
Multipurpose Rooms, 2nd Floor, Peterborough Public Health

1. **Call to Order & Land Acknowledgement**

   Example: We respectfully acknowledge that we are on the Treaty 20 and traditional territory of the Mississauga Anishnaabeg. We offer our gratitude to the First Nations for their care for, and teachings about, our earth and our relations. May we honour those teachings.

2. **Confirmation of the Agenda**

3. **Declaration of Pecuniary Interest**

4. **Consent Items to be Considered Separately**

   Board Members: *Please identify which items you wish to consider separately from section 9 and advise the Chair when requested. For your convenience, circle the item(s) using the following list: 9.2 a b c d 9.3.1 9.3.2 9.3.3 9.3.4 9.3.5 9.3.6 9.4.1 9.4.2*

5. **Delegations and Presentations**

   5.1. Delegation: CUPE – Because Public Health Matters Campaign

   - Cover Report

   5.2. Delegation: Pickleball Noise

   - Cover Report

6. **Confirmation of the Minutes of the Previous Meeting**

   - Cover Report

   a. Minutes, October 9, 2024

7. **Business Arising From the Minutes**

8. **Staff Reports**

8.1. Stewardship Committee: No Merger 2025 Budget

- Staff Report

a. Draft 2025 Budget

9. Consent Items

9.1. Correspondence for Direction

9.2. Correspondence for Information

- Cover Report

a. Health Canada Response – Nicotine Pouches
b. alPHa – October e-newsletter
c. PPH Letter – Student Nutrition Programs
d. alPHa – Ontario's Fall Economic Statement

9.3. Staff Reports

9.3.1. Q3 2024 Financial Report

- Cover Report

a. Q3 2024 Financial Report

9.3.2. Q3 2024 Program Status Report

- Report

9.3.3. Q3 2024 Strategic Plan Report

- Report

9.3.4. Q3 2024 Risk Management Report

- Report

9.3.5. Staff Report - Preparedness for Future Health Emergencies

- Staff Report

a. Walport Report - Recommendations and Summary of Key Findings

9.3.6. Staff Report - A Provincial Immunization Registry for Ontario

- Staff Report

9.4. Committee Reports

9.4.1. Indigenous Health Advisory Circle

- Cover Report

a. Minutes, August 23/24

9.4.2. Stewardship Committee

- Cover Report

a. Minutes, October 4/24

10. In Camera to Discuss Confidential Matters

In accordance with the Municipal Act, 2001, Section 239(2)
(d) Litigation or potential litigation, including matters before administrative tribunals affecting the Board;

(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or by or on behalf of the municipality or local board.

11. Motions for Open Session

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

Wednesday, December 11, 2024, 5:30 p.m.
Peterborough Public Health

13. Adjournment

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Delegation: CUPE – Because Public Health Matters Campaign**
DATE:	**November 13, 2024**

PROPOSED RECOMMENDATIONS

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

- Title: CUPE – Because Public Health Matters Campaign
- Presenter: Pam Pressick, Administrative Assistant, PPH; Vice President, CUPE Local (presenting on behalf of the Because Public Health Matters Campaign and Committee)

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Delegation: Pickleball Noise**
DATE:	**November 13, 2024**

PROPOSED RECOMMENDATIONS

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

- Title: Pickleball Noise
- Speaker: Richard Scott

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Approval of Meeting Minutes**
DATE:	**November 13, 2024**
PREPARED BY:	**Alida Gorizzan, Executive Assistant**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health approve the minutes of the meeting held on October 9, 2024.

ATTACHMENTS

a. Minutes, October 9, 2024

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, October 9, 2024 – 5:30 p.m.
Hiawatha First Nation

In Attendance:

Board Members:	**Deputy Mayor Ron Black**
	Warden Bonnie Clark (virtual, joined at 5:51 p.m.)
	Mayor Matthew Graham
	Councillor Dave Haacke
	Mr. Paul Johnston
	Councillor Nodin Knott (virtual)
	Councillor Joy Lachica, Chair
	Dr. Ramesh Makhija (virtual)
	Mr. Dan Moloney
	Councillor Keith Riel
	Dr. Hans Stelzer
	Councillor Kathryn Wilson
Staff:	**Ms. Hallie Atter, Director, Health Promotion Division**
	Ms. Donna Churipuy, Director, Health Protection Division
	Ms. Alida Gorizzan, Executive Assistant (Recorder)
	Ms. Luisa Magalhaes, Registered Dietitian
	Dr. Thomas Piggott, Medical Officer of Health & CEO
	Mr. Larry Stinson, Director of Operations

Chief Laurie Carr welcomed Board Members to Hiawatha First Nation.

1. Call to Order

Councillor Lachica called the meeting to order at 5:49 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved.
Moved: Mayor Graham
Seconded: Councillor Haacke
Motion carried. (M-2024-078)

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately

MOTION:
That the following items be passed as part of the Consent Agenda: 9.2 a,c; 9.4.1
Moved: Mr. Moloney
Seconded: Mayor Graham
Motion carried. (M-2024-079)

MOTION (9.2 a,c):
That the Board of Health for Peterborough Public Health receive the following for information:
a. Association of Local Public Health Agencies (alPHa) e-newsletter dated September 16, 2024.
c. Email response dated October 4, 2024 to the Board Chair from the Executive Correspondence Officer for the Prime Minister of Canada, regarding the October 2, 2024 letter supporting Bills S-233 and C-233.
Moved: Mr. Moloney
Seconded: Mayor Graham
Motion carried. (M-2024-079)

MOTION (9.4.1):
That the Board of Health for Peterborough Public Health receive meeting minutes of the Stewardship Committee from June 4, 2024 for information.
Moved: Mr. Moloney
Seconded: Mayor Graham
Motion carried. (M-2024-079)

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the Board of Health for Peterborough Public Health approve the minutes of the meeting held on September 4, 2024.
Moved: Warden Clark
Seconded: Deputy Mayor Black
Motion carried. (M-2024-080)

7. Business Arising From the Minutes

8. Staff Reports

8.1. Staff Report & Presentation: Food for Kids Student Nutrition Programs Annual Report 2023-24

Guest: Angela Fuchs, Community Development Coordinator, Peterborough Child and Family Centres

MOTION:
That the Board of Health for Peterborough Public Health:

- receive the staff report and presentation, *Food for Kids Peterborough and County Student Nutrition Programs Annual Report 2023-24,* for information;
- communicate to the Premier of Ontario, Minister of Child, Community and Social Services, and Minister of Education, with copies to local MPPs, Nogojiwanong Friendship Centre, and Curve Lake & Hiawatha First Nations, the importance of negotiating and signing an agreement that will see federal funding to support provincial student nutrition programs; and,
- ask the Province to increase their funding contribution by 30 cents per student to match the national median of 40 cents per student.

Moved: Warden Clark
Seconded: Mr. Moloney
Motion carried. (M-2024-081)

8.2. <u>Presentation: Respiratory Season Update 2024-25</u>

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

- Title: Presentation: Respiratory Season Update 2024-25
- Presenters: Gillian Pacey, Infectious Disease Manager; Patti Fitzgerald, Clinical Services Manager; Carolyn Pigeau, Epidemiologist

Moved: Mayor Graham
Seconded: Mr. Johnston
Motion carried. (M-2024-082)

8.3. <u>Staff Report: Health Care Worker Influenza Immunization 2023-24</u>

MOTION:
That the Board of Health for Peterborough Public Health receive the staff report, *Health Care Worker Influenza Immunization 2023-24,* for information.
Moved: Deputy Mayor Black
Seconded: Mr. Moloney
Motion carried. (M-2024-083)

8.4. <u>Stewardship Committee: 2025 Budget Preparation</u>

MOTION:
That the Boad of Health for Peterborough Public Health receive the presentation, 2025 Budget Preparation, for information.
Moved: Councillor Haacke
Seconded: Mr. Johnston
Motion carried. (M-2024-084)

Mr. Moloney departed the meeting at 7:04 p.m.

9. Consent Items

MOTION (9.2b)
That the Board of Health for Peterborough Public Health receive the following for information:
b. Letter dated October 2, 2024 from the Board Chair to the Prime Minister of Canada, additional Federal Ministers/Members of Parliament, and the Standing Senate Committee on National Finance regarding support for Bills S-233 and C-233 "An Act to develop a national framework for a guaranteed liveable income".
Moved: Councillor Haacke
Seconded: Mayor Graham
Motion carried. (M-2024-085)

The Chair requested a brief recess at 7:15 p.m. prior to going into closed session.
Dr. Makhija departed the meeting at 7:15 p.m.

10. In Camera to Discuss Confidential Matters

MOTION:
That the Board of Health for Peterborough Public Health go in camera at 7:22 p.m. to discuss three items in accordance with the Municipal Act, 2001, Section 239(2)
(d) Labour relations or employee negotiations;
(e) Litigation or potential litigation, including matters before administrative tribunals affecting the Board;
(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or by or on behalf of the municipality or local board.
Moved: Mayor Graham
Seconded: Councillor Haacke
Motion carried. (M-2024-086)

MOTION:
That the Board of Health rise from the In Camera session at 8:36 p.m.
Moved: Mr. Johnston
Seconded: Councillor Riel
Carried. (M-2024-087)

11. Motions for Open Session

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

Wednesday, November 13, 2024, 5:30 p.m.
Peterborough Public Health

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Warden Clark
Seconded: Dr. Stelzer
Motion carried. (M-2024-088)

The meeting was adjourned at 8:36 p.m.

Chairperson

Medical Officer of Health

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH – STAFF REPORT

TITLE:	**No Merger 2025 Budget**
DATE:	**November 13, 2024**
PREPARED BY:	**Larry Stinson, Director of Operations**
APPROVED BY:	**Thomas Piggott, Medical Officer of Health and CEO**

PROPOSED RECOMMENDATIONS

The Stewardship Committee met last on October 22, 2024. At that meeting, the Committee reviewed the contents of this report and made the following recommendation:

That the Board of Health for Peterborough Public Health:

- receive the *No Merger 2025 Budget* Staff Report for information; and,
- approve the 2025 Cost-Shared Program Budget for $13,475,983 as presented, should there be no provincial and shared Board approval for the proposed merger.

FINANCIAL IMPLICATIONS AND IMPACT

Budget preparation and approvals for cost-shared programs are commonly completed prior to the fiscal year, which begins January 1st of each year. For 2025, this process is further complicated by the potential for a merger with the Haliburton, Kawartha-Pine Ridge District Health Unit (HKPR). Given the lack of direction from the Province regarding mergers at this time, an independent budget for Peterborough Public Health (PPH) has been prepared. This budget must comply with provincial requirements to be a balanced budget.

BACKGROUND

The Board of Health (BOH) was provided with information in February 2024 about fiscal challenges that would be faced in 2025, without an approved merger and related funding, to provide context for the decision to proceed with an intent to merge with the HKPR District Health Unit. In September 2024, the Board was provided an update on this information. In these reports, it was highlighted that the Province announced in August 2023 that their contribution to cost-shared budgets for 2024, 2025 and 2026 would be limited to 1% year over year. It is recognized that this increase would be inadequate to offset the increased cost of operations, including but not limited to negotiated compensation increases. The shortfall in the provincial contribution, according to the Health Protection and Promotion Act, must be covered by obligated municipalities, to ensure levels of service are not to be further compromised.

At the October 4, 2024 meeting of the Stewardship Committee, the fiscal challenges for a 2025 budget for cost-shared programs were provided. This included a 10.9% overall increase in expenses over 2024 based on anticipated and known increases for each budget line and the

assumption that 2024 service levels would be sustained. It was also recognized that the 2024 service levels fall below the requirements as outlined in the Ontario Public Health Standards, and that it would require an additional 1.9 million dollars to achieve what the province defines as a minimum level of service delivery. A general summary of budget assumptions includes:

1. Staffing allocations for 2025 will remain consistent with 2024 with the exception of allocation of management positions to cost-shared budget (previously Safe Sewage and Healthy Babies, Healthy Children), continued assignment for Program and Team Lead positions, and increased allocation to Infectious Disease, previously approved as COVID-funded.
2. Compensation is based on negotiated or anticipated wage increases and proportional increase for benefits.
3. Increases to known or anticipated increases related to technology, insurance, condominium fees and travel.
4. Decreases in offset revenue due to loss of Safe Sewage program and fully recognizing decreases in dental fees received under the Healthy Smiles Ontario program.

Due to provinces pronouncement to limit increases in their contribution to cost-shared budgets to 1% annually for 2024, 2025 and 2026, the required revenue to achieve a balanced budget puts undue hardship on local funders. If the entire amount required to balance was made up through levies to local funders, the contributions from local funders would be a 42% increase over 2024; an increase of $1,323,941 resulting in a shift of proportional contributions from the province and local funders from 71.9:28.1 to 65.1:34.9.

The alternatives to allocating the revenue shortfalls to local funders is to i) utilize accumulated reserves, or ii) reduce staffing levels and therefore OPHS compliance and service to our community. Given the uncertainty of the future, including but not limited to: future plans for mergers; planned revisions to the OPHS; and revisions to the funding methodology for public health, it is recommended that staffing be retained and a short-term dependence on reserves be applied for the 2025 budget year.

The current state of reserves held by PPH is as follows:

	Balance at Jan 1/2024	
Unrestricted Reserves	$2,114,303 [1]	
Less:		
Funds committed in 2024	$383,000	COVID/Infectious Disease Positions
Net Unrestricted Reserves	$1,731,303	

1 Per 2023 Audited Financial Statements – Occupancy/Renovation, Local Vaccination, Food Security, Program, Contingency

RATIONALE

The recommended budget for 2025, in a non-merger scenario, includes:

1. A total revenue and expense of $13,475,337, an increase of 10.9% or $1,323,941 over 2024.
2. An increase in local levy to municipalities and First Nations of 12%, or $389,492 over 2024.
3. Use of $974,337 in Reserves.
4. Retaining 2024 service levels.

Given the possible scenarios for the future, current public health needs and pressures faced by local governments, this is a balanced and strategic approach, ensuring retention of highly valued staff, sustaining critical public health work, while avoiding undue hardship on local funders.

The use of reserves is considered appropriate for addressing short-term pressures. The BOH previously approved minimum balances for the Occupancy/Renovation Reserve of $250,000 and Contingency Reserve of $500,000, to sustain financial operations and to allow for continuation of program delivery. Thus, maintaining the reserve balance of $750,000 would leave approximately $980,000 available to help offset a portion of the projected shortfall for 2025. Although this significantly reduces the amount available for future needs, the current situation is aligned with the intended purpose for reserves and we need to trust that provincial efforts to "strengthen public health" will be applied through 2025 to mitigate these challenges in future years.

The impact on local funders of a 12% increase is highlighted below.

Summary of Individual Municipal Partner (MP) and First Nation Contributions

PARTNER	%	CURRENT 2024	2025 (12% INCREASE)	VARIANCE
CITY OF PETERBOROUGH	56.64	$1,838,499	$2,059,119	$220,620
COUNTY OF PETERBOROUGH	42.76	$1,387,739	$1,554,268	$166,529
CURVE LAKE FIRST NATION	.45	$14,747	$16,517	$1,770
HIAWATHA FIRST NATION	.15	$4,779	$5,352	$573
TOTAL	100	$3,245,764	$3,635,256	$389,492

APPENDICES:

a. Draft Budget 2025

PETERBOROUGH PUBLIC HEALTH
2025 COST-SHARED BUDGET - Mandatory Programs
DRAFT

		2025 Budget	2024 Budget	Change	% Change	
	REVENUES					
1	Ministry of Health - Mandatory Programs	8,382,091	8,299,100	82,991	1.0%	Base increase per MOH three year fiscal plan
2	- Indigenous Communities	10,000	10,000	-	0.0%	No increase anticipated
3	Municipal Partners - Note 1	3,635,256	3,245,764	389,492	12.0%	
4	Offset revenue and expenditure recoveries	474,300	597,178	(122,878)	-20.6%	Fee for services, allocated administration, and interest
5	Transfer from reserves	974,336	-	974,336	100.0%	Fund required to balance budget given MOH and municipal partner increases
	TOTAL REVENUES	**13,475,983**	**12,152,042**	**1,323,941**	**10.9%**	
	EXPENDITURES					
1	Salaries and wages	8,720,333	7,741,446	978,887	12.6%	See staff report
2	Employee benefits	2,633,769	2,338,973	294,796	12.6%	See staff report
3	Staff learning and development	46,450	45,539	911	2.0%	
4	Board of Health committee	35,800	35,098	702	2.0%	
5	Travel	77,395	75,877	1,518	2.0%	
6	Occupancy and building maintenance	690,871	718,671	(27,800)	-3.9%	Savings on cleaning contract net of 2% increase, increase for 3% condo fees
7	Office supplies and equipment	50,361	49,374	987	2.0%	
8	Program materials and resources	438,308	429,714	8,594	2.0%	
9	Professional and purchased services	554,931	544,050	10,881	2.0%	
10	Communication and media	83,753	82,111	1,642	2.0%	
11	Information technology and equipment	144,012	91,189	52,823	57.9%	2% inflation plus increase for IT equipment/software
	TOTAL EXPENDITURES	**13,475,983**	**12,152,042**	**1,323,941**	**10.9%**	
	NET COST SHARED BUDGET - BALANCED	-	-	-		

Note 1

MUNICIPAL PARTNER CONTRIBUTIONS

	2025 Contribution	2024 Contribution	Change	% Municipal Contribution
City of Peterborough	2,059,119	1,838,499	220,620	56.64%
County of Peterborough	1,554,268	1,387,739	166,529	42.76%
Curve Lake First Nation	16,517	14,747	1,770	0.45%
Hiawatha First Nation	5,352	4,779	573	0.15%
PARTNER CONTRIBUTIONS	**3,635,256**	**3,245,764**	**389,492**	**100.00%**

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Correspondence for Information**
DATE:	**November 13, 2024**
PREPARED BY:	**Alida Gorizzan, Executive Assistant**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

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

a. Letter dated October 11, 2024 from Health Canada, in response to the Board's original letter dated April 30, 2024, regarding nicotine pouches.

b. Association of Local Public Health Agencies (alPHa) e-newsletter dated October 15, 2024.

c. Letter dated October 29, 2024 from the Board Chair to the Premier, Ministers Parsa and Dunlop, regarding student nutrition programs.

d. Email dated October 30, 2024 from alPHa regarding Ontario's Fall Economic Statement.

From: NNHPD Consultation / DPSNSO (HC/SC)
Sent: Friday, October 11, 2024 10:00 AM
To: Alida Gorizzan
Subject: Nicotine Replacement Therapy

Dear Alida Gorizzan,

Thank you for your correspondence.

In Canada, nicotine replacement therapy (NRT) products are classified as a drug under the *Food and Drugs Act* (FDA) as they are intended for use by adults aged 18 years and older for smoking cessation. Health Canada regulates NRTs under the FDA to ensure regulatory requirements for safety, efficacy and quality are met before authorizing them to be sold in the Canadian market.

All NRTs need market authorization from Health Canada and must carry an approved health claim for smoking cessation to be legally sold in Canada.

As part of its process, Health Canada reviews the evidence behind health claims to make sure that the product does what it claims to do, and the benefits outweigh the risks. Depending on the amount of nicotine contained or delivered by the product, an NRT would be considered a prescription drug or a natural health product.

Strong concerns have been raised regarding the access and potential appeal to youth of certain new and emerging NRTs, such as nicotine pouches, and the way they are marketed. Youth smoking rates are at an all-time low in Canada and advertising of NRTs should not be appealing to youth.

As indicated in the Notice of Intent published on March 20, 2024, Health Canada committed to taking action to address risks associated with the access and apparent youth appeal of certain NRTs, such as nicotine pouches.

In June 2024, Departmental officials consulted on the potential new requirements for the regulation of certain NRTs with a variety of partners and stakeholders, including representatives from provincial and territorial (PT) ministries of health, health advocacy groups, health professional associations, industry, pharmacists' associations, and consumers with lived/living experience with smoking and smoking cessation.

The engagement approach was consistent with the *Statutory Instruments Act* (**https://ow.ly/vX9R50ST8Hm**) and the *Cabinet Directive on Regulation* (**https://ow.ly/OBH250ST8KS**).

The Department received wide-ranging and constructive feedback during these engagement sessions which informed the development of the *Supplementary Rules Respecting Nicotine Replacement Therapies Order* (the Order) as announced on August 22, 2024.

The Order came into force immediately upon publication in Canada *Gazette*, Part II, on August 28, 2024, subject to a six-month transition period in respect of packaging, labelling, and advertising requirements and a sell-through period in some circumstances.

The Order introduced new measures for NRTs to reduce the appeal of access to, and use of these products by youth, while maintaining access for adults who need them to quit smoking. More specifically, the new measures:

- Prohibit NRTs in new and emerging dosage forms (for example, nicotine pouches and rapid disintegration tablets) to be sold by anyone other than a pharmacist or an individual working under the supervision of a pharmacist. New and emerging dosage forms must not be accessible for self-selection, meaning they will be kept behind the pharmacy counter;
- Prohibit the sale of NRTs under brand names that may mislead purchasers or consumers about their intended use, be appealing to, or be associated with, young people, or be mistaken for a cannabis or food product;
- Prohibit the manufacturing or sale of NRTs in certain flavours as set out in the Order. For example, the use of any flavour other than mint and menthol is prohibited for NRTs in new and emerging dosage forms (for example, pouches and rapid disintegration tablets);
- Prohibit labels and packages from being appealing to youth;
- Require mock-ups of labels and packages to be submitted for all new NRT product licence and amendment applications, including those arising from a change to an NRT's brand name or non-medicinal ingredient affecting its flavour;
- Require a front-of-package nicotine addiction warning on NRT labels, as well as a clear indication of the intended users (in other words, people who smoke intending to quit smoking) on the outermost label; and
- Prohibit advertising or promotion that could be appealing to youth under the age of 18 or convey a use other than smoking cessation and require a health warning statement on all advertisements.

Health Canada also continues to work on identifying and seizing unauthorized nicotine products in retail locations across Canada and disrupting the supply of these products into the country by working closely with the Canada Border Services Agency.

Sincerely,

Natural and Non-prescription Health Products Directorate Consultation

Health Canada, Government of Canada

nnhpd.consultation-dpsnso@hc-sc.gc.ca

Direction des Produits de santé naturels et sans ordonnance consultation

Santé Canada, Gouvernement du Canada

nnhpd.consultation-dpsnso@hc-sc.gc.ca

ID: 24-002655 - 488

From: allhealthunits
Sent: October 15, 2024 3:16 PM
To: AllHealthUnits
Subject: [allhealthunits] October 2024 InfoBreak

PLEASE ROUTE TO:

All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

October 15, 2024

October 2024 InfoBreak

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa activities, correspondence, and events. Visit us at alphaweb.org.

Leader to Leader - A message from alPHa's Chair - October 2024

"Ultimately, leadership is not about glorious crowning acts. It's about keeping your team focused on a goal and motivated to do their best to achieve it, especially when the stakes are high and the consequences really matter, it is about laying the groundwork for others' success and then standing back and letting them shine."

– Chris Hadfield, Canadian Astronaut

In its governance role, your 2024-2025 alPHa Board of Directors team is indeed motivated and focussed on achieving alPHa's strategic goals. September's inaugural board meeting was preceded with an orientation on good governance, guided by alPHa's Strategic Plan. The Board of Directors welcomed guest speakers Dr. Kieran Moore, Ontario's Chief Medical Officer of Health, Executive Lead Elizabeth Walker, and Michael Sherar, President and CEO, Public Health Ontario. As well as regular business, board discussions centred on forward planning based on alPHa's strategic goals, legal obligations, and laying the groundwork for further development of the series of *Public Health Matters* infographics and videos with availability anticipated in the spring of 2025.

The Association of Local Public Health Agencies Operating By-law No. 2 (June 2024) is compliant with the Ontario Not-for-Profit Corporations Act, 2010. Loretta Ryan, alPHa's Chief Executive Officer, alPHa volunteers, and alPHa's legal counsel are currently conducting a fulsome review and revision of policies and procedures to ensure alignment with the new By-law, and compliance with the

legislation. The compendium of policy and procedures will be brought to the alPHa Board of Directors for review and approval. It is a time-consuming process as there are many detailed legal requirements within the Act that must be followed. The membership will be updated at the alPHa 2025 Winter Symposium. Many thanks to the many volunteers, staff and legal counsel for their work on this important initiative.

alPHa continues to provide strategic leadership in building collaborations and partnerships across stakeholder groups, focussing on strengthening Ontario's local public health system. The Board of Directors receives regular updates from its Sections and from the Affiliate member organizations of alPHa. Loretta Ryan, Chief Executive Officer, works with the alPHa Executive Committee, Board of Directors, public health agencies, Ministry of Health, and with her leadership counterparts from other partner organizations. Key information for alPHa members is sent out via the monthly edition of *Information Break*, which is alPHa members' information portal with links to the alPHa website, and other pertinent resources. Although alPHa tries to limit inundating members' email inboxes, if time is of the essence, information is transmitted through email. alPHa's *Information Break* and emails are sent to the administrative key contact at each local public health unit. This is the most efficient, effective and timely way to disseminate information to their local public health senior leadership and board of health members. It ensures that everyone receives the information equitably, especially in the event of leadership and board of health member turnovers.

There is an exciting line-up for alPHa's 2024 Fall Symposium (click here to view the flyer). Included in the symposium registration are two free workshops on November 6 and 7. The Symposium's plenary sessions are on Friday, November 8, followed by the afternoon Section meetings. At the Symposium, alPHa is launching Mentimeter for feedback, surveys, and voting at all future events. On November 5, alPHa is offering the 2024 alPHa Executive Assistant/Administrative Assistant Fall Virtual Workshop as part of support for those who work closely with our members.

Fall is a time of thoughtful, and appreciative reflection with National Day for Truth and Reconciliation, Thanksgiving, and Remembrance Day. This leads to further reflection on the dedicated work, and the significant challenges that you, as Ontario's public health leaders, along with your teams on the ground, face each and every day. I gratefully acknowledge my colleagues on the alPHa Board of Directors, the alPHa staff, and to each and every one of you, for your unwavering commitment to local public health. Thank You! Merci! Maarsii! Miigwech!

With gratitude,

Trudy Sachowski

Chair, alPHa Board of Directors

Registration for the alPHa Fall Symposium, Section Meetings, and Workshops closes on October 30!

Thank you to all the members who have registered. We're pleased to see so many of you sign up for this important educational and networking event!

Have you registered for the online 2024 Fall Symposium, Section Meetings, and Workshops that are taking place November 6-8 yet? If not, registration closes at the end of the month. This event will discuss a variety of issues of key importance to public health leaders and you won't want to miss out.

On Friday, November 8, from 8:30 a.m. to 4:30 p.m., there is an exciting lineup of Symposium and Boards of Health Section meeting speakers and topics. This includes a public health video showcase; welcoming remarks from the alPHa Chair, Trudy Sachowski, and Robin Jones, President, Association of Municipalities of Ontario; an *alPHa Update* from Trudy Sachowski, the BOH Section Chair, René Lapierre, the COMOH Section Chair, Dr.Lianne Catton, and the Affiliate Representative, Cynthia St. John, and Dr. Charles Gardner; an *Update from the Office of the Chief Medical Officer of Health*, Executive Lead, Liz Walker; an *Update from Public Health Ontario*, featuring President and Chief Executive Officer, Michael Sherar, and staff; an *Update on Public Health Workforce Burnout: A Canadian Cross-sectional Study* from Dr. Jessica Hopkins, Chief Health Protection and Emergency Preparedness Officer, Public Health Ontario; an *Update on Rapid Review of Public Health Recovery, Renewal, and Resilience Building Post Pandemic: A Thematic Synthesis of Essential Organizational Imperatives* from Julia Roitenberg, General Manager and Chief Nursing Officer at York Region Public Health; *Public Health Unit Mergers* featuring Dr. Miriam Klassen, Medical Officer of Health and CEO, Huron Perth Public Health, Peter McKenna, Chair, Board of Health, Leeds, Grenville and Lanark District Health Unit, Amy Martin, Chair, Board of Health, Haldimand-Norfolk Health Unit and *So, What's Still Keeping You Up at Night?* from Sabine Matheson and John Perenack, Principals, StrategyCorp, and alPHa Chief Executive Officer, Loretta Ryan.

In conjunction with the Symposium and Section meetings, we are holding two workshops. The first one, *Artificial Intelligence (AI) and Public Health*, is on Wednesday, November 6, from 9 a.m. to 4:30 p.m. **As an important update, access to this workshop is through an individual and customized Zoom meeting link. You will need to be individually registered and have the passcode in order to access the workshop. This is a vital way to ensure all attendees have paid and are supporting alPHa in doing so.** The workshop objectives are: to assist alPHa members in improving understanding of artificial intelligence and public health; to achieve a shared understanding of the risks and benefits of artificial intelligence in LPHAs, and to learn from academic, government, and industry leaders in artificial intelligence. To view the agenda (last updated on October 9), please click here.

On the afternoon of Thursday, November 7, from 1 p.m. to 4:30 p.m., we will hold the second workshop with the Canadian Centre on Substance Use and Addiction. This workshop, titled *Working for a future with less alcohol harms in Ontario: Public Health's Role*, will provide an opportunity for participants to understand the partnerships, body of work and evidence underpinning Canada's Guidance on Alcohol and Health (CGAH). Breakout sessions will provide opportunities to discuss how it serves as a key tool across sectors to guide health promotion activities, and inform the work of health care providers and policy development.

These workshops are being offered at no additional cost to Symposium registrants and you will be registered automatically when you sign up for the Fall Symposium. Separate registrations are not available for individual events.

The event flyer can be accessed by clicking here. Please keep your eyes on the main Symposium webpage for regular updates. The Symposium program (last updated on October 2) is available here and, for the BOH Section Meeting agenda (last updated on October 2), click here. Also posted on the webpage is a call for public health unit videos and a document on Zoom troubleshooting tips.

If you have any questions regarding these events, please contact alPHa Staff at: info@alphaweb.org.

Please note, after the Fall Symposium, alPHa will collect any presentations shared by the speakers with the membership and will distribute the presentations as soon as these are available.

alPHa would like to thank the University of Toronto's Dalla Lana School of Public Health and Eastern Ontario Health Unit for their generous event support!

Ontario Public Health Directory: **September 2024 update**

The *Ontario Public Health Directory* has been updated and is available on the alPHa website. Please ensure you have the latest version, which has been dated as of **September 18, 2024**. To view the file, log into the alPHa website.

National Collaborating Centre for Methods and Tools

With your team balancing a full workload and the pressure to keep up with evidence-informed decision-making competencies, finding the time to build those skills can seem impossible!

Make the most of the time you have by reaching out to the National Collaborating Centre for Methods and Tools (NCCMT) to set up a custom virtual team assessment to explore your strengths and needs. The NCCMT's experienced Knowledge Brokers help you navigate professional development planning by creating a needs-based, guided learning plan that includes both free and paid recommended learning opportunities. Contact the NCCMT at nccmt@mcmaster.ca to learn more about tailored learning plans.

Public Health Sudbury & Districts: ***Unlearning and Undoing White Supremacy and Racism Project***

At the Board of Health for Sudbury & Districts meeting in September, members of the Indigenous Engagement team presented the Unlearning & Undoing White Supremacy and Racism project. The Board unanimously resolved to join the public health agency's staff in the *Unlearning and Undoing White Supremacy and Racism Project*. This project was originally developed by the Office of the Provincial Health Officer in British Columbia. Public Health is adapting the project, with the permission of the OPHO, to fit the local context. The project addresses colonization, racism, and white supremacy in an 18-month voluntary commitment that allows learners time to read, watch, listen, reflect, and start to understand their role in upholding these harmful systems and how to do better. Since the Board of Health committed to this work, there has been extensive media coverage, including the following interview on CBC Radio.

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alPHa Workplace Health and Wellness: GenWell

GenWell, alPHa's newest Workplace Health and Wellness partner, is promoting Talk to a Stranger Week, which will be held November 18-24, 2024. This campaign is an opportunity to build a sense of connection and community that many need in a post-pandemic world. It is seizing the opportunity that many of us have each day to make a difference in our own lives and the lives of others by simply saying hello, smiling or striking up a conversation with a stranger. To learn more, click here.

Boards of Health: Shared Resources

A resource page is available on alPHa's website for Board of Health members to facilitate the sharing of and access to information, orientation materials, best practices, case studies, by-laws, Resolutions, and other resources. **In particular, alPHa is seeking resources to share regarding the province's Strengthening Public Health Initiative, including but not limited to, voluntary mergers and the need for long-term funding for local public health.** If you have a best practice, by-law or any other resource that you would like to make available via the newsletter and/or the website, please send a file or a link with a brief description to gordon@alphaweb.org and for posting in the appropriate library.

Resources available on the alPHa website include:

- Orientation Manual for Boards of Health (Revised Jan. 2024)
- Review of Board of Health Liability, 2018, (PowerPoint presentation, Feb. 24, 2023)
- The Ontario Public Health Standards
- Public Appointee Role and Governance Overview (for Provincial Appointees to BOH)
- Ontario Boards of Health by Region

- Legal Matters: Updates for Boards of Health (Video, June 8, 2021)
- Obligations of a Board of Health under the Municipal Act, 2001 (Revised 2021)
- Governance Toolkit (Revised 2022)
- Risk Management for Health Units
- Healthy Rural Communities Toolkit
- The Canadian Centre on Substance Use and Addiction
- List of Units sorted by Municipality
- List of Municipalities sorted by Health Unit
- Map: Boards of Health Types
- NCCHPP Report: Profile of Ontario's Public Health System (2021)
- The Municipal Role of Public Health(2022 U of T Report)
- Boards of Health and Ontario Not-for-Profit Corporations Act

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Affiliates update

Ontario Association of Public Health Nursing Leaders

On October 9, 2024 Nicole Welch assumed the role of OPHNL President and will be the OPHNL Affiliate representative to alPHa's Board of Directors starting in the new year. During this transition, OPHNL's priority is to continue to advance the work of the 2024-2027 OPHNL Strategic Plan. High level priorities include: (1) Advancing Public Health Nursing; (2) Providing Meaningful Opportunities for Public Health Nursing Leaders, and (3) Strengthening the Voice of Public Health Nursing Leaders. OPHNL has engaged with members to establish work groups addressing priority work. We wish to thank Jen Vickers-Manzin for her leadership and dedication to public health nursing.

alPHa Correspondence

Through policy analysis, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities. A complete online library of submissions is available here. These documents are publicly available and can be shared widely.

Public Health Ontario

The Ontario Immunization Advisory Committee releases a new position statement: A Provincial Immunization Registry for Ontario

The Ontario Immunization Advisory Committee (OIAC) has recently released Position Statement: A Provincial Immunization Registry for Ontario, which provides recommendations on developing and implementing a comprehensive immunization registry in Ontario. The Statement is centred on three guiding principles and seven recommendations for a comprehensive provincial immunization registry for Ontario.

The seven recommendations outlined in the Statement focus on:

- Implementing a provincial immunization registry that assesses, maintains and documents immunizations across the lifespan to deliver vaccines efficiently, equitably and appropriately across the health system.
- Engaging with groups who use immunization data to meet the needs of diverse populations and ensure timely and equitable access to individual immunization records.
- Having supportive legislation and policy, as well as leveraging existing technology and standards, to support the real-time collection, use and sharing of confidential immunization data across the health system.
- Capturing real-time individual-level immunization data to monitor the uptake, safety, effectiveness and impact of new and existing vaccine programs as well as for individuals and health care providers to make informed decisions about their health.

The Statement includes a detailed overview of each of the recommendations, as well as a plain language and executive summary.

The OIAC is an external group of experts that provides advice to Public Health Ontario about new and existing vaccines and Ontario's immunization programs.

For more information about the Committee, visit the OIAC webpage.

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alPHa's Strategic Plan

alPHa's 2024-2027 Strategic Plan is available here.

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
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peterboroughpublichealth.ca

October 29, 2024

Hon. Doug Ford
Premier of Ontario
premier@ontario.ca

Hon. Michael Parsa
Minister of Child, Community and Social Services
MinisterMCCSS@ontario.ca

Hon. Jill Dunlop
Minister of Education
minister.edu@ontario.ca

Dear Premier Ford and Honourable Ministers:

Re: Funding support for Student Nutrition Programs

The Board of Health at Peterborough Public Health would like to stress the importance of the Government of Ontario negotiating and signing an agreement with the federal government that will see federal funding to support provincial student nutrition programs (SNPs), as outlined in the National School Food Policy. In addition, the Board of Health urges that the Province address and increase government funding to SNPs that would close the gap between the national median contribution and provincial contribution. Specifically, the Board urges an increase of provincial funding contribution by $0.29/student/day to match the national median (provincial/territorial and municipal government contribution) of $0.39/student/day.

Universal access to nourishing food every day at school supports students' academic success, reduces tardiness, and improves student behaviour. An important step towards health equity and well-being, student nutrition programs contribute to students' physical and mental wellness and foster social connection in a welcoming, stigma-free environment. Program success requires all levels of government to be engaged and supportive of an adequately funded delivery model.

The Board of Health supports negotiating the terms to enhance current programming and help fund new SNPs at schools. As public health experts with extensive experience, including a 32-year history of supporting local programs and working with Ontario SNPs, we urge that a universal program provide a nourishing and culturally appropriate daily meal, use best practices in food safety and delivery, as well as function in inspected and adequately equipped spaces. Programs teach students Canada's Food Guide messages by providing a hands-on learning opportunity to eat more vegetables and fruit, whole grains and protein foods in a socially inclusive environment where they enjoy, prepare and eat healthy food with others.

While a sustainable school food program does not replace adequate income support for underserved families, they do provide nourishment so that students are better able to learn and participate in school, establish healthier eating habits (which may reduce the risk of chronic disease), and foster academic success with improved scores in math, reading and science.

We look forward to seeing the Province enhance their support for adequately funded SNPs in order that all children have access to nourishing food at school every day which will contribute to their overall health and well-being and academic success.

Sincerely,

Original signed by

Councillor Joy Lachica
Chair, Board of Health

cc: Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

alPHa Summary
2024 Ontario Economic Outlook and Fiscal Review
Building Ontario for You

October 30, 2024

The 2024 Economic Outlook and Fiscal Review, entitled "Building Ontario for You", was released on October 30, 2024. This announcement, often referred to as the fall economic statement (FES), is akin to a mid-term report between provincial budgets and includes updates on Ontario's debt, the cost of various government programs and details of the economic outlook. It also includes more formal announcements of new budget priorities, many of which are hinted at in the preceding days in media.

Continuing with the priorities that the Ontario Government has clearly signaled since its election, there is a heavy emphasis on infrastructure, most notably in transportation (highways and transit), job creation, and addressing health care capacity. Most of these are not new and have already had plenty of media attention.

Although there is no direct mention in the report of public health, the prominent topic of expanding alcohol availability and other changes to the beverage alcohol distribution system, there is a brief mention of "$10 million over five years to support social responsibility and public health efforts to ensure alcohol continues to be sold and consumed safely in the expanded marketplace" (p. 102).

In past years, the FES Information was also provided about the launch of pre-budget consultations for the following year, but this was not included this time. alPHa will keep an eye out for further announcements and is already working on its submissions to make the usual case for local public health when the opportunities for 2025 present.

Links to the official documents:

- The landing page for the 2024 Ontario Economic Outlook and Fiscal Review is here.
- The full statement can be read online or downloaded here.
- The highlights of the Report are provided here.
- The News Release is here.

We hope that you find this information useful.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Q3 2024 Financial Report (July 1 – September 30, 2024)**
DATE:	**November 13, 2024**
PREPARED BY:	**Dale Bolton, Manager, Finance & Property**
APPROVED BY:	**Larry Stinson, Director of Operations** **Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive the report, Q3 2024 Financial Report (July 1 – September 30, 2024), for information.

ATTACHMENTS:

a. Q3 2024 Financial Report

Financial Update Q3 2024 (Finance: Dale Bolton)

Programs Funded January 1 to December 31, 2024

	Funding Type	2024 Approved Budget	YTD Budget $ Based on 2024 Approval (100%)	YTD Expenditures to Sept 30	YTD % of Budget	YTD Variance Under/(Over)	Comments
Mandatory Public Health Programs - all combined cost-shared	Ministry of Health (MOH) Cost Shared (CS)	11,551,737	8,663,803	8,554,949	74.1%	108,854	Year-to-date (YTD) underspending from January through December based on the approved cost-shared budget. The total funding includes MOH and local partners. Effective January 1, 2024, the Ministry approved a 1% annualized increase to the prior year cost-shared funding for base and mitigation funding. The total MOH funding is $8,299,700 for 2024. Through third quarter, expenditures of $8,554,949 just below budget based on the approved Board of Health (BOH) budget due to some position gapping and timing of planned program spending during year. Through the balance of the year, expenditures will increase as program staff fulfill operational plans, continue ongoing work of the Strategic Plan, and staffing costs adjust for budgeted increases in accordance with collective agreements.

100% Program funded January 1 to December 31, 2024

	Funding Type	2024 Budget Submission	YTD Budget $ Based on 2024 Submission (100%)	YTD Expenditures to Sept 30	YTD % of Budget	YTD Variance Under/(Over)	Comments
Ontario Seniors Dental	100%	898,100	673,575	668,842	74.5%	4,733	YTD expenditures are above budget throught the second quarter, based on prior year budget approval of $898,100. The 2024 Annual Service Plan base budget submission was increased to $1,295,715 to address operational pressures, manage client waitlist, and sustain contracted service levels. At this time, the Ministry has indicated a base increase will not be approved for 2024. Instead, PPH can apply for one-time funding as part of the Q3 Ministry In-Year Report to offset program operational pressures. Given the delay in the funding announcement, projected spending has reduced from the budget submssion. Program delivery continues to be offered through in-house staff and contract dentists; and the use of specialist or other contract services is prioritized and considered for emergency treatments to minimize financial risk. At this time, projected spending through the end of the year is expected to exceed the prior year base budget approval; thus, an in-year one-time request of $71,000 has been submitted to the Province for consideration with the Q3 In-Year Report.

Programs funded April 1, 2024 to March 31, 2025 - Ministry of Children, Community and Social Service (MCCSS)							
	Funding Type	**2024 - 2025 Approved Budget**	**YTD Budget $ (100%)**	**YTD Expenditures to Sept 30**	**YTD % of Budget Approval**	**YTD Variance Under/(Over)**	**Comments**
Infant Child Development Program	100% MCCSS	253,283	126,642	125,276	49.5%	1,366	Program operating just below budget for the second quarter based on the MCCSS approval of $253,283. Program spending is on track and anticipate operating within budget through the end of the fiscal year.
Healthy Babies, Healthy Children	100% MCCSS	1,018,064	509,032	497,634	48.9%	11,398	Program operating just below budget for the second quarter based on the MCCSS approval of $1,018,064. Budget increase to allow for some increased staff time and development over the next six months. Program spending is on track and anticipate operating within budget through the end of the fiscal year.

Funded Entirely by User Fees January 1 to September 30, 2024							
	Funding Type	**2024 Budget**	**YTD Revenue $ (100%)**	**YTD Expenditures to Sept 30**	**YTD % of Budget Approval**	**YTD Variance Under/(Over)**	**Comments**
Safe Sewage Program	Fee for Service	274,600	211,333	246,776	89.9%	(35,443)	Program funded entirely by user fees. Expenditures exceed revenue as new permit applications are below through the third quarter resulting in a deficit of ($35,443). Divesting of program will take place in November, however Anticipated an increase in program activity through the past two quarters; however, local building activity for the municipalities being served by PPH program has been slower impacting revenue to date. Additionally, four of the larger municipalities commenced oversight of issuing permits in April that were anticipated to continue with PPH through November 2024. Over the remaining quarter, staff will continue to close files and support new permits generating revenue to offset operating costs. A portion of fees may be returned to municipalities for files not complete before final divesting of program. Excess expenditures may be offset through the sewage program reserve; or adjustments made to program delivery to balance operations for the year.
Non-Mandatory Re-inspection Program	Fee for Service	13,000	1,625	16,561	127.4%	(14,936)	Program funded entirely by fees. Expenditures to date are $16,561 and exceed revenue earned to date, due to staff program planning during the first quarter. Onsite reinspections commenced in April and will continue through October, pending weather and as requested. Fees will be collected through the balance of the fall pending final inspections completed. Excess expenditures may be offset through program reserve.
Total - All Programs		**14,008,784**	**10,186,010**	**10,110,038**	**72.17%**	**75,972**	Variance represents year to date underspending in cost-shared programs net of deficits in fee for service programs.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Q3 2024 Status Report (July 1- September 30, 2024)**
DATE:	**November 13, 2024**
PREPARED BY:	**Donna Churipuy, Director, Health Protection Division** **Hallie Atter, Director, Health Promotion Division** **Larry Stinson, Director of Operations** **Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive the report, Q3 2024 Status Report (July 1- September 30, 2024), for information.

SUMMARY

Summary of Key Issues from the Medical Officer of Health
Directors & MOH to populate

Accomplishments:

- Informative and engaging All Staff Day completed in October with presentations on Residential Schools, PPH Values, and Diversity, Equity and Inclusion.
- PPH in collaboration with HKPR has begun providing services as part of new provincial funding to the health units for IPAC Hub support in congregate living settings. This 100% provincially funded program improves IPAC capacity to support these settings.
- Addition of new Manager of Indigenous Health now supporting further engagement in relationships with Indigenous communities, and reflections on internal practices.
- Ongoing collaboration between HKPR and PPH supporting program discovery and improvements as we work towards the merger

Challenges:

- Lack of Ministry communication regarding merger decision.
- Inadequate funding to meet all mandated programs and services.

PROGRAM TRACKER

Status of Mandated Programs and Requirements

Ontario Public Health Standard Mandated Programs	# Requirements Compliant (Q3 2024)	# Requirements Compliant (Q2 2024)
Program Standards		
Chronic Disease Prevention and Well-Being	3/5	3/5
Food Safety	5/5	5/5
Healthy Environments	11/11	11/11
Healthy Growth and Development	2/3	2/3

Ontario Public Health Standard Mandated Programs	# Requirements Compliant (Q3 2024)	# Requirements Compliant (Q2 2024)
Immunization	10/10	10/10
Infectious and Communicable Diseases Prevention and Control	21/21	21/21
Safe Water	8/8	8/8
School Health	9/10	9/10
Substance Use and Injury Prevention	2/4	2/4
Foundational Standards		
Population Health Assessment	6/6	6/6
Health Equity	4/4	4/4
Effective Public Health Practice	8/9	9/9
Emergency Management	1/1	0/1
Other Mandated Programs	**Status**	
Infant and Child Development	ME	ME
Safe Sewage Disposal	ME	ME

ME: Meeting Expectations PME: Partially Meeting Expectations

Link to Ontario Public Health Standards

PROGRAM SUMMARIES

Chronic Disease Prevention and Well-Being

Program Compliance:

Requirement #1 and 2: Due capacity, we are currently unable to fully analyze relevant data related to chronic disease prevention, nor fully deliver interventions using a comprehensive health promotion approach that addresses risk and protective factors of all chronic disease. We are currently prioritizing public health interventions that address healthy eating behaviours and oral health.

Healthy Growth and Development

Program Compliance

Requirement #2: We are unable to fully deliver interventions using a comprehensive health promotion approach that reduce risk and promote the protective factors for healthy growth and development. We are currently prioritizing public health interventions that focus on the reduction of Adverse Childhood Experiences.

School Health

Program Compliance

Requirement #7: Vision screening was not prioritized for 2024 and there has not been progress on this work. While this remains in the standards at present, the province has communicated that this activity is currently being reviewed in context of the new OPHS.

Substance Use and Injury Prevention

Program Compliance

Requirement #1 and 2: We are currently prioritizing public health interventions that address opioid poisonings. Due to capacity, we are currently unable to fully analyze relevant data related to injuries and substance use, nor fully deliver interventions using a comprehensive health promotion approach that addresses risk and protective factors of all preventable injuries and substance use.

Foundational Standards

Program Compliance:

Requirement #8: Effective Public Practice requirements related to quality improvement and impact evaluations have been affected by staffing gaps of 2 FTEs.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Q3 2024 Strategic Plan Report (July 1 – September 30, 2024)**
DATE:	**November 13, 2024**
PREPARED BY:	**Hallie Atter, Director of Health Promotion** **Donna Churipuy, Director of Health Protection, Chief Nursing Officer & Privacy Officer** **Larry Stinson, Director of Operations**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive the report, Q2 2024 Strategic Plan Report (April 1 – June 30, 2024), for information.

Strategic Plan – Board of Health Q3 2024 Reporting (July 1 – September 30, 2024)
Reference: PPH Strategic Plan 2023-25

Strategic Plan Direction	Goal	Most Relevant Linked Long-Term Changes (#1-9)*	Status**	Brief Description of Activities – Q3
Our Team	Healthy Organizational Culture	7	Initiated	• Diversity, Equity and Inclusion (DEI) Consultant engaged and staff presented priorities and proposed actions, which were supported by the Sponsor. • Continued transparency and information sharing regarding potential merger with Haliburton, Kawartha, Pine-Ridge District Health Unit (HKPR).

Strategic Plan Direction	Goal	Most Relevant Linked Long-Term Changes (#1-9)*	Status**	Brief Description of Activities – Q3
				• A successful All Staff Day was held with presentations on DEI and Reconciliation.
	Staff Wellbeing and Development	8	Initiated/Implemented	• Guarding Minds at Work Committee completed review of the survey results and presented recommendations for actions. Enhanced Education Fund policy and procedure implemented. • Office 365 licensing upgrades implemented. • Code of Conduct Policy and Procedure introduced for review. • Train the trainer completed for Non-Violent Crisis Intervention and training dates scheduled.
	Effective Teams	9	Initiated/Implemented	• Quality improvement and measuring impact initiatives were provided support from Foundational Standards staff. • Initial continuous quality improvement (CQI) Assessment conducted with Corporate Services Team Managers of both merging health units. • Continued Learning and Development sessions at Management Committee on key topics.
Our Community	Drug Poisoning Crisis	3, 4, 5	Implemented	**Peterborough Youth Substance Use Prevention Project:** • Engaging partners to initiate a steering committee including District School Boards

Strategic Plan Direction	Goal	Most Relevant Linked Long-Term Changes (#1-9)*	Status**	Brief Description of Activities – Q3
				(approx. 30 partners engaged through various presentations; meetings, etc.). • Completed a media interview on the project with Trent Radio. • Provided vaping professional development for Peterborough Victoria Northumberland and Clarington Catholic District School Board (PVNCCDSB) K-12 educators in collaboration with HKPR/Durham Regional Health Department. • Participating in the Planet Youth Academy Training.
		1,3,4,5	Implemented	• Working with the Consumption and Treatment Site (CTS) on evaluation. • As of September 30th, 430 samples have been checked using the Fourier Transform Infrared Spectrometer (FT-IR) since onset of program. • Participated in Hiawatha First Nation's International Overdose Awareness Day. • PPH's Opioid Harms Snapshot has been introduced to Peterborough Drug Strategy (PDS) partners and informs their planning • Housing/Homelessness mortality data collection continues enhanced by regular data from the Coroner's office.

Strategic Plan Direction	Goal	Most Relevant Linked Long-Term Changes (#1-9)*	Status**	Brief Description of Activities – Q3
				• Plans for offering clinical services (i.e., oral health) at Trinity Community Centre are being developed.
	Adverse Child Experiences (ACEs) Prevention & Child Development	1,2,3,4,5	Implemented	• Nurse Family Partnership (NFP) currently has 34 active clients (PPH/HKPR), 16 of which are clients of PPH. • "Parenting in Peterborough" survey closed September 30th. Over 400 surveys being analyzed. Community focus groups, in partnership with Trent are continuing to further explore the needs of parents. • PPH staff participated in the development of a provincial ACEs Framework. • Community Resilience Collaborative continues to meet regularly. Co-chairs for this committee have been established and the group is currently doing Community Resilience Core Training. Mechanism for parent lived experience to inform Coalition is being developed.
	Climate Change	3, 4, 6	Implemented	• Presentations to City and County Council on the Climate Change and Health Vulnerability Assessment (CCHVA). • Applied for a Health Canada Health Adapt Grant in collaboration with HKPR. • Continue to coordinate the Extreme Temperatures Network (ETN) with external partners. At the July 16th meeting

Strategic Plan Direction	Goal	Most Relevant Linked Long-Term Changes (#1-9)*	Status**	Brief Description of Activities – Q3
				– Terms of Reference approved; presented results from the Communication and Resources Survey. • Review of literature regarding warming room best practices initiated. • The Extreme Heat Subplan Appendix D "Extreme temperature community partner distribution list" was updated with current information. • Communications focused on extreme heat relating to health impacts, vulnerability and adaptation to support vulnerable populations is ongoing. • Indigenous engagement with HKPR/ Cambium Indigenous Professional Services (CIPS) is ongoing, first session planned with Curve Lake First Nation (CLFN) in October.
Our System	Partners in Health Equity			• Information provided to health care providers moved from systemic use of faxes to email via subscription as per recommendation of primary care providers. • New Terms of Reference drafted for Peterborough Family Health Team and PPH Leadership Table with a focus on mutually beneficial advocacy efforts.

Strategic Plan Direction	Goal	Most Relevant Linked Long-Term Changes (#1-9)*	Status**	Brief Description of Activities – Q3
	Indigenous Allyship	5,7	Implemented	• Manager, Indigenous Health started in role mid-August. Initial introductions of Manager to Indigenous communities and organizations have begun. • Engagement sessions with Indigenous communities completed as part of CIPS Two-Eyed Seeing Climate Change project in collaboration with HKPR and informed by IHAC.
	Public Health System	4	Implemented	• New Terms of Reference drafted for Peterborough Family Health Team and PPH Leadership Table with a focus on mutually beneficial advocacy efforts. • Advocacy for strengthening public health system including voluntary mergers that are supported through provincial funding.

***DESIRED LONG-TERM CHANGES FOR 'OUR COMMUNITY' AND 'OUR SYSTEM' (7-10 YEARS)**

1- Individual basic needs (eg. income, housing, food security) are being met;
2- Children's developmental needs are being met;
3- Community programs and services are driven by relevant data, are evidence-informed and oriented to the needs of priority populations;
4- Organizations, associations and institutions from various sectors are working together to influence health-enhancing policy;
5- The voices and actions of the people most affected are shaping organizational and public policy;
6- Populations most vulnerable to health hazards and changes in the physical and natural environment are protected

LONG-TERM CHANGES FOR 'OUR TEAM'

7 – Healthy Organizational Culture
- Organizational decisions are clear, consistent, transparent & evidence-based.
- Shared purpose & values.
- Increased diversity among staff.
- Culture of safety.
- Good governance.

8 – Staff Wellbeing & Development
- Staff pursue opportunities for ongoing learning, development, & effective practice.
- Increased mental & physical wellbeing.
- Accomplishments are recognized and celebrated.

9- Effective Teams
- Coaching-based leadership is consistently practiced by all managers.
- Teamwork & interdisciplinary practice
- Commitment to learning, continuous quality improvement & impact
- A flexible & adaptable workforce.
- Effective conflict resolution.

****STATUS:**

Not yet Initiated: Planning has not yet begun. Specific actions not yet developed.

Initiated: Planning has begun, such as initial planning discussions and the development of specific actions to achieve desired outcomes.

Implemented: Planned actions are being carried out. Actions planned as part of the activities for the reporting period (eg. strategies, initiatives, products and/or services) are in process and/or are on-going.

Completed: Activities and/or deliverables planned for current year are fully completed and no longer require any action. Note: This is not meant to be a status indicator for specific activities but overall status across the work plan for various goals.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH – STAFF REPORT

TITLE:	**Q3 2024 Standards Activity Report – Risk Management**
DATE:	**November 13, 2024**
PREPARED BY:	**Larry Stinson, Director of Operations**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive the staff report, Q3 2024 Standards Activity Report – Risk Management, for information.

BACKGROUND

The Ontario Public Health Standards Activity Reports are a set of reporting tools that boards of health are required to submit quarterly as per the Ontario Public Health Standards and Public Health Funding and Accountability Agreement.

The intent of the report is to communicate quarterly financial forecasts and interim information on program achievements. Through these reports, boards of health will have the opportunity to identify risks, emerging issues, changes in local context, and programmatic and financial adjustments in program plans.

The Risk Management portion of this report is required only for the Q3 Ministry Report and has been appended for your information. The purpose of this worksheet is for boards of health to report, in a standardized manner, the high risks and key risk mitigations that are currently being managed by each board.

ATTACHMENTS

a. Q3 2024 Standards Activity Report – Risk Management Worksheet

Q3 2024 Standards Activity Report – Risk Management Worksheet

Description	Category	Impact	Likelihood	Mitigation
Due to limited capacity some Requirements within the Ontario Public Health Standards are not being met. Revisions to OPHS were intended to address this risk but have yet to be implemented. A lack of compliance can lead to relationship and reputational harm and liability for negative health outcomes.	Operational / Service Delivery	5	3	Strategic and Operational Planning considered the impact of each intervention and the risk of de-prioritization. The Senior Leadership team and the Board of Health continue to report on areas of non-compliance and to advocate for adequate resourcing.
The Board for PPH and for the HKPR District Health Unit have expressed their intent to merge and have sought funding approval from the Ministry of Health. There is risk whether provincial and Board approval is achieved related to adequate funding for implementation and program continuity, staff wellbeing and staff retention.	Governance / Organizational	5	5	Joint merger planning at the Board, Senior Leadership and Management level has begun for pre-implementation strategies. Continued planning and broader engagement will be necessary to manage plans for the future whichever direction decisions take.
The Seniors Dental Program is a 100% Ministry funded program, with a set annual approved budget. The service levels, however, are based on demand. The Ministry provides one-time funding for extra-ordinary cost pressures created by demands, but approvals for this funding is often months after service is required. PPH therefore must take the risk of delivering service without full assurance of funding approvals.	Operational / Service Delivery	4	3	Operations are modified to operate within a reasonable deficit budget based on prior year approvals of one-time funding and assurance from Ministry staff.

Description	Category	Impact	Likelihood	Mitigation
The risk of attacks on our data and information through hacking, ransomware and phishing continues and requires additional diligence when operating in a hybrid work model.	Technology	4	4	Policies and procedures and ongoing training support staff to avoid higher risk behaviours. The IT Manager and staff work with the Ministry, our insurance provider and industry leaders to ensure adequate levels of protection within our systems. A system assessment completed as part of the merger process has identified key risk reduction strategies that can be implemented independently or as part of an integrated system of a merged entity.
The broader workforce shortage and more specifically, health service sector shortage presents potential recruitment challenges for public health.	People / Human Resources	3	4	The HR program uses a comprehensive approach to recruitment and is developing strategies to reduce barriers based on diversity, equity and inclusion (DEI). The Our Team strategic direction from our Strategic Plan seeks to ensure PPH has a workplace that attracts the best talent.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH – STAFF REPORT

TITLE:	**Preparedness for Future Health Emergencies**
DATE:	**November 13, 2024**
PREPARED BY:	**Director, Health Protection Programs and Chief Nursing Officer**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health:

- receive the staff report, Preparedness for Future Health Emergencies, for information;
- send correspondence to the provincial and federal Ministers of Health supporting recommendations in the Health Canada Report, *The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Science Advice and Research Coordination*; and
- send correspondence requesting the Ontario Minister of Health and Chief Medical Officer of Health confirm the status of annual reporting on preparedness activities to the legislature as recommended in the Chief Medical Officer of Health 2022 Annual Report.

FINANCIAL IMPLICATIONS AND IMPACT

There are no financial implications arising from this report.

DECISION HISTORY

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

BACKGROUND

It has been five years since we learned of the outbreak in China that preceded the declaration of a global pandemic. We have learned significantly in public health and more broadly from these experiences and several reports have been authored summarizing the learnings and calling for sustained investment in emergency preparedness.

In 2022, the Office of the Chief Medical Officer of Health (CMOH) published the 2022 Annual Report *Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics*[1] that included findings at the provincial level and a need for ongoing vigilance and reporting to the Ontario provincial legislature on pandemic readiness on an annual basis.

More recently, Health Canada published *The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Science Advice and Research Coordination*[2], which takes a similar, yet higher level call to sustained investment and commitment to emergency

preparedness including coordination of research and scientific advice across the country and close attention to addressing inequities and determinants of health.

"The pandemic exposed and exacerbated the weaker elements of Canada's health research and science advisory systems. It also highlighted severe shortcomings of health data systems and an inability to conduct timely and adequate observational studies, including infectious disease surveillance, and clinical trials."[3]

The major findings of the Expert Panel Report (also referred to as the "Walport Report" after Panel Chair, Sir Michael Walport) include:

- Canada must act now to be prepared for the next health emergency;
- Greater pan-Canadian coordination of research and science advice is required;
- A greater focus needs to be placed on equity and addressing social and structural determinants of health;
- Indigenous health expertise must be embedded in research coordination and science advice processes;

The recommendations are enclosed as an appendix.

These calls for action historically follow major human health emergencies, yet time and time again, funding and emergency preparedness activities wane over time.

The 2022 CMOH report recommended annual reports as a mechanism for ensuring continued work and development of emergency preparedness capacity, however, to date public health reporting to the Province has not changed and to the best of our knowledge the legislature has not yet received a report on preparedness activities for 2023 and 2024. Failing to implement the recommendation for ongoing reporting to the legislature on pandemic readiness would be a significant setback for both the public and public health. Furthermore, the federal Walport Panel's recommendations, which emphasize the need to improve and sustain emergency preparedness in advance of future crises, underscore the importance of transparent, consistent reporting. Without this essential accountability, Ontario risks falling behind in its readiness for future emergencies, which could have dire consequences for public health and safety.

RATIONALE

As a result of the COVID-19 pandemic, both provincial and federal public health experts call for ongoing investment in health emergency preparedness activities. Globally, many infectious diseases including Mpox, Marburg virus, H5N1, and various vaccine preventable diseases are a constant threat to the health of populations. We know that emerging diseases such as COVID-19 disproportionately impact low-income communities and those who live with homelessness, are racialized or are vulnerable because of other conditions. Residents of Peterborough County, City, Curve Lake First Nation and Hiawatha First Nation are not immune to these threats.

Peterborough Public Health has taken steps within its capacity to be prepared but the broader health, social, research and governmental systems need to collaborate and ensure that robust systems are well-established and prepared to respond to these and unknown threats. It is only through regular and transparent public reporting and sustained investment to address recommendations to improve emergency preparedness that we can be ensured that we are 'ready' for the next threat.

STRATEGIC DIRECTION

This report applies to the following strategic direction: *Our System: Stronger health system through relationships with primary care and health system partners (ensure a strong, collaborative, and sustainable health system and public health response to the COVID-19 pandemic and future emerging/re-emerging disease threats).*

APPENDICES:

a. Recommendations and Summary of Key Findings - The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Science Advice and Research Coordination. (Excerpt from full report, pages 6-24)

REFERENCES:

[1] Ontario Ministry of Health. Toronto. 2022. *2022 Annual Report — Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics* (ontario.ca)
[2] Health Canada. Ottawa. 2024. *The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Science Advice and Research Coordination* (canada.ca)
[3] Ibid.

The Time to Act is Now

Report of the Expert Panel for the Review of the Federal Approach to Pandemic Science Advice and Research Coordination

Health Canada Santé Canada

Canada

Recommendations and Summary of Key Findings

The COVID-19 pandemic reinforced the critical importance of scientific research and advisory systems to support timely responses to an uncertain and evolving public health emergency. In reaction to the pandemic, Canada's federal government quickly activated existing emergency coordination structures, made research investments to enhance understanding of the virus and its impacts, and sought scientific evidence and advice through a wide range of mechanisms. These actions supported the country's overall response and relatively positive outcomes as compared with other G10 countries.[1] However, the pandemic had disproportionate impacts on Canadians who have historically experienced systemic barriers to health care access, higher rates of underlying health conditions, and increased adverse social determinants of health that can exacerbate the impact of health emergencies.[2] The pandemic also highlighted important gaps and inefficiencies in science advisory and research coordination systems. It is important to reflect on what has been learned, to improve readiness well in advance of the next pandemic or other public health emergency.

Mandate and Approach

In August 2023, Health Canada asked an independent expert panel to conduct a review of the federal approach to pandemic science advice and research coordination, take stock of the lessons learned, and provide concrete recommendations to strengthen Canada's preparedness in these areas for future health emergencies. The scope of the review was developed in consultation with the Public Health Agency of Canada, the Canadian Institutes of Health Research, the Office of the Chief Science Advisor, and other federal departments and agencies. The panel's work is also relevant to other emergencies and to the management of research and science advice in general. Its mandate did not extend to an evaluation of the impact of research funding, how science advice factored into government decision-making processes, or the outcomes of government policies and actions.

Through interviews and roundtable discussions, the panel consulted with more than 300 individuals across the country, from government departments, public health agencies, academia, and the private sector, and Indigenous knowledge holders and health practitioners. It also reviewed relevant national and international literature on research coordination in emergencies and the provision of scientific advice to government. The panel found a high level of consistency between the views expressed in its consultations and the research it undertook.

Major Findings

Four broad, cross-cutting findings emerged from the panel's consultations, research, and deliberations. These underpin its recommendations:

- **Canada must act now to be prepared for the next health emergency:** A common thread running through the panel's recommendations is the urgent need to improve and sustain readiness in advance of the next emergency. The pandemic exposed and exacerbated the weaker elements of Canada's health research and science advisory systems. It also highlighted severe shortcomings of health data systems and an inability to conduct timely and adequate observational studies, including infectious disease surveillance, and clinical trials. To overcome these challenges, the federal government and other levels of government implemented a wide range of supplemental ad hoc mechanisms. See Appendix A, Appendix B, and Appendix C for a full inventory of bodies and timelines. However, these took time to put in place. The lack of ready infrastructure and processes delayed the generation of evidence and synthesis of knowledge to inform urgent policy decisions. The long-term funding for newly created critical infrastructure and networks is uncertain; a lack of continued investment could return Canada to a pre-2020 state of readiness. Immediate and sustained actions are required to address these issues to prevent possible disastrous health, social, and economic consequences of a future emergency, which could be faster moving and more severe than the COVID-19 pandemic. Advance preparation for pandemics and other key threats to public health is a more cost-effective approach than waiting for the next emergency to strike before acting. It will also improve the overall health of Canadians during times of stability.[3]
- **Greater pan-Canadian coordination of research and science advice is required:** The response to the COVID-19 pandemic spurred unprecedented collaboration among governments, public health officials, researchers, and other relevant groups and partners across Canada and abroad. Well-established federal-provincial-territorial health, public health, laboratory, and other coordination bodies were quickly activated in early 2020 (see Appendix B for a COVID-19 timeline) and met regularly to support information exchange. However, there was a lack of sufficiently robust systems for specifically coordinating research and science advice across the country in response to a nationwide emergency of such scale.[4] This led to duplication of efforts and challenges in areas including identifying, communicating, and funding research priorities. New mechanisms are needed to bring together national efforts on key issues, and coordinate internationally, both in preparation for and in response to future national and global emergencies. More effective pan-Canadian collection and triage of public health research questions are required, along with better coordination of intramural and extramural research, knowledge synthesis, guidance development, and advisory processes. Canada must also harness a broader range of expertise, including from social, economic, behavioural, and applied sciences, and remove barriers to interdisciplinary, transdisciplinary, and cross-sectoral collaboration. These processes must be put in place now and tested and refined through simulations and exercises before the next health emergency.

- **A greater focus needs to be placed on equity and addressing social and structural determinants of health:** COVID-19 disproportionately negatively impacted communities already experiencing inequities and health disparities.[5] This included lower-income Canadians, homeless and under-housed populations, Black and other racialized populations, and individuals living in vulnerable conditions. People living in congregate living settings, such as long-term care homes, were also heavily impacted. The social and economic conditions that are well known to influence differences in health status greatly shaped differential exposure and vulnerability to the SARS-CoV-2 virus and access to treatment.[6] While the importance of these social determinants and underlying structural determinants of health is well understood, a greater focus must be placed on reducing their impacts before the next pandemic strikes. This requires greatly increased research on the effectiveness of public health and other interventions, accompanied by science advice to policy makers. Such prior research is essential to guide equitable preparation for, mitigation of, and responses to future health emergencies, as well as efforts to address the underlying inequities.
- **Indigenous health expertise must be embedded in research coordination and science advice processes:** Indigenous populations were disproportionately negatively impacted by the COVID-19 pandemic due to longstanding health inequities with well-documented differential access to health and social services.[7] In addition, the advice of Indigenous health experts and engagement with their communities were not sought early enough in decision-making processes. Before the next health emergency strikes, Indigenous health expertise and considerations for the unique needs of their communities must be integrated in data collection, risk assessment, expert advice, and research funding processes to support their health and wellness and advance reconciliation.

Many previous expert panels dating back decades have called for action in these areas. For example, the 2003 report of the National Advisory Committee on SARS and Public Health chaired by Dr. David Naylor noted the following:

> There have been many calls to strengthen public health infrastructure in Canada over the last decade. For example, in late 1993, given the global spread of HIV, Health Canada organized an Expert Working Group on Emerging Infectious Disease Issues. This 'Lac Tremblant' group called for "a national strategy for surveillance and control of emerging and resurgent infections", support and enhancement of "the public health infrastructure necessary for surveillance, rapid laboratory diagnosis and timely interventions for emerging and resurgent infections", coordination and collaboration in "setting a national research agenda for emerging and resurgent infections", "a national vaccine strategy", "a centralized electronic laboratory reporting system to monitor human and non-human infections", and strengthening "the capacity and flexibility to investigate outbreaks of potential emerging and resurgent infections in Canada". A decade later, very similar recommendations are repeated in our report.[8]

Considerable progress has been made on these issues, but important gaps remain. Many of the 2003 report's recommendations remain salient and are echoed in the recommendations of this panel.

Recommendations

Building on the major findings, the panel developed 12 recommendations organized into four areas.

1. National health risk governance
2. Science advisory mechanisms
3. Health research prioritization, funding, and coordination
4. Health data availability and use

These recommendations aim to build on the wide range of actions taken by the federal government in response to the COVID-19 pandemic. If effectively implemented, they will enable a stronger and more systematic Canadian response to future health emergencies. The panel made two additional recommendations, strongly related to its findings but broader than the remit of its review.

National Health Risk Governance

Following the lessons from HIV, SARS-CoV-1, MERS, and Ebola, the COVID-19 pandemic was a forceful reminder of the critical importance of robust and effective mechanisms for the identification, assessment, mitigation, and management of natural hazards and human threats. Plans need to be prepared in advance to guide rapid and efficient resource allocation, including for research funding, infrastructure, and timely sourcing of scientific evidence to inform urgent policy decisions during an emergency.

National risk registers offer a systematic approach to help countries identify, plan for, and address population-level health risks. A risk register's four main purposes are to i) prevent risks from transpiring as far as is possible; ii) mitigate the worst effects of risks through advance preparation; iii) handle risks when these transpire; and iv) support recovery. This requires an active process, led centrally within government, working with the relevant government departments for each risk (and recognizing that, in catastrophic emergencies, risks can cascade across the activities and responsibilities of many government departments). Continuous horizon scanning is essential to ensure the continuing salience of a national risk register.

Public Safety Canada is currently leading the development of a National Risk Profile[9] (similar to a risk register) that includes considerations relating to pandemics but omits consideration of biological and health hazards and threats in and of themselves. The Public Health Agency of Canada has also invested to bolster its internal capacity and governance relating to risk assessment and response. These are important steps towards a more comprehensive assessment and preparedness plan to address the full range of the most serious health hazards and threats facing the country. Risk analysis needs to be made available to inform research priorities and other preparedness actions by all levels of government and other relevant groups. Canada's emergency management plans,[10] pandemic plans,[11] and federal-provincial-territorial public health emergency response plans[12] do not currently outline protocols for science advice or research coordination. Other countries—such as the United Kingdom, New Zealand, and the Netherlands—maintain and publish more comprehensive national risk assessments and response plans.[13,14,15]

Well-coordinated surveillance systems are critical to inform health risk assessment. The 2003 report of the National Advisory Committee on SARS and Public Health called for the development of an integrated risk assessment capability for public health emergency response, and a comprehensive and national public health surveillance system to collect, analyze, and disseminate laboratory and health care facility data on infectious diseases and non-infectious diseases to relevant groups.[8] Yet, the panel heard that during the COVID-19 pandemic, surveillance data were incomplete and not consistently available to the public health officials, researchers, and relevant groups who required them. Since many jurisdictions did not collect demographic information, they did not know which segments of the population were disproportionately impacted.

In response to the pandemic, the federal government funded new surveillance networks, including wastewater monitoring networks that provided critical data on infection. However, the panel heard that the future of some of these networks is uncertain because they have not received long-term funding and that processes for real-time clinical surveillance and data sharing are lacking. Given the federated nature of the Canadian health care system, solutions to these problems require actions by all levels of government and strong intergovernmental collaboration.

Recommendation 1: Put in place a comprehensive national health risk management system

a. Develop a national health risk register and preparedness plan including mitigation, response, and recovery elements. This should encompass the health implications of environmental, zoonotic, chemical, biological, radiological, nuclear, and other natural hazards and human threats that could originate domestically or internationally. It should be updated regularly based on horizon scanning, and an external version should be published at least annually. The Health Portfolio should lead this process in coordination with Public Safety Canada and other departments and agencies as required. The plan should be developed in collaboration with provincial/territorial public health agencies and health departments.

b. Incorporate the health risk register and preparedness plan within broader national emergency protocols, clearly outlining the roles and responsibilities of relevant departments and agencies. Plans should be rehearsed and refined through regular table-top simulations and exercises.

c. Establish a standing health risk assessment and planning advisory body to inform the health risk register and preparedness plan. This should include a dedicated standing expert advisory committee on infectious diseases and pandemic preparedness.

Recommendation 2: Ensure that surveillance systems adequately support real-time assessment and public health security

a. Provide sufficient long-term funding for clinical, public health, and laboratory surveillance networks and infrastructure for emerging infectious diseases and risks to public health, accompanied by the underpinning technical infrastructure, in coordination with provincial/territorial governments and First Nations, Inuit, and Métis partners.

b. Systematically provide the results of all federally managed and funded public health surveillance efforts to provincial/territorial, local, and Indigenous health agencies and pursue reciprocal sharing agreements.

Science Advisory Mechanisms

Effective mechanisms for the transmission of scientific advice to senior policy makers are crucial to a government's ability to make informed, timely policy decisions during health and other emergencies. This is especially important when the threat is novel and rapidly emerging, where there is significant uncertainty, and where the full extent of the health, social, and economic impacts is not clearly understood. In response to COVID-19, the federal government went to great lengths to seek science and expert advice through both established structures and newly created ad hoc advisory bodies. See Appendices A, B, and C for a full inventory of bodies and timelines.

The effectiveness of federal advisory structures varied depending on many factors including the timing of their establishment, membership, mandate, access to data, how advice was delivered, and whether that advice related to matters within federal jurisdiction or to that of other levels of government. The panel heard that among federal advisory bodies, those relating to vaccines were the most effective. For example, the expert roster, strong secretariat, and clear mandate of the Vaccine Task Force created in June 2020 enabled it to rapidly deliver advice directly to Ministers, which was vital to making critical procurement decisions.[16] The pre-existing National Advisory Committee on Immunization[17] provided important guidance on vaccine administration and sped up its processes during the pandemic; however, its advice was not consistently timely due to a shortage of surge capacity.

Roundtable participants highlighted the insufficient guidance for diagnostics, therapeutics, non-pharmaceutical interventions, and patient care in Canada. Australia,[18] France,[19] Germany,[20] the United Kingdom,[21] and the United States,[22] for example, had more robust processes for providing national clinical guidance, informed by the best available clinical trial results and international studies.

Overall, the absence of pre-existing emergency protocols for science advice in Canada caused significant delays, with time being of the essence in an emergency, as well as coordination issues within and across all levels of government. Various science advisory tables led by the Health Portfolio, other federal departments and agencies, and the Chief Science Advisor of Canada resulted in multiple streams of advice. Given the rapidly changing knowledge environment, this advice was sometimes conflicting and there was a lack of capacity to coordinate the advice. As a result, additional ad hoc coordination mechanisms were developed for this complex landscape of advisory tables.

Science and expert advisory structures should be established and ready to be activated in advance of an emergency, rather than created in response to one. An emergency is not the time to decide on the nature of the bodies, identify and secure experts, establish terms of reference, put in place organizational support, and establish efficient and effective work patterns. Other countries have systems that are ready to provide advice in response to an emergency, such as the United Kingdom's Scientific Advisory Group for Emergencies.[23] This system was immediately activated in January 2020 to support COVID-19 decision-making.

The panel's experience, insights collected in consultations, and a literature scan conducted by the Public Health Agency of Canada[24] point to four key features of effective science advisory bodies. First, they operate with a high degree of independence, yet have strong ties to government and a clear "customer" in the form of senior government policy makers who are receptive to their advice. Second, they are properly resourced, have access to required data, and are populated with a diversity of perspectives and expertise. This enables the provision of interdisciplinary advice based on the best available evidence at the time. Third, they provide timely advice that observes principles of effective science communication,[25] with advice publicly released soon after its provision to government. Finally, they are sufficiently connected to government to understand the context in which science information for decision making is needed.

The panel observed considerable duplication of experts across the various federal advisory bodies active during the pandemic. Certain bodies lacked sufficient diversity and breadth of expertise, including in relation to Indigenous health, behavioural sciences, and health equity. In addition, the output of many federal advice bodies was not publicly released in a timely manner. In contrast, the Ontario COVID-19 Science Advisory Table (which operated largely independently while having strong links into government) publicly released more than 70 briefs during its operation from July 2020 to September 2022. However, this ad hoc advisory body also took time to establish and was stood up after the first wave of the pandemic was largely over.[26]

It is critical that scientific advice, including clarity on the level of certainty of the underlying evidence, be publicly communicated (except for information that is confidential in nature or could jeopardize security). During an emergency, the time interval between the delivery of the advice to policy makers and its public release should be as short as possible. The information benefits all levels of government, provincial/territorial and local public health officials, public and private organizations, other relevant groups, and citizens. Its accessibility is important for maintaining trust in the policy-making process and combatting misinformation and disinformation.

Canada requires a more structured approach to science advice for future emergencies. Independent advice, which benefits from a broad range of interdisciplinary expertise and considers health equity and Indigenous health implications, must be quickly and widely available at any time. A more coordinated, streamlined, and transparent federal advisory process, with advice flowing in real time to other levels of government, and publicly in a timely fashion, will reduce duplication and improve efficiency by providing a foundational resource for provinces and territories, local public health units, and others.

Recommendation 3: Establish a science advisory system for emergencies

a. Create a central federal mechanism that is designed to immediately activate a specialized expert advisory group in response to a health emergency to provide the best independent scientific advice directly to Cabinet. This system should be co-led by the Privy Council Office and the Health Portfolio, in collaboration with the Office of the Chief Science Advisor, Public Safety Canada, and other departments and agencies as required.

b. Ensure that this mechanism is ever-ready by establishing a standing interdepartmental government secretariat with sufficient ongoing and surge capacity. The secretariat should have knowledge mobilization and communications expertise, and access to all required intelligence. It should maintain a roster of experts relating to key health risks (as per the proposed health risk register in recommendation 1). Preparedness work should include training the roster of experts, secretariat members, and government decision makers on best practices for providing, receiving and communicating evidence; as well as simulations and exercises.

c. Designate the activated expert advisory group as the main federal science advisory body for health emergencies. This group should typically be convened jointly by the Chief Public Health Officer and Chief Science Advisor. Members should be assembled based on the nature of the emergency, drawing from the roster of experts, standing advisory committees, and elsewhere as required. The majority of members should be independent experts, chosen solely for their expertise. Expertise should be diverse with health, social, behavioural, humanities, and applied sciences as required, and cut across sectors, including intramural, extramural, industry, health equity, Indigenous health, and other relevant experts. Other relevant senior government officials should participate as liaisons. Supporting sub-groups and task forces should be formed as required.

d. Embed this advisory system in overall government emergency protocols; establish strong links with other domestic health advisory bodies, federal-provincial-territorial health and emergency networks, and international emergency advisory systems; and invite provincial/territorial governments and Indigenous partners to name liaisons.

e. Expand this advisory system over time to cover all emergencies, not just health emergencies.

Recommendation 4: Improve external communication of advice from federal advisory bodies

a. Stipulate in terms of reference that during an emergency, advisory bodies should publicly release evidence and advice briefs in a timeframe commensurate with the urgency of the situation, typically within days of their provision to government unless there are extenuating circumstances.

b. Develop corresponding internal emergency communications protocols that accelerate and streamline release processes to achieve releases in this timeframe.

c. Include provisions to protect sensitive and confidential information, and require that the level of uncertainty of evidence and advice is clearly communicated in all outputs.

Recommendation 5: Improve national guidance for the use of diagnostics, non-pharmaceutical interventions, and therapeutics in response to an emergency

a. Put in place sufficient emergency capacity and protocols to develop and release timely clinical and community guidance in these areas as reliable evidence emerges, in a similar fashion to the National Advisory Committee on Immunization's role on vaccines.[i]

[i] However, as noted, NACI did not have sufficient surge capacity during the COVID-19 pandemic.

Figure 1: Proposed inter-emergency standing advisory bodies, and "sleeping" emergency advisory group for health emergencies

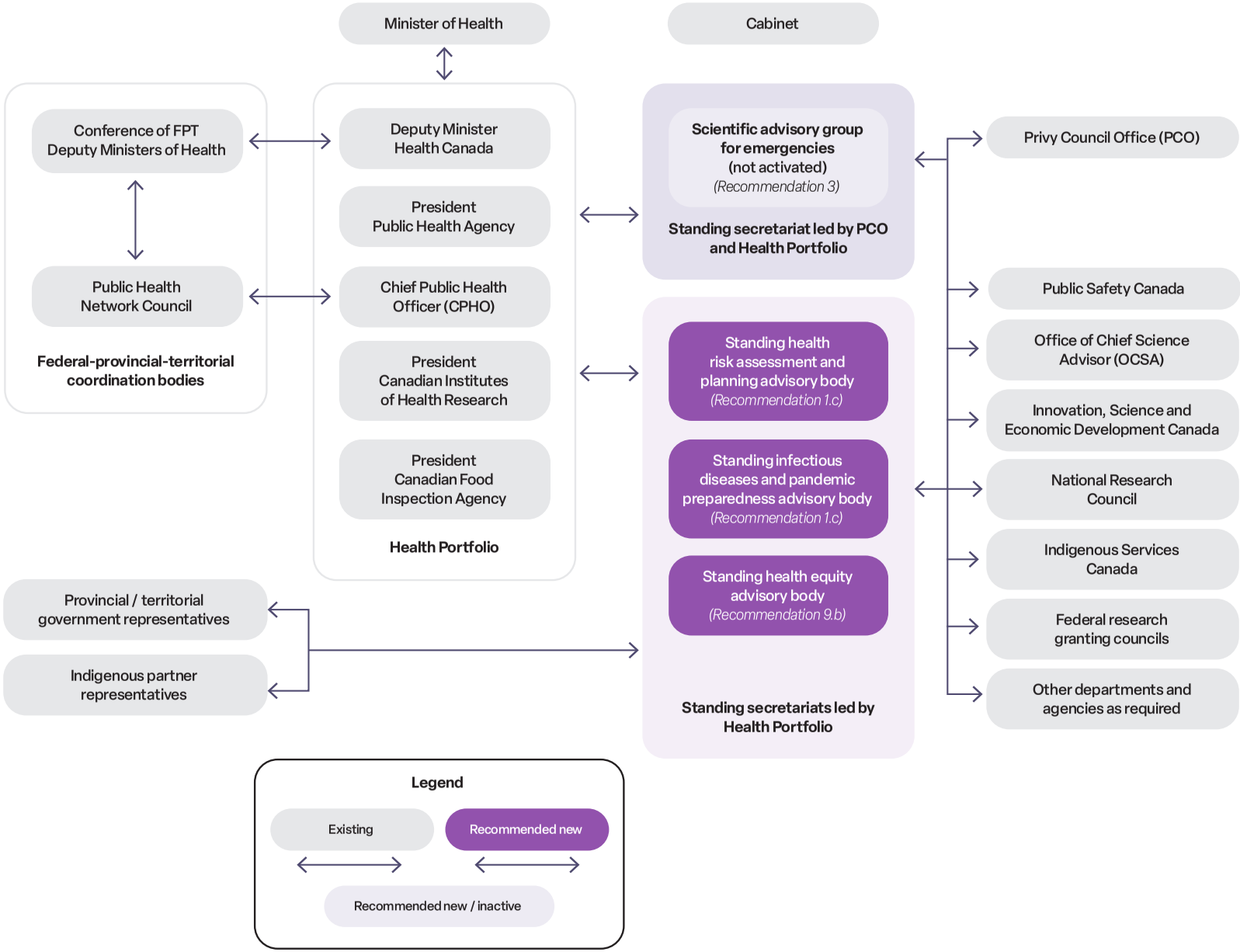
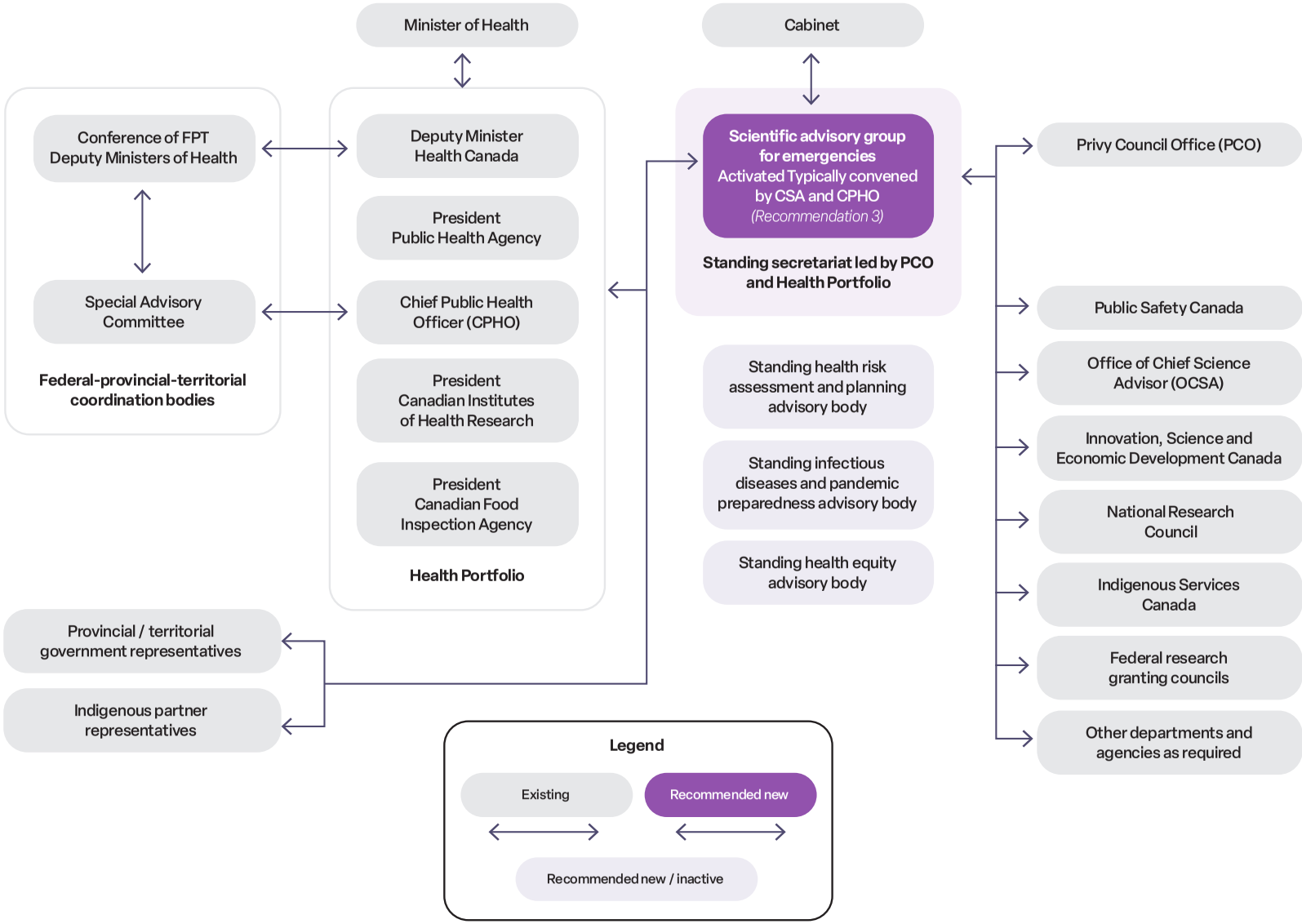


Figure 2: Proposed central scientific advisory group for emergencies activated in response to a health emergency to provide advice directly to Cabinet



Health Research Prioritization, Funding, and Coordination

In response to the COVID-19 pandemic, the federal government quickly mobilized to make additional research funding available through rapid response funding competitions starting in February 2020. However, the panel heard that research was not sufficiently directed and coordinated to address the most important and urgent knowledge gaps, including how the pandemic was manifesting across Canada; modes of transmission; appropriate use of non-pharmaceutical interventions; development of rapid diagnostic tools, therapeutics, and vaccines; and understanding and addressing issues of misinformation, disinformation, and vaccine hesitancy. Concerns included the lack of a central voice for research prioritization across the federal government; the need for better coordination among federal, provincial, and territorial governments, including their funding agencies; and the limited ability of the granting councils to coordinate research efforts at a national scale or insist on enhanced sharing of suitably anonymized data.

Expert panels dating back to 1993 have called for a national research agenda for emerging and resurgent infectious diseases. The National Advisory Committee on SARS and Public Health reflected on research coordination issues during the 2002–03 SARS outbreak and recommended that the federal government establish mechanisms with provincial/territorial health agencies to set research priorities for emerging infectious diseases, and clear protocols for the management of future epidemic research responses.[8] Despite previous warnings, processes in place when COVID-19 emerged in 2020 were unable to quickly identify key research priorities, effectively communicate these to all relevant groups, and direct funding accordingly and promptly. No federal body was able to set out a clear overall research agenda for many months to support the varying needs of public health practitioners, health care providers, industry, and policy makers.

In response, and in a similar fashion to the establishment of the many ad hoc scientific advisory bodies, the federal government facilitated and supported a broad range of new research coordination, knowledge synthesis, and modelling networks. The panel heard that many of these efforts played important roles during the pandemic. However, their funding and implementation took time (see Appendices A, B, and C for a full inventory of bodies and timelines) and researchers struggled to overcome administrative challenges to starting their work expeditiously, including accessing facilities and obtaining the ethics approvals and data sharing agreements required to access biological samples and data. In contrast, pre-existing bodies and networks with federal funding, such as Genome Canada[27] and the Canadian Immunization Research Network,[28] were able to leverage established expertise, relationships, and agreements, and immediately pivot to pandemic priorities. This demonstrated the importance of maintaining capacity in inter-emergency periods, rather than attempting to establish new mechanisms during an emergency.

In January 2022, the federal government created the Centre for Research on Pandemic Preparedness and Health Emergencies within the Canadian Institutes of Health Research,[29] with a mission to grow Canada's capacity to research and mobilize knowledge to prevent, prepare for, respond to, and recover from existing and future pandemics and public health emergencies. However, the panel heard repeatedly that a more robust interdepartmental and intergovernmental undertaking is required to achieve this critical mission.

The research needs of public health practitioners, health care providers, industry, and policy makers in pandemics extend far beyond infectious diseases. They encompass other areas of medical research, including consideration of the mental health and other health consequences; social and behavioural considerations; operational research related to the maintenance of critical national infrastructure; economics; education; and more. Answering many of the questions about these wider consequences requires a transdisciplinary approach. Researchers noted that federal granting council eligibility requirements, including finely delineated subject-matter boundaries between councils,[30] were not fit for purpose during an emergency. In addition, funding restrictions for researchers affiliated with government agencies presented barriers to collaboration between academia and intramural scientists. The 2023 Advisory Panel on the Federal Research Support System[31] and others[32] have provided related observations and recommendations on Canada's research funding processes.

There were also major gaps in the research response to COVID-19. More work needed to be done to determine vaccine efficacy in different population demographics across Canada, which should have been possible using routinely collected clinical data. While the federally funded COVID-19 Immunity Task Force did seroprevalence studies[33,34,35,36] and Canada had some major randomized control trials[37,38] and vaccine effectiveness studies,[39,40,41,42] the federated health system and a lack of coordination and timeliness hampered the effectiveness and impact of this important work. There is a need for continued investment in Canada's clinical trial infrastructure, including streamlining research ethics approval and data and specimen sharing processes for anticipated areas of research, and for the establishment of emergency processes for working with industry. In response to the pandemic, the federal government has invested heavily in medical countermeasure research and development and clinical trial infrastructure via its Biomanufacturing and Life Sciences Strategy.[43] Investments under this strategy should be systematically informed by the panel's proposed new health risk register to maximize the likelihood that they will most effectively prepare Canada for future health emergencies.

To achieve more equitable health outcomes, greater focus and investment is needed to support transdisciplinary research to identify the best ways to implement public health and other interventions to tackle well-documented inequalities. The panel heard that additional research is required before the next health emergency to examine the effectiveness of interventions aimed at reducing the disproportionate risk posed to certain populations such as those experiencing homelessness. The panel also heard that federal research grant funding processes do not adequately value Indigenous knowledge and processes and are not compatible with the realities of Indigenous communities including those in northern Canada. Overall, better prioritization and coordination of research will increase the efficiency of government funding and improve health outcomes for Canadians.

While optimization of research coordination structures will pay significant dividends, Canada needs to substantially increase its overall investment in scientific research and support of trainees (an area where it objectively lags behind peer nations)[44] to ensure that the necessary expertise exists and to fully realize the benefits of these changes for Canadians. Over the last 20 years, Canada's public investment in research and development as a percentage of gross domestic spending has steadily declined; it currently sits at 1.55%, compared with the G7 and OECD averages of 2.6% and 2.7%, respectively.[44] Without an adequate foundation of expertise, Canada cannot effectively prepare for and respond to future health and other emergencies. While these issues are outside the remit of this panel, they have been addressed by other expert panels including the Advisory Panel on the Federal Research Support System. Its report emphasized that a modern research enterprise must be equipped to respond to the needs of government in order to provide benefits to Canadians, and increased funding for research and talent must be a top priority to make the Canadian system globally competitive.[31]

Recommendation 6: Improve pan-Canadian coordination of health emergency-related research

a. Establish a central interdepartmental mechanism within the federal government to work with other levels of government, academia, industry, First Nations, Inuit, and Métis health experts, and international partners to identify research priorities relating to the preparation for, and response to, health emergencies, and coordinate with provincial health research funders. This mechanism should be led by the Health Portfolio in collaboration with federal research granting councils and other departments and agencies.

b. Use the proposed new national health risk register and response plan, including the standing health risk assessment and planning advisory body (in recommendation 1), to inform this research prioritization during periods of stability. In response to an emergency, the activated special scientific advisory group for that emergency (as per recommendation 3) should take the lead advisory role in supporting the prioritization of new research questions as these arise in real time.

c. Establish a mechanism (linked to the above) for the prioritization of medical countermeasure research and development, working closely with industry and other relevant groups, informed by supply chain intelligence and coordinated with international allies.

Recommendation 7: Enhance the readiness of research and clinical trial networks and infrastructure

a. Create and maintain domestic and international research networks during inter-emergency periods. Some of these networks can be maintained in the form of "sleeping protocols", capable of rapid activation in the event of an emergency, while others should operate continuously and be used to address ongoing health priorities. These networks should put in place, as much as possible, the required inter-organizational agreements and ethical and other approvals, considering what may be required in response to potential future health emergencies including those identified in the proposed national health risk register (in recommendation 1).

b. Ensure that critical intramural and external health research infrastructure and human capacity are available and can operate during the next health emergency through sufficient and sustained funding. This should include creating an inventory of relevant assets, establishing protocols for the operation of federal facilities during an emergency, and publishing guidance for external labs.

c. Continue to increase the speed, scale, and inclusiveness of clinical trial infrastructure and processes by ensuring sufficient funding for the human capacity and necessary infrastructure required across the country.

Recommendation 8: Strengthen the emergency preparedness of the federal research granting councils

a. Put in place processes and protocols so that granting councils operate collectively in an emergency, with rapid decision making, streamlined review processes, and processes to facilitate collaboration on projects that are of sufficient scale to address national priorities. Funding conditions should include the timely completion of new inter-institutional agreements between collaborating research institutions as required, and the timely release of research data and results where appropriate.

b. Facilitate interdisciplinary research by removing subject-matter boundaries currently specified in very fine detail between the granting councils, and through capacity building where necessary.

c. Remove barriers to intramural and extramural research collaboration including federal funding eligibility restrictions for provincial and territorial intramural researchers. Operating funding envelopes for federal intramural researchers collaborating with recipients of grants and contributions should also be put in place.

Recommendation 9: Increase investments in research on actions required to better support and prioritize the needs of groups disproportionately impacted by health emergencies

a. Provide sufficient funding for research on the implementation of public health, government policy, and other interventions to mitigate inequities and address the underlying health needs of priority groups, including those in poverty or experiencing homelessness, Black and other racialized communities, and residents and employees of long-term care facilities. This research should be developed and conducted in concert with affected communities.

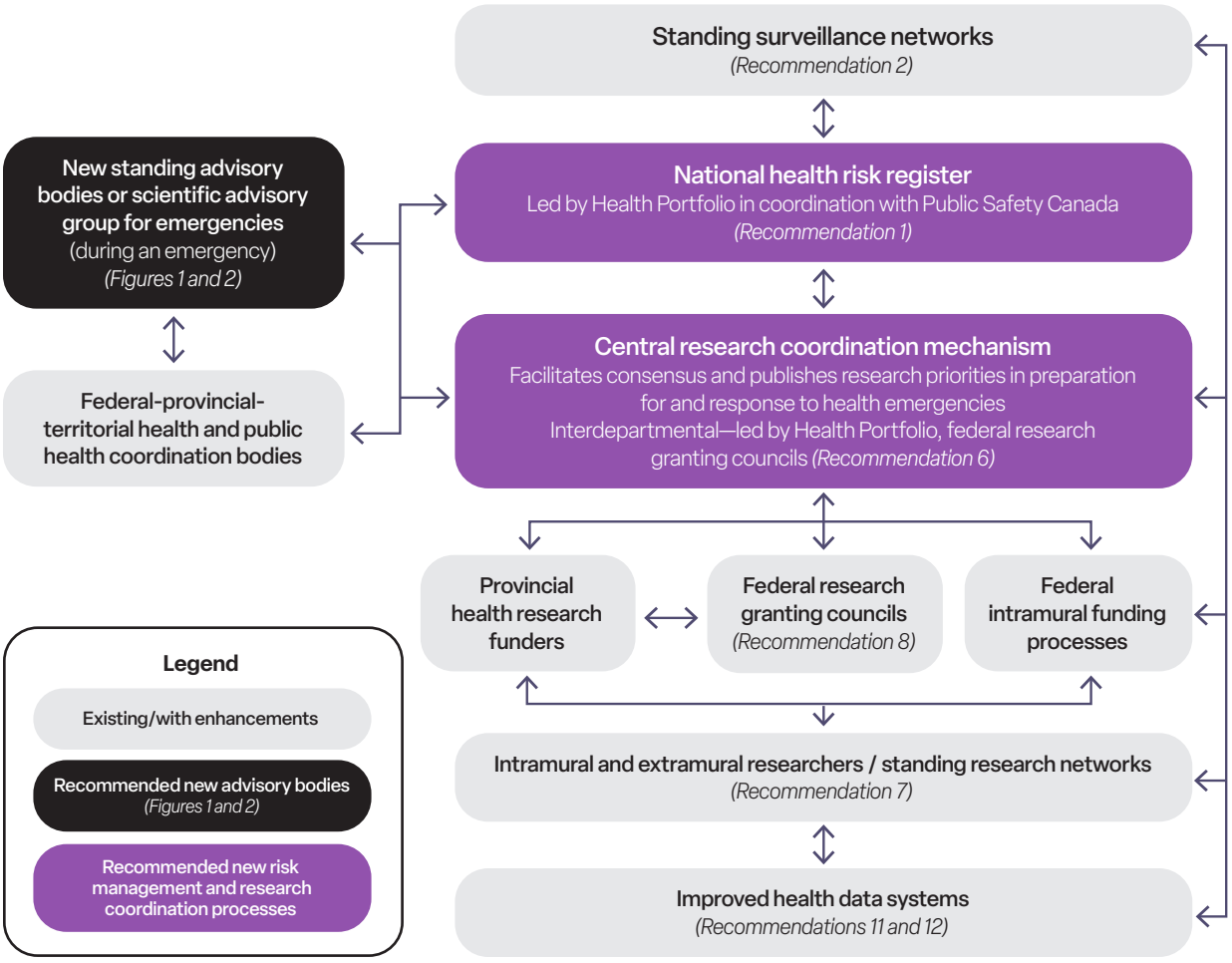
b. Establish a standing science advisory body of independent experts on health equity, supported by a secretariat within the Health Portfolio, to inform government policies and public health measures in this area.

Recommendation 10: Increase investments to advance research on actions required to improve Indigenous health outcomes

a. Co-develop health priorities with First Nations, Inuit, and Métis health experts and communities and provide sufficient funding for research on actions to address these priorities. This should include increased investments to advance Indigenous-led research and training in areas including epidemiology.

b. Cultivate and invest in the development of expertise in the coordination and funding of Indigenous health research, in and among federal departments and agencies.

Figure 3: Proposed central research coordination mechanism in relation to proposed national health risk register and advisory bodies



Health Data Availability and Use

Many previous reports have outlined the deficiencies in the Canadian health data system and the harms that Canadians are experiencing from an inability to properly collect, share, and use health data.[5,8,45,46,47] The panel consistently heard about challenges in collecting and accessing both public health and health care data, which are essential for important research, scientific advice, and health delivery. The timely collection of key data, and the sharing of these data between health care systems, levels of government, and research institutions, was a key barrier to a well-coordinated and consistent national response to the pandemic. While these issues remain unsolved, all Canadians are vulnerable. The most disadvantaged will remain the most vulnerable to the worst health outcomes; health research and policy advice will be hampered; and Canadian scientific innovation will not reach its full potential.

The most effective health data systems globally operate as data stewards, providing appropriate real-time access to clinicians, researchers, public health officials, and public servants. They protect the privacy of individual citizens as an integral part of promoting public health research. In these systems, research is seen as an intrinsic part of care. Canada is currently operating a health data custodianship model, primarily concerned with data security and privacy.[47] Its fragmented data system means that it is less equipped to make evidence-informed decisions, including during a health emergency.[47]

Provincial/territorial health data systems vary greatly in their ability to collect data and make them available. During the COVID-19 pandemic, some provinces made detailed anonymized health data available to researchers and advisory bodies, enabling critically important insights. These successes demonstrate that essential data are available in some provinces and can be responsibly accessed by researchers. They also raise further questions as to why real-time, disaggregated data cannot be leveraged inter-emergency to better support the provision of health services and prepare for and mitigate the effects of future health emergencies. The panel heard that some jurisdictions had to collect basic data manually, leading to delays and inconsistency in reporting. One of the most important predictors of infection exposure and outcomes—basic sociodemographic data at the individual level including information on race and ethnicity—was largely absent in almost all jurisdictions.

Some provincial governments are currently winding down the vaccine registries they created during the pandemic despite their potential to capture accurate and precise information on the distribution, uptake, and effectiveness of vaccines. There are compelling reasons for this type of routine data collection. The United Kingdom has recently published work, using routine information collected from approximately 59 million people, to examine the effectiveness of different numbers of vaccine doses in relation to the risk of hospitalization for severe clinical manifestations of COVID-19.[48] The results showed that even missing one recommended vaccine dose was associated with a substantially increased risk of severe infection requiring hospital admission.

In recent years, the federal government has worked with provinces and territories to receive advice from an Expert Advisory Group.[49] As a condition of their federal funding provided through the 2023 *Working Together to Improve Health Care for Canadians Plan,*[50] provinces and territories have committed to work with the federal government and other partners to improve the collection, sharing, use, and reporting of health information. Health data priorities are being implemented through a *Joint Federal-Provincial-Territorial Action Plan on Digital Health and Health Data*[51] and a *Pan-Canadian Health Data Charter*.[52] The federal government has also provided funding to the Canadian Institute for Health Information, Canada Health Infoway, and Statistics Canada to support this health data agenda. However, many individuals expressed skepticism to the panel that these measures would be sufficient in the absence of strong and sustained federal, provincial/territorial, and Indigenous political leadership and support.

Given the substantial challenges to data sharing, close monitoring of the impact of these investments on improving the scope, scale, interoperability, and responsiveness of the health data structure, as well as accountability for expected outcomes, is critical.

The federal government must continue to take a leadership role and place an even higher priority on these efforts. For the efforts to effectively support health emergency preparedness and response, Canada needs to be able to generate, and make available to researchers, real-time health and related data from across the country, including sociodemographic and race-based data, de-identified in such a way as to protect individual privacy. This will enable characterization at a national scale of the incidence and prevalence of infection, hospitalizations, deaths, therapeutic interventions, vaccination data and possible adverse effects, and other critical issues at all times. Efforts to do so will provide benefits in crisis periods and in periods of stability, further improving health outcomes and addressing inequalities. Ultimately, sustained political leadership across federal and provincial/territorial governments is essential to overcome the barriers to the collection and use of data that have great potential to provide health benefits to all Canadians.

A critical piece of transforming Canada's health data systems is the co-development of culturally relevant, distinction-based health data systems for First Nations, Inuit, and Métis peoples. An Expert Advisory Group[49] on health data stressed that jurisdictions must demonstrate support for First Nations, Inuit, and Métis data sovereignty across geographies. It also highlighted the importance of meaningful Indigenous participation and representation on senior health data committees and governance tables to ensure support for, and alignment with, First Nations, Inuit, and Métis data principles and strategies.[45] The recently endorsed *Pan-Canadian Health Data Charter* also commits to support and respect First Nations, Inuit, and Métis data sovereignty and Indigenous-led health data governance frameworks.[52] The federal government must continue efforts to meaningfully engage with Indigenous Peoples to support their respective health data strategies and advance shared digital health and health data priorities.

Recommendation 11: Resolve the longstanding issue of the non-availability and fragmentation of essential public health and clinical data

a. Accelerate dedicated efforts with the provinces and territories to establish data standards, interoperable data systems and data sets, and provide access to data that are essential for assessing and managing public health between and during emergencies, reducing the health disparities between sociodemographic groups, and enabling the conduct of innovative and important research. This should include the systematic collection and availability of de-identified routinely collected health data, including vaccination data, across the country.

b. Provide sufficient resources to the Public Health Agency of Canada, the Canadian Food Inspection Agency, other relevant departments and agencies, and federally funded health data research networks to build and maintain interoperable data systems and data sets and make these available to provinces and territories, Indigenous health authorities, and researchers.

Recommendation 12: Continue efforts to meaningfully engage with Indigenous Peoples and their communities to support their respective health data strategies and advance shared digital health and health data priorities

a. Support and collaborate with First Nations, Inuit, and Métis communities and authorities across the country to bring their health data systems in line with the most robust systems in Canada, while preserving Indigenous data sovereignty and ensuring data integration and interoperability with provincial/territorial and federal systems, further to the commitment in the *Pan-Canadian Health Data Charter*.

Broader Recommendations

The panel proposes two additional recommendations that relate to its key findings but are broader than the scope of its remit.

Unlike the role of the Chief Public Health Officer, the position of the Chief Science Advisor of Canada is not enshrined in legislation and its mandate does not have a formal role in the event of an emergency. In an increasingly complex and interconnected world, scientific information is critical to inform government decision making during and between emergencies. To support science advisory processes at all times, it is imperative that the role of the Chief Science Advisor be clarified and set in legislation.

Broader recommendation A: Pursue legislation to formalize the role of the Chief Science Advisor of Canada. This should include defining the role in preparation for and response to health and other emergencies.

The panel's consultations pointed to insufficient Indigenous health expertise within the Health Portfolio. Discussions also highlighted that efforts to seek this expertise through contractual and advisory roles were inadequate to properly factor health considerations for Indigenous populations into health research prioritization and other processes during the pandemic. A plan to recruit this expertise is needed, and this should include creating a new dedicated senior role in the Public Health Agency of Canada.

Broader recommendation B: Create a new Deputy Chief Public Health Officer position that is fully dedicated to Indigenous health. This role should be held by an Indigenous person and have the mandate to ensure that First Nations, Inuit, and Métis health issues are integrated into the priorities and processes of the Public Health Agency of Canada. It should interface with other areas of the Health Portfolio, Indigenous Services Canada, and other departments and agencies as required.

Addendum

The work of the Expert Panel was completed prior to the release of the 2024 federal budget, which included commitments relating to research funding and coordination in general. The panel has not assessed these commitments but notes that the implementation of the envisioned measures will benefit from the findings and recommendations of this report.

Conclusion

To be prepared for the next health emergency, and improve overall health outcomes for Canadians, there is an urgent need for the federal government to act now to build on previous efforts and make significant improvements to the approach to science advice and research coordination. The panel's recommendations centre around the need for a more sophisticated national risk assessment and preparedness planning process; a more robust science advisory system that is ready to immediately activate in response to an emergency; ongoing research infrastructure that is ready to mobilize; centralized leadership to facilitate the prioritization and coordination of major public research investments; and improved health data systems.

The panel considers its recommendations to be cost effective, especially when compared with the consequences of inadequate preparedness. The actions will also improve the effectiveness and efficiency of a broad range of government investments. To achieve success, these efforts require enhanced interdepartmental and international coordination, and, given the federated nature of Canadian health systems, actions by and collaboration with provincial and territorial governments. Success also requires increases to ongoing public investment in health research. Previous expert panels, dating back at least 30 years, have called repeatedly for action in these areas. The government must take action now to comprehensively address these shortcomings and to prevent or mitigate, as far as possible, the potentially disastrous health, social, and economic consequences of a future health emergency.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH – STAFF REPORT

TITLE:	**Provincial Immunization Registry for Ontario**
DATE:	**November 13, 2024**
PREPARED BY:	**Director, Health Protection Programs and Chief Nursing Officer** **Patti Fitzgerald, Manager, Manager, Sexual Health & Immunization Programs**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health:

- receive the staff report, Provincial Immunization Registry for Ontario, for information;
- send correspondence to the Ministry of Health indicating its support for the Ontario Immunization Advisory Committee's recommendation to establish an Immunization Registry for all residents of Ontario; and
- copy local Members of Provincial Parliament (MPPs), Peterborough Ontario Health Team, Peterborough Family Health Team, Peterborough Regional Health Centre, the Association of Local Public Health Agencies and Ontario Boards of Health.

FINANCIAL IMPLICATIONS AND IMPACT

There are no financial implications arising from this report.

DECISION HISTORY

On February 20, 2020 the Board of Health for Peterborough Public Health passed a motion to: receive correspondence from the City of Hamilton Board of Health, dated October 30, 2019, and correspondence from the Council of Ontario Medical Officers of Health (COMOH), dated March 19, 2019, for information; and, support their positions related to a provincial immunization registry and communicate this support to the Ontario Minister of Health, with copies to the Ontario Chief Medical Officer of Health, local MPPs, Opposition Health Critics, COMOH, the Association of Local Public Health Agencies (alPHa) and Ontario Boards of Health.

BACKGROUND

Immunizations registries are centralized electronic systems that hold immunization information of residents. They facilitate "timely, accurate recording of all relevant immunization information, regardless of where and by whom vaccines are administered.[1]" Currently, the immunization records for residents of Ontario may be stored at a wide variety of locations including physician offices, clinics, public health agencies, and pharmacies, to name a few.

In September, 2024, the Ontario Immunization Advisory Committee (OIAC) released a position statement strongly urging that Ontario Ministry of Health develop a provincial immunization registry. The OIAC recommends that such a registry include vaccination records for all residents and ensure real-time access to everyone, including their health care providers. The OIAC position statement also outlines seven recommendations on what is needed for Ontario to implement an immunization registry[2] that meets the "need of diverse populations and ensure timely and equitable access to individual immunization records."[3]

RATIONALE

An Ontario-wide immunization registry would address many of the challenges with the current system. It would:

- eliminate the need for parents to report vaccinations to local public health agencies;
- reduce the risk of inaccurate information being reported;
- help identify individuals who are overdue on their immunizations;
- prevent duplication of immunizations;
- reduce resources needed to enter data;
- lower school suspension rates; and
- enable evaluation of immunization programs.

An immunization registry would also assist in the investigation of outbreaks of vaccine preventable diseases since susceptible and vulnerable individuals could be identified more quickly.

STRATEGIC DIRECTION

This report applies to the following strategic direction: *Our System: Stronger health system through relationships with primary care and health system partners.*

REFERENCES:

[1] Immunization records: Canadian Immunization Guide - Canada.ca
[2] OIAC Position Statement: A Provincial Immunization Registry for Ontario (publichealthontario.ca)
[3] Ibid.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Indigenous Health Advisory Circle Report**
DATE:	**November 13, 2024**
PREPARED BY:	**Alida Gorizzan, Executive Assistant, on behalf of Liz Stone, Committee Chair**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive meeting minutes of the Indigenous Health Advisory Circle (IHAC) from August 23, 2024 for information.

BACKGROUND

IHAC met last on October 25, 2024 and requested that this item come forward to the Board of Health.

ATTACHMENTS

a. Minutes, August 23, 2024

Indigenous Health Advisory Circle
MINUTES
Friday, August 23, 2024 – 2:30 – 4:00 p.m.
Board Room, 3rd Floor, PPH, 185 King Street

Present: Councillor Dave Haacke (virtual)
Paul Johnston
Councillor Joy Lachica
Professor David Newhouse
Ashley Safar
Elizabeth Stone, Chair)
Rebecca Watts (virtual)
Councillor Kathryn Wilson

Regrets: Kristy Kennedy
Councillor Nodin Knott

Staff: Hallie Atter, Director, Health Promotion Division
Alida Gorizzan, Executive Assistant, Recorder
Dr. Thomas Piggott, Medical Officer of Health & CEO
Samantha Roan, Manager, Indigenous Health

Guests: Dr. Natalie Bocking, Medical Officer of Health & CEO, Haliburton, Kawartha Pine Ridge District Health Unit
Elisha Rubacha, Community Impact Officer, United Way Peterborough & District
Betsy Farrar, Director of Community Impact, United Way Peterborough & District

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1. Call to Order and Welcome

Liz Stone, Circle Chair, called the meeting to order at 2:30 p.m.

2. Introduction – Samantha Roan, Manager, Indigenous Health

Samantha Roan was introduced as the new Manager for Indigenous Health at Peterborough Public Health, her first day was August 19th.

Samantha shared that she comes from Big Grassy River First Nation, part of the Grand Council Treaty #3 Territory. Her education background includes an undergraduate degree in Native Studies and a Master of Public Health, she is currently working on her PhD in Indigenous Studies.

Circle Members welcomed Samantha to the meeting, and to Peterborough Public Health.

3. Confirmation of the Agenda

The agenda was confirmed as circulated.

4. Minutes of the Previous Meeting

4.1. June 3, 2024

The minutes from June 4, 2024 were approved as circulated. **ACTION: The minutes will be circulated to the Board of Health at their next meeting.**

5. Items Arising From the Minutes *(nil)*

6. New Business

6.1. Consultation – United Way Anti-Poverty Consultation

- Guests Elisha Rubacha and Betsy Farrar from the United Way joined for this item.
- *Question - How does the IHAC envision our community working collaboratively to end poverty (i.e., what has worked):*
    - Professor Newhouse noted a presentation based on work by the Poverty Action Research Project from the Make Poverty History project with the Assembly of First Nations which he participated in (March 2018). While the focus was on First Nations on reserve communities, he shared that it was clear that poverty was seen as multi-dimensional and that material deprivation, albeit important, was only seen as one aspect of poverty. Professor Newhouse circulated the slide deck to Circle Members.
    - He noted that it would be important to bring together a multi-faceted group with a wide variety of experiences (e.g., First Nations, Urban Indigenous, Métis Nation of Ontario, Women's Groups, public/private sector, non-governmental organizations, post-secondary institutions). It would be ideal to have a public meeting followed by smaller working groups.
    - Liz Stone added that rather than have a specific Indigenous group, it would be important to involve Indigenous people in other groups so their voices and experiences can be shared within these diverse groups.
    - Katie suggested the inclusion of Dnaagdawenmag Binnoojiiyag Child & Family Services. Other groups to consider would be artistic groups, environmental, local service clubs (Lions/Kiwanis), newcomers groups.

- *Question – Is there a particular issue that should be worked on collectively?*
    - Ensure any response is culturally responsive (at all levels, services, projects, programs and people) and look to amplify the voices of those with lived experience.
    - Increase supply of affordable housing.
    - Consider the needs of rural communities, how they access services and how the United Way is reaching them.
- *Question – How can we as a community strategically advocate for upstream change:*
    - Write/communicate to local politicians, and look to tap into political agendas (e.g., the Mayoral Task Force on Poverty in 2008 was a significant driver at the time).
    - Invite people that are doing front line work, but also engage business leaders and post-secondary institutions; advocate for time on agendas during important local events (e.g., Ignite at Fleming College).
    - Members noted that the United Way plays an important leadership and coordination role in these efforts.
- *Question: What capacity is there to attend an anti-poverty or income security table?*
    - It was noted that there may be other mechanisms to consider, for example, perhaps a community meeting or other options to have more voices, and additional opportunities for engagement and input.
    - Members noted the importance of decolonizing the process:
        - consider community meetings vs. a task force;
        - look at the structures and processes that are used in order to talk about societal issues; and,
        - include Indigenous Peoples in a meaningful way.
- Elisha's contact information was shared with Circle Members for additional feedback/follow up.

6.2. <u>Merger Update</u>

- Dr. Piggott shared that there had been no further news since the last IHAC meeting on this front, however, a consultant has been engaged to coordinate the development of new a vision and branding for the merged organization. It is expected that a consultation with IHAC will occur as part of this work.

6.3. <u>Fall Vaccination Update</u>

- Dr. Piggott provide an update on vaccine guidance which was just recently issued by the Ministry.
- With respect to RSV vaccine, he shared details regarding eligibility which is

targeted for high-risk individuals and settings.
- Communications (social media, etc.) is planned for both RSV and influenza, and Indigenous-specific clinics are in development - one confirmed with the Nogojiwanong Friendship Centre (NFC).

6.4. IHAC Work Plan

- The remaining elements of the 2024 work plan were reviewed.
- Professor Newhouse requested a future discussion on access to primary care physicians, when appropriate (currently being discussed by the NFC).

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

Friday, October 25, 2024 – 2:30 – 4pm, PPH

8. Adjournment

The meeting was adjourned at 4:10 p.m.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Stewardship Committee Report**
DATE:	**November 13, 2024**
PREPARED BY:	**Alida Gorizzan, Executive Assistant, on behalf of Mayor Matthew Graham, Committee Chair**
APPROVED BY:	**Dr. Thomas Piggott, Medical Officer of Health & CEO**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive meeting minutes of the Stewardship Committee from October 4, 2024 for information.

BACKGROUND

Stewardship met last on October 22, 2024 and requested that this item come forward to the Board of Health.

ATTACHMENTS

a. Minutes, October 4, 2024

Board of Health for
Peterborough Public Health
MINUTES
Stewardship Committee Meeting
Friday, October 4, 2024 – 3:00 – 4:30 p.m.
Dr. J.K. Edwards Board Room, 3rd Floor, PPH

Present:	Mayor Matthew Graham, Chair Councillor Joy Lachica Councillor Keith Riel Dr. Hans Stelzer
Regrets:	Councillor Kathryn Wilson
Staff:	Alida Gorizzan, Executive Assistant, Recorder Dr. Thomas Piggott, Medical Officer of Health & CEO Dale Bolton, Manager, Finance and Property Mr. Larry Stinson, Director of Operations

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1. Call to Order & Land Acknowledgement

Mayor Graham, Committee Chair, called the meeting to order at 3:01 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved.
Moved: Councillor Lachica
Seconded: Dr. Stelzer
Motion carried. (M-2024-007-SC)

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately *(nil)*

5. Delegations and Presentations *(nil)*

6. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the minutes of the meeting of June 4, 2024 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Dr. Stelzer
Seconded: Councillor Lachica
Motion carried. (M-2024-008-SC)

7. Business Arising From the Minutes *(nil)*

8. Staff Report *(nil)*

9. Consent Items *(nil)*

10. New Business *(nil)*

11. In Camera to Discuss Confidential Matters

MOTION:
That the Stewardship Committee go In Camera at 3:04 p.m. to discuss one item under the Municipal Act, 2001, Section 239 (2) (d) Labour relations or employee negotiations.
Moved: Dr. Stelzer
Seconded: Councillor Riel
Motion carried (M-2024-009-SC)

MOTION:
That the Stewardship Committee rise from the In Camera session at 4:33 p.m.
Moved: Counsellor Riel
Seconded: Councillor Lachica
Motion carried. (M-2024-010-SC)

12. Motions for Open Session

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

Tuesday, October 22, 2024 – 2:30 p.m.
Virtual

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Dr. Stelzer
Seconded: Mayor Graham
Motion carried. (M-2024-011-SC)

The meeting was adjourned at 4:33 p.m.

Chairperson

Medical Officer of Health