Meeting of the Northern Health Authority
Board of Directors
Public Session

Fort Nelson, British Columbia

Woodlands Inn & Suites – Aspen Meeting Room

Monday, June 9, 2014

northern health

the northern way of caring

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Public Session

AGENDA

June 9, 2014
Aspen Room, Fort Nelson BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Open Board Session	Chairman Jago		**1:15pm**	
2. Opening Remarks	Chairman Jago			
3. Conflict of Interest Declaration	Chairman Jago			
4. Approval of Agenda	Chairman Jago	Motion		**1**
5. Approval of Previous Minutes: April 14, 2014	Chairman Jago	Motion		**3**
6. Business Arising from Previous Minutes	Chairman Jago			
7. CEO Report	C Ulrich	Information		**9**
7.1 Human Resources Report	J Lindstrom	Information		**13**
8. Audit & Finance Committee				
8.1 Public Comments Fiscal Y/E 2013/14	M De Croos	Information		**21**
8.2 Major Capital Projects Summary & Dashboards	M De Croos	Information		**22**
9. Performance, Planning & Priorities Committee				
9.1 Programs				
9.1.1. Chronic Disease	R Chapman	Information		**24**
9.2 Emergency Preparedness	M Leisinger	Information		**28**
10. Care in the Right Place - Presentation	B Morris	Information		
• **Presenter:** Chris Morey, Health Service Administrator				
11. Governance & Management Relations Committee				
11.1 Policy Manual BRD 200 Series	C Leclerc	Motion		**32**
11.2 2015 Board Meeting Calendar	M Leisinger	Motion		**74**
11.3 Regulatory Framework: Emergency Health Services Act	M Leisinger	Information		**76**
Adjourned			**3:00pm**	

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Public Motions

Meeting Date:
June 9, 2014

Agenda Item		Motion	Approved	Not Approved
3.	Conflict of Interest Declaration	Does any Director present have a conflict of interest they wish to declare regarding any business before the Northern Health Board at this meeting?	☐	☐
4.	Approval of Agenda	The Northern Health Board approves the public agenda as presented	☐	☐
5.	Approval of Minutes	The Northern Health Board approves the April 14, 2014 public minutes as presented	☐	☐
11.1	Policy Manual BRD 200 Series	The Northern Health Board approves the revised BRD 200 Series	☐	☐
11.2	2015 Board Meeting Calendar	The Northern Health Board approves the revised 2015 Board Calendar.	☐	☐
			☐	☐

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Board Meeting

Date: April 14, 2014

Location: Brunswick Board Room

Chair:	Dr. Charles Jago	**Recorder:** Desa Chipman
Board:	• Sharon Hartwell • Gary Townsend • Carol Leclerc • Ben Sander	• Edward Stanford • Rosemary Landry • Maurice Squires • Louise Burgart
Regrets	• Gaurav Parmar	
Executive:	• Cathy Ulrich • Michael Leisinger • Fraser Bell • Mark De Croos	• Jane Lindstrom • Dr. Ronald Chapman • Penny Anguish • Steve Raper

Public Minutes

1. Call to Order Public Session

Chairman Jago called the meeting to order at 1:17pm.

2. Opening Remarks

C Jago welcomed the public to the board meeting and acknowledged that it was a pleasure to be visiting Kitimat.

3. Conflict of Interest Declaration

Chairman Jago asked if any Director present had a conflict of interest they wish to declare regarding any business before the Northern Health Board at this meeting.

- There were no conflict of interest declarations made related to the April 13, 2014 Board Only agenda.

4. Approval of Agenda

Moved by S Hartwell seconded by R Landry
The Northern Health Board approves the April 14, 2014 public agenda as presented.

5. Approval of Board Minutes

Moved by G Townsend seconded by M Squires
The Northern Health Board approves the February 17, 2014 public minutes as presented

6. Business arising from previous minutes

There was no business to bring forward from the previous minutes.

7. CEO Report

C Ulrich provided an overview of the CEO report and highlighted the following:

- Quality Forum 2014: This is an annual conference that is organized by the BC Patient Safety and Quality Council. A Board and Executive Quality Forum was held on the first day of the conference and featured Robert Francis, QC, the chair of the Mid Staffordshire National Health Services Foundation Trust Public Inquiry. Several Northern Health staff attended the Quality Forum not only as participants but as presenters.
- Northern Health's Spring Leadership Forum was held in Prince George in March and brought together managers from across Northern Health. The theme was "Integrated Health Services: Moving Forward". Details from the conference were provided for information.
- Moving Forward: Building Culturally Safe Organizations. This conference was held on March 24-26, 2014 in Vancouver and was organized by the Provincial Health Services Authority. A team from Northern Health had the opportunity to present and engage in discussion on "Building Cultural Safety at all levels in Northern Health".
- Chairman Jago and Cathy Ulrich had the opportunity to attend the Kordyban Lodge – 1st Anniversary Celebration on March 27, 2014.
- Information on the Capital Projects that have been completed or are underway in the northwest was highlighted as follows:
  - The Kitimat Hospital and Health Centre celebrated the completion of the Emergency Department renovation project on Tuesday, March 18, 2014.
  - Queen Charlotte/Haida Gwaii Hospital and Health Centre replacement are proceeding on schedule
  - Mills Memorial electrical upgrade – planning complete with work beginning mid-April
  - Mills Memorial visiting specialist clinic – planning in progress
  - Mills Memorial concept planning – nearing completion
  - Atlin Health Centre concept planning - complete
- The Foundations and Hospital auxiliaries in the Kitimat and Terrace area have enabled Northern Health to improve the quality of the services we provide through several donations, including:
  - Kitimat Hospital Foundation provided $10,000 towards equipment for the emergency department and has committed $43,000 funding for a portable ultrasound system.
  - Max Lange Fund has committed $90,000 towards additional monitoring equipment for the Kitimat General Hospital emergency department.
  - Kitimat Hospital Auxiliary has funded ceiling lifts for resident rooms in Mountain View Lodge plus an additional two lifts for acute care patient rooms.
  - Over the last three years the REM Lee Foundation in Terrace has provided $57,000, $83,000 and $135,000 for a variety of equipment, including an ultrasound machine.
- Emergency preparedness and business continuity has had focused attention over this past year across the northwest. A list of planned activities was included in the report.
- Recently Northern Health managers and staff were saddened to learn that MaryAnne Arcand had passed away in Prince George, BC. Dr. David Bowering, past Chief Medical Health Officer provided the following comments in memory of MaryAnne.

MaryAnne was a true friend of Northern Health and a strong advocate for working in partnership and in community to build a healthier North. She was a key activator of at least two of our longest lasting and most successful collaboration: Health Eating and Active Living and RoadHealth.

It is safe to say that RoadHealth would not have happened without her vision and commitment and that it would have been a shadow of what it was without her enormous energy and passion to save lives...At one point in the RoadHealth project, MaryAnne oversaw the production of a video documentary showing the profound effect of road crashes on the people involved and their families.

In it she talks about her sister who died in a crash as a teenager. Her humanity and the strength of her commitment to preventing more unnecessary road deaths shines through the tears in her eyes as she talks about the life her sister missed. The video was called IMPACT. No one has had more of an impact than MaryAnne. She will be greatly missed by those of us who had the good fortune to work with her and to be her friends.

Thank you, MaryAnne, for your amazing legacy. None of us will ever forget you. We send our deepest condolences to the family. We truly share your loss, both as a health authority, and as citizens of Northern BC.

7.1. Human Resources Report

Jane Lindstrom, VP Human Resources provided an overview of the Human Resources Report as follows:

- Workplace Health & Safety initiatives
  - The Provincial Violence Prevention Committee was formed in 2006 and will be incorporated into an expanded committee with a mandate that includes all program aspects of occupational health and safety. Northern Health is increasing the availability and frequency of Violence Prevention Education as part of an increased attention on violence prevention and improving the management of this risk.
  - Implementation of the Employee Absence Reporting Line (EARL) continues and by the end of March 2014, 51% of Northern Health Employees will be using the Employee Absence Reporting Line to report all unplanned absences.
- Recruitment
  - Difficult-to-fill (DTF) vacancy numbers continue to decrease as two more of these vacancies have been filled since the last board report – the number of DTF has dropped from 47 to 45.
- Leadership Development
  - The second cohort of Core LINX based in Prince George graduated in February of this year with the Terrace based cohort due to graduate in May.
  - Planning for the next Experience LINX cohort due to begin in September 2014.
- Policy Development
  - The Healthy Workplace Policy development project is now nearing its conclusion with the integration of WorkSafe BC regulations, the clarification of definitions, and the streamlining of processes.
  - The Employee Service Recognition Policy is being reviewed to ensure clarity and consistency.

8. Audit and Finance Committee

8.1. Period 11 Public Financial Statement

M De Croos provided an overview of the Period 11 Financial Statements as follows:

- Year to date Period 11, revenues exceeded expenses by $5,697,000.
- Revenues are favourable to budget by $6.4 million or 1.0%. Expenses are unfavourable to budget by $0.7 million or 0.1%.
- Better than expected patient revenues are contributing to the favourable variance in revenues. The unfavourable variance in expenses is due to higher than expected patient activity in Acute and Residential Care.
- At this time, Northern Health is forecasting to be in a balanced position at yearend. The yearend forecast may be impacted by the actuarial valuation of Northern Health's accrued long term disability obligation. The actuarial report will not be available until late March or early April.

Moved by B Sander seconded by C Leclerc
The Northern Health Board approves Northern Health's Period 11 financial statement, as presented.

8.2. Major Capital Projects Summary

- M De Croos provided an overview of the major capital projects summary dashboard for period 11 and provided additional explanation and details for projects that are experiencing delays.

9. Performance Planning and Priorities Committee

9.1. Communications Plan Progress Report

S Raper provided the Board with an update on the current status of the communications and actions related to the Strategic Communications Plan as follows:

- The new structure for communications completed its first year. The shared planning between Population/Public health and communications with respect to health promotions has proven successful with a number of creative campaigns and joint planning on initiatives.
- Media relations continue to be a proactive endeavor to achieve a two to one rate of positive stories to negative across the region.
- The area of significant development has been internal communications. With the emphasis and work in quality and integrated health services, as well as the rebuild of the employee intranet 'OurNH', the growth in demand for communications support has been significant.
- The communications department continues to focus on developing Northern Health's digital web presence. The pressure to stay current and relevant on the web while managing the fast paced innovations that is the nature of that work is challenging.
- Chairman Jago commended the Communications Department for the work that they are doing.

10. 'Kick it up' Kitimat Presentation

Darlene Schmid, RN, Public Health Nurse, Northern Health and Shaun O'Neill, Deputy Director Leisure Services, District of Kitimat joined the Board meeting to present on 'Kick it up' Kitimat which is a community driven program created for the purpose of educating, encouraging, facilitating, and supporting the residents of Kitimat as they move towards a more active lifestyle.

The goal is to build on the strength of the community and involve a network of health and wellness conscious professionals and community members to work together for the health and wellness of Kitimat.

Chairman Jago thanked the guests for the presentation and presented them with a small token of appreciation.

11. Governance and Management Relations Committee

11.1. Policy Manual BRD 100 Series

- C Leclerc presented the BRD 100 Services for approval which have been reviewed and edited at the GMR Committee level.

Moved by C Leclerc seconded by S Hartwell
The Northern Health Board approves the revised BRD 100 Series

11.2. Code of Conduct / Conflict of Interest signing (BRD 210)

- Board Policy BRD 210 Code of Conduct and Conflict of Interest Guidelines stipulate that each Director shall annually sign a declaration that they have read and considered the policy and agree to conduct themselves in accordance with the policy.
- The Director Declaration Forms were handed out to each Director for their completion and signature. An update will be provided at the June 2014 to confirm that all Directors have completed and returned the forms.

11.3. Integrated Ethics Framework Update

- The Board was provided an update on the Accreditation Canada standards dealing with ethics and were provided an overview of the Integrated Ethics Framework for Northern Health.
- The upcoming Accreditation Canada Survey is occurring the week of June 1 to 6, 2014 and will include a focus on Governance which is considered a high priority process.
- Discussion took place around producing the Integrated Ethics Framework information in both hard copy and electronically for board members and Northern Health staff.

11.4. Regulatory Framework – Legislative Compliance

11.4.1. Human Rights Code

- The Human Rights Code was provided to update the Board on the legislative compliance review process.
- The review suggests that Northern Health staff members are aware of and understand the Code and have policy guidance with respect to interpretations and application of the Code. They also have access to support through Human Resources and Risk Management when situations arise.
- Certificates of compliance have been signed by the Chief Operating Officers and the VP of Human Resources. The Code and this Legislative Compliance Review were reviewed by the Executive Team.

Public Presentation Session:

1) BC Association of Community Response Networks

Presenters:

- Sherry Baker, BC CRN Executive Director
- Heather Archer, BC CRN Team Leader
- Belinda Lacombe, North West Regional Mentor

- The BCCRN promotes safe communities, through the development of community response networks (CRNs) where individuals, not for profit, private and public sector organizations participate in activities to prevent abuse, neglect, and self-neglect of adults. We also support communities to build and maintain effective responses to adults who are experiencing or at risk of experiencing abuse, neglect, or self-neglect.
- CRNs also facilitate prevention and education activities with local stakeholders and liaise with the BC CRN to assist in identifying common themes, barriers, and issues which require work at the regional, provincial and sometimes national level.
- The presentation provided to the Board focused on issues of adult abuse and neglect and the roles of our respective organizations in effectively and collaboratively building the safety net for citizens of northern BC.

2) Kitimat Health Advocacy Group
Rob Goffinet, Director – Chairperson, Kitimat Health Advocacy Group (KHAG) presented to the Board with the following key points:

- Acknowledge and give its continued support to the efforts of Northern Health to consult, dialogue, and react to the singular stressors health care in Kitimat is presently experiencing.
- Re-commit to doing whatever it can with the resources given it by the District of Kitimat, to help Northern Health mitigate such stressors.
- Highlight ways support can be provided to Northern Health in the future with recruitment and retention issues.
- Can see there is mental health & addictions recruitment taking place right now and hope to encourage augmentation.

Chairman Jago thanked the guests for their presentations and expressed appreciation for the information that was shared.

The public session was adjourned at 3:45
Moved by C Leclerc seconded by S Hartwell

Dr Charles Jago, Chair

Desa Chipman, Recording Secretary

Northern Health Regional Office
600-299 Victoria Street,
Prince George, BC V2L 5B8

CEO REPORT

Meeting:	Northern Health Board Meeting	Date:	May 28, 2014
Agenda Item:	CEO Report		
Purpose:	Information		
Prepared by:	Cathy Ulrich		

Over the last couple of months, a number of Northern Health staff have been recognized with the following awards. We congratulate the staff and physicians who are the recipients of these prestigious awards.

Excellence in BC Health Care Awards:

Health Care Hero – Northern Health (Gold Apple)
Dr. Marius Pienaar – Physician Specialist: Obstetrician Gynecologist (Northwest Cluster)

Collaborative Solutions (Award of Merit)
Project: Interior Health & Northern Health Workplace Health & Safety
Project Lead: Frank Talarico, Director Workplace Health & Safety (Interior Health)

The 8th Annual Excellence in BC Health Care Awards luncheon will be held in Vancouver on Monday, June 23, 2014

College of Registered Nurses of British Columbia Awards:

Six nurses are receiving awards from the College of Registered Nurses of British Columbia (CRNBC) at the ceremony taking place in September 2014.

The **Excellence in Nursing Practice award** recipients from Northern Health include:

- Celia Evanson, Nurse Practitioner in Fort St James
- Linda Keefe, Program Coordinator, AIDS Prevention Program / Needle Exchange in Prince George
- Leslie Murphy, Manager, Maternal Child at UHNBC in Prince George
- Barb Schuerkamp, Head Nurse in Tumbler Ridge

The Excellence in Nursing Administration award recipient is:

- Valerie Waymark, Regional Manager Community Care Facility Licensing, from Prince George

The Rising Star award recipient is:

- Lisa Cox, a registered nurse from Valemount

College of Licensed Practical Nurses of British Columbia Awards:

Helena Hawes, LPN, Program Coordinator, Home Support in Smithers received the **Excellence in Leadership** award from the College of Licensed Practical Nurses of British Columbia (CLPNBC). Helena will receive her award at a reception in Burnaby on June 11th.

The Canadian Public Relations Society Awards:

The Queen Charlotte/Haida Gwaii Hospital Project Procurement Communications work received the **Canadian Community Relations Campaign of the Year distinction.** There are only three awards in this category given out each year.

The project was led by Jonathon Dyck, Northern Heath Lead for Public Affairs and Media Relations and Katie White, Partnerships B.C. Director of Communications. The award was received for the work undertaken from project announcement on April 12, 2012 to ground breaking on July 30, 2013. The communication project included community meetings to explain the procurement process and working with the Misty Isles Economic Development Society on a procurement database for companies and workers.

Jessica Quinn, Regional Manager of Health Promotion and Community Engagement, and Chelan Zirul, Health Promotion and Communications Officer, both from the Communications team, recently travelled to the Canadian Public Relations Society (CPRS) National Conference in Banff, AB, to receive two awards for the "My Healthy Workplace: Taking Care of Business" campaign that was implemented in 2013/14. The CPRS awards program recognizes excellence in public relations across Canada.

This campaign was developed by the HYPE (Healthier You Promotions & Engagement) team and implemented by Jessica and her team. Over 75 teams from northern BC communities registered to participate a workplace health challenge, including physical activity, healthy eating, and injury prevention.

The awards received were:

- **Canadian Marketing Communications Campaign of the Year** (bronze)
- **Canadian Advocacy and Social Marketing Campaign of the Year** (bronze)

International Association of Business Communicators (IABC) Awards:

Jessica Quinn also attended the International Association of Business Communicators (IABC) World Conference in Toronto during the week of June 8, 2014 to accept a **Gold Quill Award of Meri**t in the *Social Media* category for the "My Healthy Workplace: Taking Care of Business" campaign.

2014 Order of British Columbia:

Dr. Bill Clifford, M.D., B.Sc., B.Med.Sci, M.ScF, FCFP is a primary care physician and Northern Health's Chief Medical Information Officer. Dr Clifford is one of the twenty-five British Columbians who have contributed to the province in extraordinary ways and will be appointed to the **Order of British Columbia** on November 6, 2014 in Victoria British Columbia. Dr. Clifford has demonstrated extraordinary dedication and commitment to the people who live in northern BC and to improving the quality of health care and primary care across the North. Since the Order was first introduced in 1989, 370 people have been appointed.

Integration Work in Fort Nelson:

Community services and acute care staff from Fort Nelson came together on May 30, 2014 to learn more about the implementation of integrated health services in primary and community care. Staff discussed the story of Mary which illustrates the fragmented journey of a young woman who is experiencing mental health challenges. Mary's story reveals how coming together in interprofessional teams to work with Mary to plan and coordinate services would better meet Mary's needs. Ideas to move forward locally towards team based care are under consideration in partnership with the community.

North Central Local Government Association

On May 8th and 9th, 2014, Dr. Charles Jago and I traveled to Fort St John to attend the North Community Local Government Association conference where we had the opportunity to meet with local government representatives to discuss health care concerns. We met with 8 Regional Districts/Regional Hospitals Districts and 5 Municipalities.

Canadian Foundation for Healthcare Improvement: Northern Rural or Remote Healthcare

Northern Health attended the Northern Rural or Remote Healthcare: Enhancing Improvement through Collaboration conference held in Banff, Alberta on May 29-30, 2014.

- The purpose of the conference is to foster dialogue on cross-regional collaboration and improvement within primary care and mental health services in the northern, rural or remote context. This invitation-only event brought together senior healthcare leaders from across Canada with the objective to:
  a) Identify effective, evidence-based approaches to improving the organization and delivery of health services in northern and rural regions.
  b) Assess alignment of current service delivery improvement priorities and identify opportunities for cross-regional collaboration.

- Those who attended from Northern Health included Dr. Margo Greenwood, VP Aboriginal Health, Jim Campbell, Executive Lead, Mental Health & Addictions, Dr. Candida Graham**,** Psychiatrist and Medical Lead, Mental Health and Addictions and Michael Simpson**,** Director, Northern Interior Mental Health & Addictions.

Fort St John Physician Recruitment and Unattached Patient Clinic

Focused work continues in partnership with the Division of Family Practice and the City of Fort St John to recruit physicians to the community of Fort St John. Partnered work is continuing to organize an Unattached Patient Clinic in Fort St John. This work is progressing on schedule for a clinic opening in early July. The interprofessional Perinatal Clinic continues to operate very successfully and is improving access to perinatal care for mothers and their families in Fort St John.

Vanderhoof St John Hospital Renovations Completed

Almost $5 million in renovations at the St. John Hospital to improve patient flow in and out of the emergency room, and add an independent ambulance bay are now complete. The renovations focused on the emergency department to improve the patient experience, including adding a separate waiting room for families of patients in emergency care. The entrance for emergency was also relocated and there are now three entrances into the hospital: one for patients coming into emergency, one for ambulances bringing patients into emergency, and one for all other hospital services. The project was funded by the Province of B.C., Stuart-Nechako Regional Hospital District, and Northern Health. The project was completed by IDL Projects based in Prince George, B.C.

Human Resources Board Report

June 2014

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Workplace Health and Safety

Partnerships in Prevention (PIP)

The Provincial Respiratory Protection Program will be launched within the next few months. A partnership with British Columbia Emergency Health Services (BCEMS) is available for sites that choose to engage BCEMS for fit testing services.

The Safe Patient Handling (SPH) program recently added a new learning resource series on iPortal: the SPH Resource Lead and Team Training Module Series. This series is a building block to the education being offered in the SPH peer champion program. The first sessions have begun in Terrace and Vanderhoof. Sessions are currently being planned for Dawson Creek and Ft St John in June and Prince George and Quesnel in the fall. WHS will continue to support peer champions via quarterly teleconferences/videoconferences and through use of a TeamSite. An information briefing note is forthcoming to executive explaining this new service from WHS (from the hiring of a trainer)

The WorkSafeBC eBook "Managing Safety in Health Care: A Guide for Leaders" content has been converted to an e-learning module and will be included in the provincial healthcare management education program. This module was developed for healthcare in partnership with Northern Health. The implementation plan includes communication of the recently completed handbook "Ensuring Staff Are Safe and Healthy: The Role of Healthcare Supervisors" developed by the Healthcare Safety Professional Association of BC (HCSPA).

Disability Management

A Duty to Accommodate (DTA) Team was created to address the ongoing issue with delayed on-going accommodation of disabled employees. An employee eligible for a DTA must have permanent functional limitations and/or restrictions impacting their ability to perform all the bona fide occupational requirements of their regular position. The Disability Management (DM) team is responsible for the collection and adjudication of all objective medical documentation relevant to a DTA Request. Once the DM team has approved the DTA Request, the case is transferred to the Human Resources (HR) team to conduct a job search for available accommodation placements. We are evaluating the effectiveness of the new approach.

We continue to work with WSBC to improve the collective efficiency and timeliness of claims management, to improve responsiveness for employees. WSBC is adopting consistent best practices across its offices to reduce unnecessary delays.

Communicable Disease Prevention

Karlene Dawson is the successful applicant for the WHS Health & Wellness Manager position effective May 5, 2014. Her previous role was supporting the provincial Enhanced Disability Management Project.

The Blood and Body Fluid Exposure policy revision is complete, approved and available on our internal website.

Human Resources Operations

The essential service plans and staffing levels are now 100 % complete.

Recruitment

Seasonal increases in vacancies are emerging as families relocate and retirements are initiated.

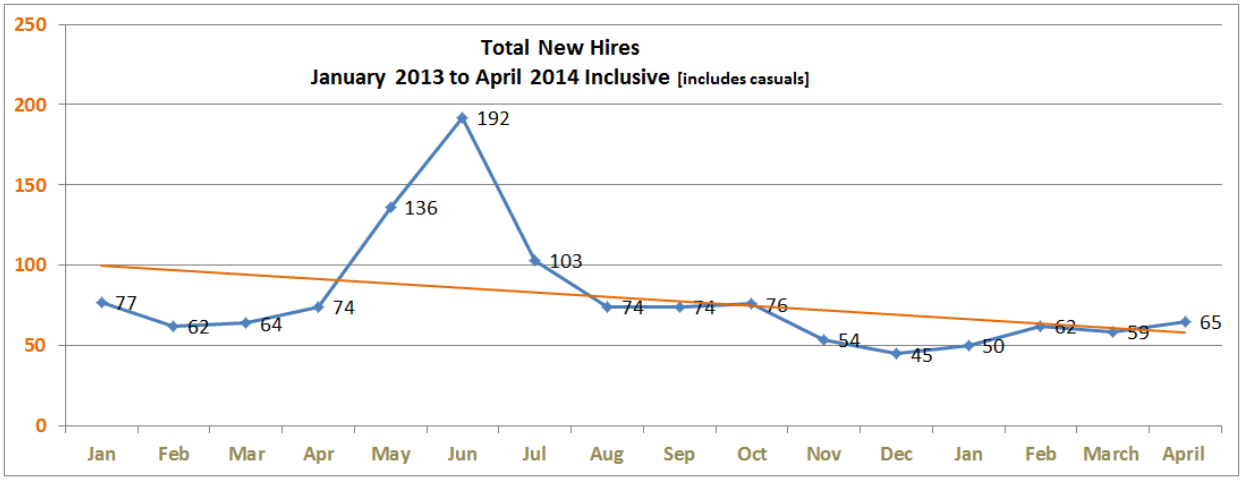
Excluded vacancies are up slightly from 10 to 12 and there continues to be activity at all levels, administrative to senior executive. Since the last board report the Director of Financial Planning and Budgeting has been filled, and the Regional Director of Preventative Public Health selection process is reaching conclusion.

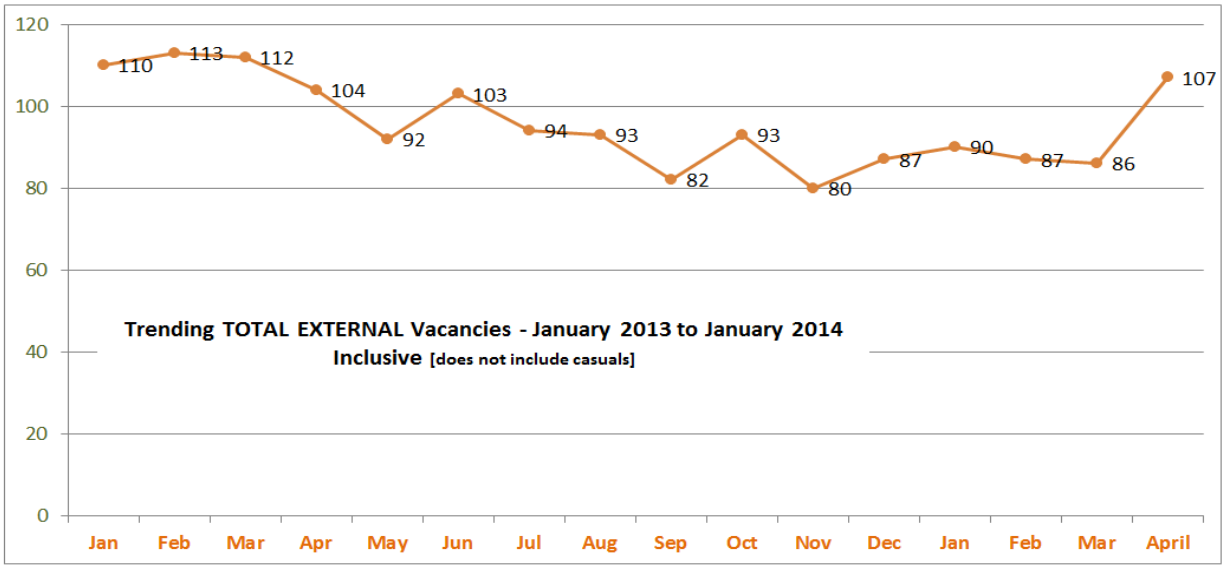
Recruitment is building external ads in the new *Now This Is Living* campaign to target our most difficult to fill vacancies.

Current vacancies requiring special focus include:

- 8 Physiotherapists
- 1 Clinical Instructor
- 7 Ultrasound/Sonographers
- 7 Resident Care Aides
- 5 Nurse Practitioners

We recently attended a new "Campus Invitational" recruiting event on the BCIT campus for diagnostic students which was very successful with dozens of students signing up to hear about Northern Health Careers. Students included Sonographers, Radiographers and Laboratory Technicians. The next recruitment events are the BC Nurse Practitioner Conference in June and a visit to UNBC's Family Nurse Practitioner students in May. Visits to UBC and University of Victoria's Family Nurse Practitioner program students are also being scheduled for July and September.




Trending TOTAL EXTERNAL Vacancies - January 2013 to January 2014
Inclusive [does not include casuals]
120
100
80
60
40
20
0
110
113
112
104
92
103
94
93
82
93
80
87
90
87
86
107
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
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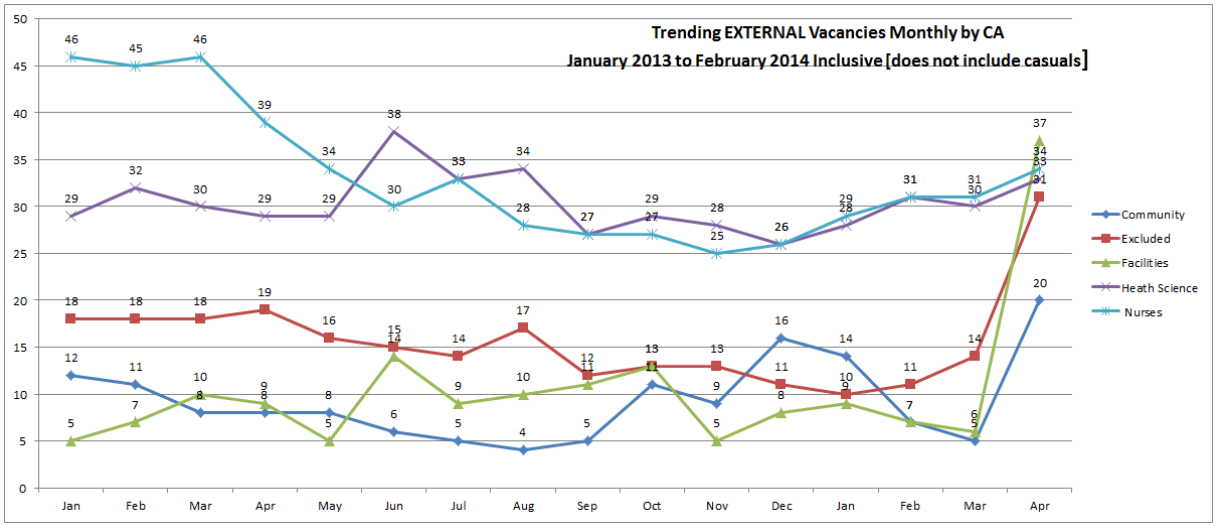
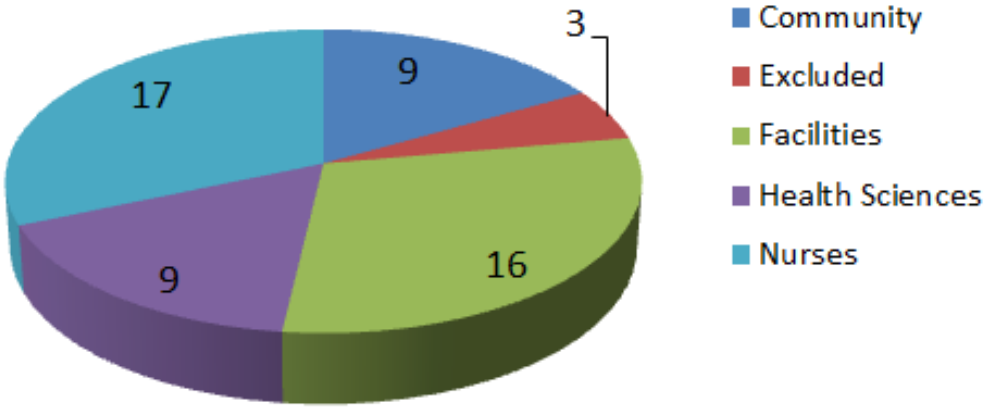
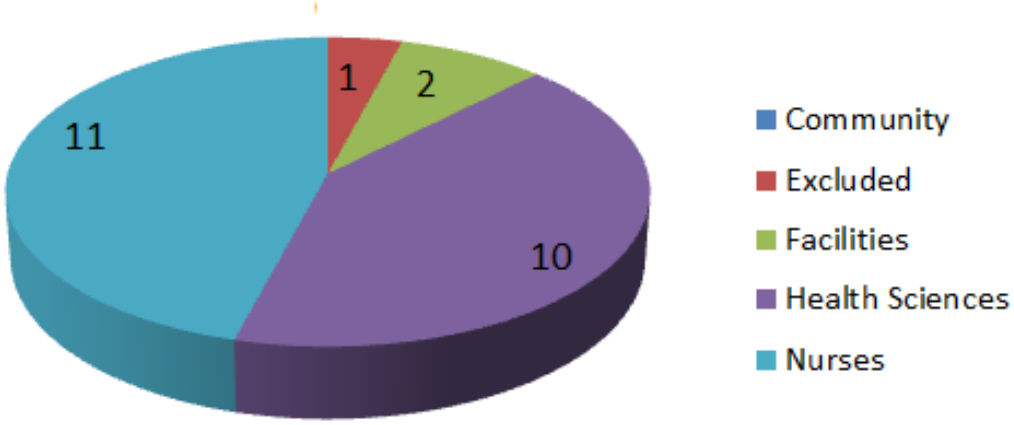
Nov
Dec
Jan
Feb
Mar
April

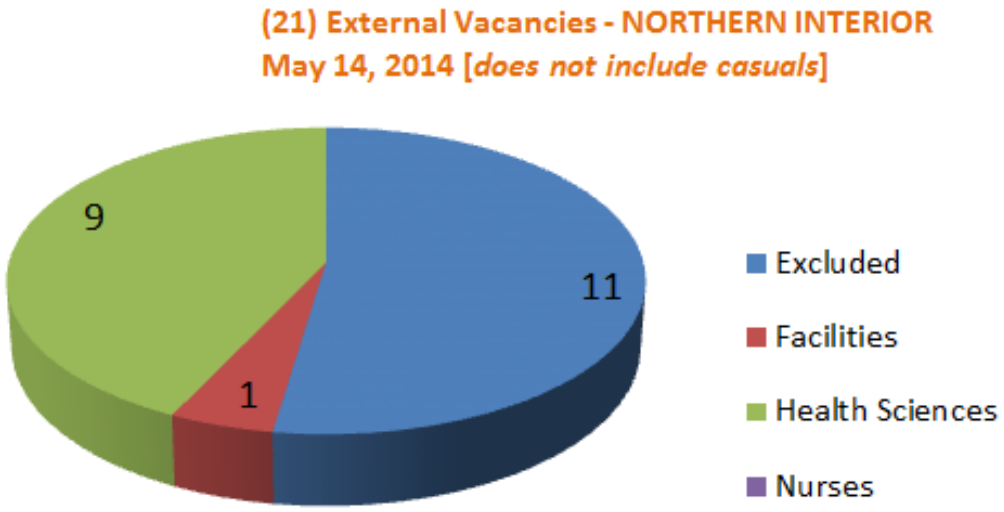

Trending EXTERNAL Vacancies Monthly by CA
January 2013 to February 2014 Inclusive [does not include casuals]
Community
Excluded
Facilities
Heath Science
Nurses
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr

(54) External Vacancies - NORTHEAST
May 14, 2014 [*does not include casuals*]



(24) - External Vacancies - NORTHWEST
May 14, 2014 [*does not include casuals*]





Organization Development and Engagement

Education Calendar

Work has begun scheduling the NH learning opportunities calendar for 2014/2015 in early May. This is in advance of the customary start time of June in order to ensure that all departments are able to coordinate learning activities with organizational need.

Coaching LINX (aka Coaching with a Twist)

Staff members in Prince Rupert recently attended the face to face portion of this course and are now involved in their coaching triad learning.

Core LINX

Online modules in the leadership track of Core LINX are now being offered through PHSA's learning management system. Most recently, the first NW cohort of the Core LINX celebrated its graduation in Terrace.

Policy Development

A diversity statement was included in the new Healthy Workplace Policy for review by NH Executive and final amendments are being incorporated. This policy replaces our previous Respect in the Workplace Policy.

A working group developed the criteria and process for the "Above and Beyond Award". This award is for teams and individuals that surpass NH's goals and objectives in fulfillment of its mission and vision. The Above and beyond Award has been included in the Employee Service and Retirement policy.

Northern CME

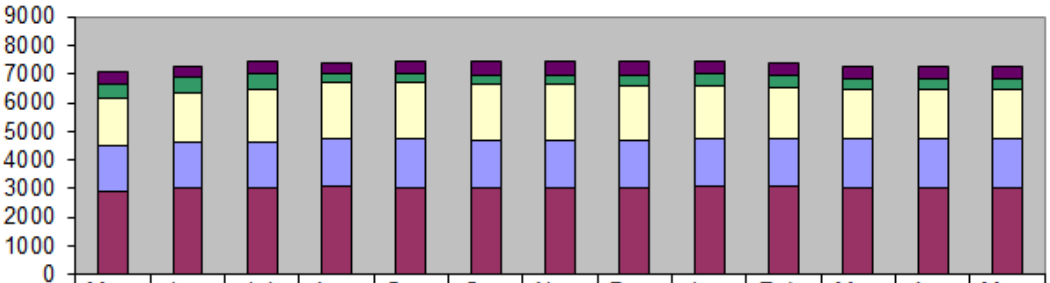
NHMAC amended its funding approval for the NCME to March 31, 2017. Recent program activities include the accreditation and organization of an oncology conference in Prince George, the scheduling of an Emergency Department Ultrasound course in Prince George, and Pediatric Advanced Life Support courses throughout the region. Work on the development of a provincial practice enhancement resource for physicians continues.

HRIS/Staffing

Employee and FTE Counts

Northern Health Employee Counts by Month

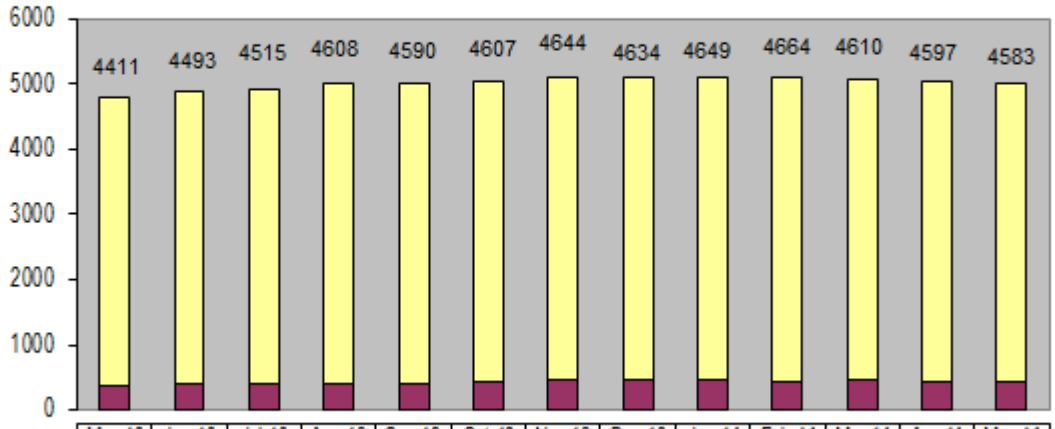
Displays the total # of employees, regardless of their status. Employee is based on unique SIN.



	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Short Term Leave*	391	398	415	415	421	451	457	450	445	453	431	428	413
Multiple ID's**	507	511	522	313	329	332	308	365	396	399	406	394	374
Casual**	1654	1733	1857	1935	1975	1954	1937	1908	1869	1803	1715	1738	1740
Part time	1573	1628	1607	1657	1667	1647	1665	1654	1653	1656	1680	1676	1675
Full time	2929	3002	3023	3084	3052	3046	3046	3047	3067	3069	3052	3045	3051
Total	7035	7054	7272	7424	7404	7444	7430	7413	7424	7430	7380	7284	7281

Northern Health FTE counts by Month

Displays the total # of FTEs across the organization, not including casual employees.



	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Full FTE	4411	4493	4515	4608	4590	4607	4644	4634	4649	4664	4610	4597	4583
Short term leave*	375	391	398	415	415	421	451	457	450	445	453	431	428

Chart notes:

*Short Term Leave – Regular employees (part time or full time) that will be absent from 2 to 24 months. Reasons include, but not limited to; maternity, sick, education, LTD, WCB. These employees and their relief are included in the total FTE count.

**Multiple ID's – Employees who work in more than one facility or certification have an ID for each area worked and receive a separate pay cheque for each employee ID.

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BOARD BRIEFING NOTE

Date:	**May 6, 2014**	
Agenda item	**2013-14 Year End Financial Statements (Public Meeting)**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Audit & Finance Committee**	
Prepared by:	**Mark De Croos – VP, Finance & Chief Financial Officer**	

Issue:

To provide the Audit & Finance Committee with an update on the status of the audit of Northern Health's 2013-14 financial statements and Government's requirements regarding disclosure of the audited financial statements to the general public.

Background:

Northern Health ended fiscal year 2013-14 on March 31, 2014. The year-end financial statements are currently being audited by KMPG. Northern Health awaits the outcome of the audit, but is confident that it will end the year in a surplus position.

Upon conclusion of the audit, the audited financial statements will be presented to Northern Health's Board of Directors for approval at the Board's June meeting. Following Board approval, the audited financial statements will be submitted to the Ministry of Health for its review and approval to release to the general public. Once Ministry approval is received, Northern Health's 2013-14 audited financial statements will be posted on its website – www.northernhealth.ca.

Recommendation(s):

Receive the above information.

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PROJECT SUMMARY REPORT
PERIOD 13 CAPITAL PROJECTS

Fiscal Period End Date **31-Mar-14**

Northern Health Major Projects Summary

	Project	*Meeting Scope *Yes/No*	**Scope Date Change	*On Schedule: *Yes/No*	**Schedule Date Change	*On Budget: *Yes/No*	**Budget Date Change
1	NE - DCH Nurse Call Replacement	Y		Y		Y	
2	NE - FSH Planning - Old Fort St John Hospital Asset Retirement	Y		Y		Y	
3	NI - BLH Lakes District Hospital & Health Centre Replacement	Y		Y		Y	12-Sep-13
4	NI - SJH Outpatient Services Renovation	Y	7-Aug-13	Y	3-Jan-13	Y	8-Jul-13
5	NI - UHN Learning & Development Commons	Y		Y	10-Oct-13	Y	10-Oct-13
6	NI - UHN Mat-Child Entrance & MM Exit	Y		Y		Y	
7	NI - UHN NCCS Patient Care Services - Renovation	Y		Y		Y	
8	NI - UHN Nechako Centre Deconstruction	Y		Y		Y	
9	NW - MMH Electrical Switchgear Replacement	Y		Y		Y	
10	NW - MMH Planning - Facility Renewal	Y		Y	10-Oct-13	Y	
11	NW - MMH Outpatient Clinic Renovaton	Y		Y		Y	
12	NW - PRR CT Suite	Y		Y	25-Jul-13	Y	
13	NW - QCC Hospital Replacement	Y		Y		Y	12-Sep-13
14	IT - NHR Data Centre Transition	N	2-Jul-13	N	3-Jan-13	Y	
15	IT - NHR Enterprise Master Person Index (EMPI) Active Integration	Y	2-Jan-14	Y	2-Jan-14	Y	31-Mar-14
16	IT - NHR Regional Nutrition Systems Project (CBORD)	N	7-Mar-14	N	2-Jan-14	N	7-Mar-14
17	IT - NHR Transcription Redesign Implementation	Y	6-Jan-14	N	6-Jan-14	Y	26-Nov-13

*** Yes denotes green health indicator**
*** No denotes yellow/red health indicator**
*** Comments related to health indicators are noted below**

**** If there is a date in these columns, it indicates the date of the latest status change to no**
**** If there is no date in these columns, the yes/no status has never changed and represents original**

14	Delays on infrastructure preparation
16	Scope may need to be reduced if additional funding necessary to support extension of schedule is not addressed. There are schedule concerns re: trainers due to less time between go-lives.
17	This project is currently on hold and the planned roll out is cancelled due to the lack of viability of the technology. We are working on an alternative approach with the vendor using different technology. If this is not successful, we will begin negotiations for reimbursement.

Please note that individual Project Status Reports on the above identified projects are received and reviewed in detail by Audit & Finance Committee. Detailed Project Status Reports are available upon request from the Regional Director, Capital Planning & Support Services.

When reviewing detailed dashboards, please note a system issue between fiscal and calendar reporting in the Budget to Date vs Actual to Date

Where significant updates are available this summary dashboard reflects current information up to:

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COMPLETED PROJECT SUMMARY REPORT (Note 1)

Fiscal Period End Date **31-Mar-14**

Projects completed during period P13

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*
NI - GRB Pharmacy - Sterile Processing Room	Y	Y	Y
NW - KIT Observation (Secure) Room	Y	Y	Y
IT - UHN SurgiNet (OR Booking & Care Documentation)	Y	N	N

Construction completed - Projects under financial review (Note 2)

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*
NE - FSJHHC Hospital & Residential Care - Equipment-Fort St John	Y	Y	Y
NI - Baker Lodge Deconstruction-Quesnel	Y	Y	Y
PSECA 3 Projects	Y	Y	Y
NI - UHN Chiller Replacement	Y	Y	Y
NE - DCH Parking Resurfacing	Y	Y	Y
NE - RMC Parking Resurfacing (Rotary Manor)	Y	Y	Y

Projects completed during Fiscal Year 13/14

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*
NW - PRRH Laboratory Redesign-Prince Rupert	Y	Y	Y
NE - FNGH Pharmacy Renovations-Fort Nelson	Y	Y	Y
NE - DCDH Maternity Renovation-Dawson Creek	Y	Y	Y
NI - SJH Nurse Call Replacement	Y	Y	Y
NW - BVDH Ventilation Systems	Y	Y	Y
NW - TVL Upgrades, Existing Building-Terrace	Y	Y	Y
NI - The Pines Nurse Call Replacement	Y	Y	Y
IT - NH SA (NACRS/Single Abstracting)	Y	Y	Y
IT - EMR Software Implementation	Y	Y	Y
NW - BVDH Electrical Upgrade-Smithers	Y	Y	Y
PSECA 1 & 2 Projects	Y	Y	Y
NW - PRRH CT Scanner & Temporary Retrofit	Y	Y	Y
NE - DCDH Window Replacement - Dawson Creek	Y	Y	Y
NE - FNGH Heating Pipe Replacement Upgrade-Fort Nelson	Y	Y	Y
NE - DCH Master Planning	Y	Y	Y
NI - GRB Master Planning	Y	Y	Y

***Comments Field: (required if "NO" selected)**

Note 1

Please note that individual Project Status Reports on the above identified projects have been received and reviewed in detail by Audit & Finance Committee. Detailed Project Status Reports are available upon request from the Regional Director, Capital Planning & Support Services.

Note 2

Financial Review is underway to assess final financial project closure related to expenses and funding sources in order to enable amortization of the asset according to generally accepted accounting principles.

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BOARD BRIEFING NOTE

Date:	April 29, 2014	
Agenda item	**New Chronic Disease Direction from November 2013 to April 2014**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**3P Committee**	
Prepared by:	**LaDonna Fehr**	
Reviewed by:	**Dr. Ronald Chapman**	

Background

Over the past years Northern Health leadership has planned and dreamed of an integrated, effective and efficient approach to caring for patients with multi-morbidities. In November 2013 the first steps towards this dream were implemented in the start of an umbrella program, Chronic Diseases, which includes Cardiac/Stroke, Renal, Blood Borne Pathogens, Oncology and Diabetes.

The following outlines the beginnings of this new work and is meant to help give you awareness of the current momentum and direction of Chronic Diseases.

Overview of November 2013 to April 2014

We have been approaching integration from two fronts: firstly to integrate the 5 programs under one portfolio and secondly the development of an integrated strategic framework for NORTHERN HEALTH Chronic Diseases.

1. **Integration of 5 NORTHERN HEALTH programs**

- The Chronic Disease leadership group and key leaders in their programs met for a one day facilitated team building workshop. This has proven to be a successful start for the new team. The Chronic Disease groups now participate in monthly team planning which have facilitated new ways to strategize. One example: optimizing "wins" from one chronic disease to be used to help in another chronic disease reaching marginalized members of the northern community.
- Realignment of Administrative Support to serve all programs within Chronic Disease. This has improved efficiencies within each of the separate budgets.
- Partnership with NORTHERN HEALTH IT for a Clinical Analyst Position to implement Integrated Community Clinical Information System (ICCIS) the chronic disease instance of Medical Office Information System (MOIS) for Oncology, Cardiac, and Renal. Position is currently posted. Expected start date of May 2014. Oncology Integrated Community Clinical Information System "go live" in fall of 2014.

NORTHERN HEALTH Renal Program

- The Renal Team has completed development of a 5 year regional strategy under the leadership of Kelly Gunn (medical affairs). The strategy has been well received in NORTHERN HEALTH through an extensive consultation with NORTHERN HEALTH physician leaders, administrators and primary care givers. The team is currently working on the operational plan to implement the strategy over the next 5 years. The Renal team has made significant strides since February on three of the stated actions for the first year of the 5 year plan.
- NORTHERN HEALTH Renal program has successfully appointed a medical lead, Dr. Anurag Singh.

Cardiac and Stroke Program

- The Cardiac Program has also completed the development of a 5 year regional strategy which is very close to completing the consultative process. Concurrently the cardiac program is developing the operational plan for the strategy.
- The Cardiac Services lean project is completed. Funding for a 1.0 FTE Cardiac Triage Coordinator to join the provincial team here in Prince George has been received from provincial cardiac program. The position is posted, expected start May 2014.
- Northern Health Stroke strategy is now complete. Next steps: currently a small working group is being formed to develop an operational plan based on the strategy.
- NORTHERN HEALTH Heart Function Clinics (NORTH) have expanded from 5 to 6 as of April 2014
- Appointment of Medical Lead is in process with planned announced in May/June 2014

Blood Borne Pathogens

- The Blood Borne Pathogens program moved from a pilot to an operational program this year. This brought a reduction in funding of 400,000 for 2014/15 and a further reduction of another 400,000 for 2015/16. Blood Borne Pathogens leaders have successfully redesigned to maintain services with reduced funding. Included in this planning is the successful realignment of community contracts for both years including more rigorous oversight of deliverables.
- Blood Borne Pathogens will be starting their 5 year regional strategic plan in May 2014.
- Appointment of Medical Lead is in process with planned announcement in May 2014.

Oncology Program

- Successful appointment of new Regional Oncology Leader in March 2014
- Responding to the invitation from Dawson Creek the Oncology Medical Lead, the Regional Oncology Leader and Director, Chronic Diseases just completed a site visit and review of the Community Oncology Clinic in Dawson Creek.
- In June the oncology team will begin work on their 5 year regional strategic plan that will address regional standardization of the 9 Community Oncology Network clinics, parenteral services in NORTHERN HEALTH hospitals, and cancer care close to home sustainability.
- Currently planning and preparing for accreditation visit for the Community Oncology Clinic in Ft St John
- Ongoing “tweaking” of the Colo- rectal screening project.

2. <u>Integrated Strategic Framework for NORTHERN HEALTH Chronic Diseases</u>

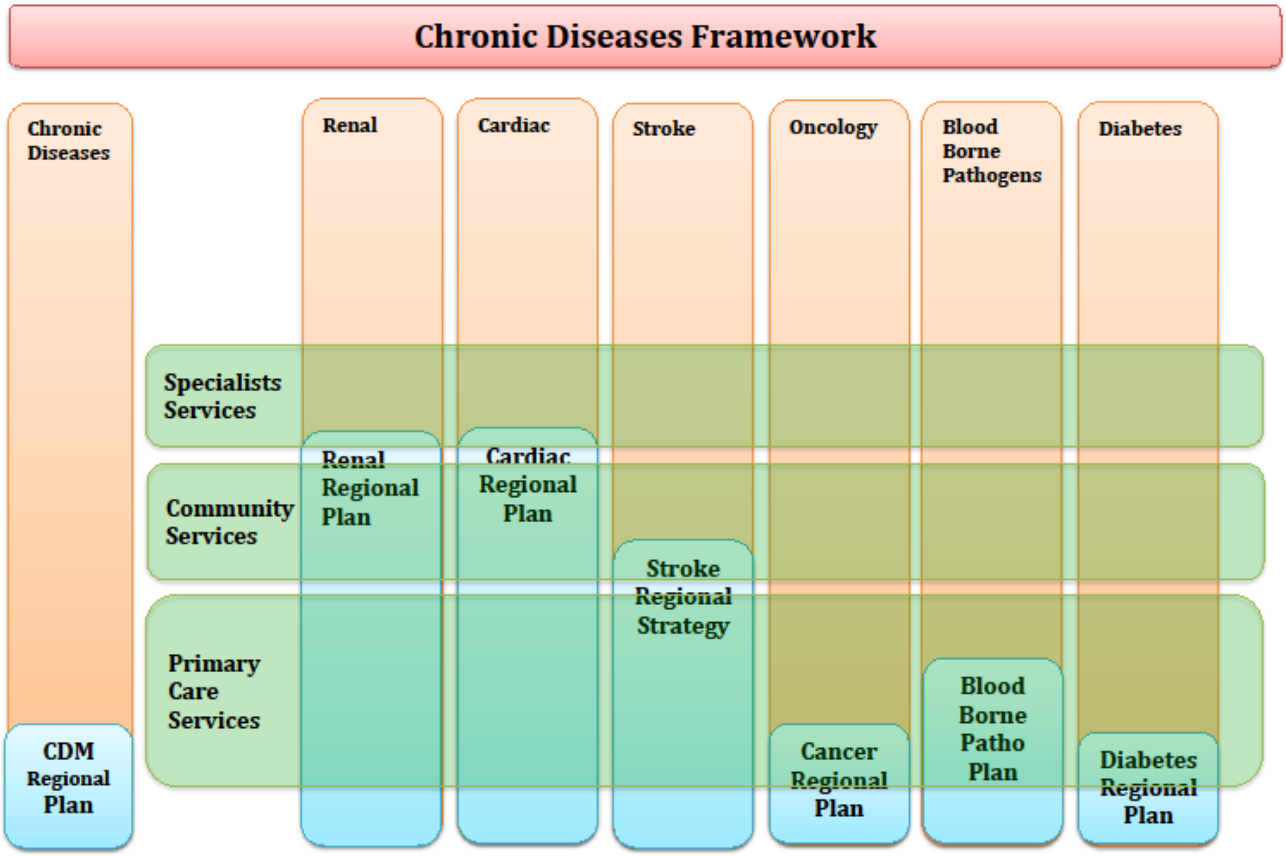
The following question and goal will be the focus for Chronic Diseases over the remainder of 2014 and into 2015.

Question:

Given the common approaches to care of chronic diseases and the large numbers of patients in the North who experience co-morbidities with needed management at the same time how do we approach integrating the services? ***See Appendix I***

Goal:
All northerners will experience the improvements that come from an integrated approach to Chronic Disease. ***See Appendix II***

Appendix I



Appendix II

How will our patients know when they have integrated Chronic Disease Care?[i]

When they:

a. Do not have to repeat their health history for each provider encounter
b. Do not have to undergo the same test multiple times for different providers
c. Are not the medium for informing their physician that they have been hospitalized or undergone diagnostic or treatment procedures; been prescribed drugs by another physician; not filled a previous prescription; or been referred to a health agency for follow-up care
d. Do not have to wait at one level of care because of incapacity at another level of care
e. Have easy-to-understand information about quality of care and clinical outcomes in order to make informed choices about providers and treatment options.
f. Can make an appointment for a visit to a clinician, a diagnostic test or a treatment with one phone call
g. Are routinely contacted to have tests that identify problems before they occur; provided with education about their disease process and provided with in-home assistance and training in self-care to maximize their autonomy.

---

[i] Leatt et al 2000 Towards a Canadian Model of Integrated health care

BOARD BRIEFING NOTE

Date:	**2014 May 13**	
Agenda item	**Board – Emergency Preparedness**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared by:	**M Leisinger**	
Reviewed by:	**C Ulrich**	

Issue:

Annual Update on Emergency Preparedness

Background:

In 2013 the health emergency preparedness function[1] transferred out of Northern Health as a result of the provincial consolidation of all health emergency management, as recommended by the BC Collaboration Council (BCCC)[2]. Through a memorandum of understanding (MOU) signed by the Health Authority CEOs it was agreed that the Health Authorities (HA) and the Ministry of Health (MoH) would pool resources currently devoted to health emergency management under a new management and governance structure, known as Health Emergency Management BC (HEMBC[3]), housed in the Provincial Health Services Authority (PHSA).

Northern Health transferred 1 FTE to HEMBC in July 2013 and began reimbursing HEMBC for salaries, benefits, and other costs incurred to support NH[4].

Early in 2014 HEMBC, in consultation with NH, undertook a revision to its structure by combining the Directors for the North and for the Interior into one Director, North & Interior position under the leadership of Rick Erland who works out of the Penticton office of HEMBC. Reporting to Rick Erland are: Acting Manager-North, Eryn Collins who also fulfills the Coordinator position for the Northern Interior. She is based out of Prince George. Jenny

[1] The functions of emergency preparedness include planning, training, response and recovery
[2] Formerly the *BC Health Organizations Support Services Redesign Steering Committee* (BCHOSSR)
[3] Logo: HEMBC
[4] In 2013-14 approximately $207,000 was paid out of the NH emergency preparedness budget: ~$80,000 before transfer and ~$127,000 after transfer. The MoH has indicated that beginning in 2014-15 NH's global grant will be reduced by approximately $92,000 in recognition of the provincial consolidation.

Hogan is the Coordinator-Northwest, based out of Terrace. A third position may be developed in 2014 to serve as the Coordinator-Northeast.

Northern Health's view is that the consolidation will only work if HEMBC staff live in the North, with a focus and expertise on rural and remote issues, and are embedded within Northern Health so as to be responsive to requests from NH managers for advice and subject matter expertise.

Benefits of the consolidation will be:

1. To create an integrated and standardized emergency management and business continuity program that provides consistent services to Northern Health
2. To identify program efficiencies
3. To plan for program enhancements

When an actual emergency/disaster occurs, HEMBC through its 24/7 monitoring of health emergency situations through the provincial alert system is able to coordinate provincial resources while the local site deals with the emergency. HEMBC also works in close association with the BC Ambulance Service (BCAS).

Northern Health responded to several emergencies in 2013 including[5]:

- Earthquakes (Haida Gwaii, Kitimat, Prince Rupert, Terrace)
- Evacuations (Masset)
- Facility-based mechanical issues (Burns Lake; Prince George; Terrace)
- Fire (Ft. St. John; Prince George; Quesnel strip mall)
- Flooding (Annual freshet; Prince George interior water line break)
- Haz-Mat (Prince George; Mile 73 Alaska Highway)
- Gas line ruptures (Downtown Quesnel; Downtown Prince George)
- Plane crash (Fort Nelson)
- Power outages (Dawson Creek; Ft. St. John; Kitimat; Mackenzie; Prince Rupert; Stewart; Terrace; Vanderhoof contingency planning)
- Interface wildfire (Decker Lake)
- Outbreaks - Community and Institutional (Atlin; Dawson Creek; McBride; Prince George; Terrace)
- Serious MVAs (Terrace)
- Tsunami warnings (Haida Gwaii, Kitimat, Prince Rupert)

Work was accomplished in 2013 related to emergency response plans:

- A gap analysis[6] was started to identify by site:
    - Which codes are in place
    - When the documents were last updated
    - When plans were last tested/implemented

[5] A centralized tracking of emergency situations does not exist. The list presented is indicative – not comprehensive.

[6] The analysis was done by Jonathon Dyck of Northern Health as a practicum project requirement for his Master's Degree in Disaster and Emergency Management at Royal Roads University and as a result was only a partial review which will require further work to provide a Northern Health-wide overview.

This gap analysis will assist HEMBC in focusing its code[7] development work in 2014.
- A regional code orange (mass casualty) policy template was developed and local site plans were created
- A regional code brown (hazardous material spills and patient decontamination) policy template was developed

HEMBC has created an advisory structure. The Customer Service Committee (CSC) has representation from each HA for the purpose of ensuring the needs of the customer organizations are being met by the provincial structure. Three meetings of the CSC took place in 2013.

Within Northern Health work is underway to create a Health Emergency Management Steering Committee to inform and coordinate work within and between NH and HEMBC. A terms of reference has been drafted and a first meeting will take place by summer 2014.

The province maintains and operates the Mobile Medical Unit[8] (MMU), a legacy asset from the 2010 winter Olympics. The MMU was deployed to Kitimat to assist during the renovations of the hospital's emergency department. Planning is currently underway for a 2015 deployment to support UHNBC during the Canada Winter Games.

The following priorities have been identified for the year ahead:

- Preparation for the Accreditation Canada survey in June
- Establishing the HEM Steering Committee
- Developing an audit schedule for training and drills
- Formalizing the 'lessons learned' process of event debriefing
- Review and revision of the Emergency Response Management System (ERMS) model and process
- Continued work on code orange, brown & red, and pandemic planning
- Ongoing and increased collaboration with communities in coordinated emergency preparedness planning, including table top exercises and disaster exercises
- Longer term priorities include
    - Development of standard regional code templates for more of the codes
    - Creation of an intranet (OurNH) presence for health emergency management
    - Development of a long-range work plan

Recommendation(s):

It is recommended that the Committee receive this update for information.

[7] See Appendix 1 for a list of codes
[8] In 2013-14 Northern Health contributed $147,000 to support base funding for the MMU

Appendix 1 – Emergency Response Codes

- Code Red: Fire
- Code Blue: Cardiac Arrest
- Code Orange: Disaster or Mass Casualty
- Code Green: Evacuation
- Code Yellow: Missing Patient
- Code Amber: Missing or Abducted Infant or Child
- Code Black: Bomb Threat
- Code White: Aggression
- Code Brown: Hazardous Spill
- Code Grey: External Air Exclusion
- Code Pink: Pediatric Emergency and/or Obstetrical Emergency
- Facility Pandemic Response plan

BOARD ROLE AND GOVERNANCE OVERVIEW V2 BRD 200

Introduction

The Board of Directors of Northern Health (the "Board") is responsible for the strategic direction of the organization and, through the President and Chief Executive Officer (the "CEO"), ensures that appropriate management processes are established to realize the strategic direction.

Principal Stakeholders

The Board is appointed by, and is responsible to, the Government of British Columbia through the Ministry of Health, recognizing and considering the interests of all stakeholders, including:

- patients/residents/clients & family members
- employees
- medical staff
- public

Board Size

Keeping in mind governance effectiveness, considerations of diversity of background and expertise, along with open and effective dialogue, the Government has established that the Board will generally be comprised of ten Directors[1].

Best Interest of Northern Health

Directors are expected to utilize their individual expertise and points of view to contribute to decision making that is in the best interest of Northern Health.

Director's Terms

1. Directors are appointed for one-, two- or three-year terms[2].
2. Directors will normally be appointed for a maximum of six years. In order to achieve staggering of appointments, to avoid too many Directors leaving at the same time, terms may be for other lengths, and in extraordinary circumstances a request may be made to the Minister of Health through the Board Resourcing and Development Office (BRDO) for an extension beyond the normal 6-year limit.
3. Director appointments may be rescinded by the ~~Government~~Minister of Health, ~~generally~~ or on the recommendation of the Board Chair.

Terms of Reference

1. Terms of reference for the Board Chair (Policy BRD120), the CEO (Policy BRD130), Directors (Policy BRD140), the ~~Vice~~ Deputy Chair (Policy BRD150), the Corporate

[1] This is the normal complement and can be more or fewer as circumstances warrant
[2] A Director's first term is usually a 1-year appointment. The final decision rests with the Minister of Health.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 17, 2013 (R)

Secretary (BRD160), and guidelines for Committees (Policy BRD300) and Task Forces (Policy BRD340) are in place for the guidance of the Board.

2. The Governance and Management Relations Committee (GMR) reviews the above noted terms of reference annually and proposes changes to the Board for approval as required.

Key Board Responsibilities

1. The Board, in conjunction with the Deputy Minister of Health, is responsible to hire the CEO to whom the management of the organization is delegated. (Policy BRD130)
2. The Board, through the GMR Committee, is responsible to ensure that both an annual performance evaluation is conducted for the CEO and that a CEO succession plan is in place in the event of an unexpected incapacity or unavailability of the CEO. (Policy BRD 400 & 435)
3. The Board is responsible to ensure that strategic planning processes are established and maintained, with particular attention to quality and ~~the~~ budget management ~~plan and quality~~. The strategic plan will generally have a five-year horizon and is to be reviewed and/or updated annually. The Board participates in the review/update process, approves the strategic plan, and monitors progress. (Policy BRD420)
4. The Board maintains a continuing understanding of the material risks associated with the organization's objectives. The CEO and the management team are responsible to ensure that the Board and its committees are kept current on material risks.
5. The Board commits to maintaining open and clear communications with the medical staff in the interest of optimal patient care and service (Policy BRD170).The medical staff bylaws describe the accountability relationship of the medical staff to Northern Health and the advisory role of the NH Medical Advisory Committee to the Board and the CEO.
6. The Board is responsible to ensure a communications plan is established that provides pertinent and relevant information to the Government and other stakeholders. See Policy BRD220, which outlines process and spokespeople for Northern Health.

Board Committees

Board committees are a mechanism that permits deeper examination of major areas for which the Board has governance responsibilities. The role of committees is to support the Board in handling its responsibilities. Board committees are not established to assume functions or responsibilities that properly rest with management. Refer to Policy BRD300, which outlines terms of reference and guidelines for Board committees.

Task Forces

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 17, 2013 (R)

Task Forces are Board committees established for a defined period of time to undertake a specific task and are then disbanded. Refer to Policy BRD340, which outlines terms of reference and guidelines for task forces.

Board Meetings and Agenda

1. The Board meets at least six times within the calendar year.
2. The Board may also meet at the call of the Board Chair or in his/her absence, the ~~Vice~~ Deputy Chair or as provided for in the Bylaws. (Policy BRD600)
3. The GMR Committee develops the agenda for each Board meeting in consultation with the CEO and the Corporate Secretary.
4. Under normal circumstances, the agenda and meeting material will be distributed to Directors ten days[3] before the meeting.
5. It is normal Board practice for all agenda items to be considered at the appropriate committee meetings prior to being placed on the Board agenda. A Director or the CEO may, however, suggest urgent additions to the agenda through the Board Chair prior to adoption of the Board agenda. (Policy BRD530)
6. Article 6.9 of the Board by-laws indicates that meetings will be conducted in accordance with Robert's Rules of Order. The Board will, however, normally conduct its business based on consensus unless Robert's Rules of Order become necessary.

Public Board Meetings

1. At the discretion of the Board, all or part of the Board meeting may be open to the public.
2. The Board may exclude the public from a meeting, or a portion of a meeting, in order to protect the interest of a person or the public interest, or if withholding information outweighs the desirability of public disclosure. (Policy BRD 220 & 600)

Board Meetings without Management

1. Practices that provide opportunity to build relationships, confidence and cohesion among Directors are essential to allow the Board to develop an understanding of its role. One such practice is a regular meeting of Directors without management present, usually at a predetermined time scheduled during the regular Board meeting time period.
2. Such meetings can be used to provide feedback about Board processes, including the adequacy and timeliness of information being provided to the Board. At times, such meetings might also focus on substantive issues that may be more difficult for some Board members to discuss with management present. They can also provide opportunities for the Board Chair to discuss areas where the performance of the Directors could be strengthened.

[3] Usually two weekends and the intervening work week prior to the Board meeting

Author(s): Governance & Management Relations Committee
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Date Issued (I), REVISED (R), reviewed (r): June 17, 2013 (R)

3. It is important that these opportunities occur regularly, even if the meetings are short, so that they become a recognized and accepted governance practice. Any issues arising in these sessions that bear on the relationship between the Board and management should be communicated quickly and directly to the CEO by the Board Chair.

Non-Directors at Board Meetings

The Board appreciates the value of having management team members and other advisors or visitors present who can provide information and opinions to assist the Directors in their deliberations at Board meetings. The Ministry of Health may request/require the attendance of a Government representative ~~who attends~~at Board meetings. The Government representative is normally recommended by the Ministry of Health and/or the CEO and approved by the Board[4].

Board/Management Relations

1. Directors may direct general questions or concerns to the CEO, Board Chair, or to the Chair of the GMR Committee.
2. Directors must respect the organization's management structure. A Director has no authority to direct any staff member.

New Director Orientation and Continuing Director Development

1. The GMR Committee and the CEO share the responsibility to ensure that there is an orientation process for new Directors and that all Directors receive continuing education/development as required.
2. New Directors will be provided with an orientation and education program, which will include written information about the duties and obligations of Directors and the business and operations of the organization, documents from recent Board meetings and opportunities for meetings and discussion with the senior management of Northern Health.
3. The orientation program for each new Director will be tailored according to that Director's needs and areas of interest and depending on the Director's committee assignment and the HSDA in which they reside.
4. An education component is to be included at every Board meeting and should be focused on relevant changes in the operating environment and critical issues.

Assessing Board Performance

The GMR Committee is responsible for ensuring that there is a process for annually assessing the performance of the Board, its committees or individual Directors, and ensuring that the process includes an opportunity to identify how the performance of the Board or of Directors could be improved. (Policy BRD410)

Outside Advisors for Committees and Directors

[4] This practice is inconsistent and varies over time.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
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Occasionally, a committee or a Director may need the services of a consultant or an advisor to assist with matters involving their responsibilities. A committee or Director wishing to engage an outside advisor at the expense of Northern Health must first obtain the authorization of the Board Chair or the Chair of the Committee, normally in consultation with the CEO.

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CODE OF CONDUCT AND CONFLICT OF INTEREST GUIDELINES FOR DIRECTORS V1 **BRD 210**

Introduction

The Board of Directors of Northern Health (the "Board") is committed to developing and maintaining a reputation for Northern Health as an ethical organization.

The fundamental relationship between each Director and Northern Health must be one of trust; essential to trust is a commitment to honesty and integrity. Ethical conduct within this relationship imposes certain obligations.

1. Directors are expected to use their best efforts to ensure that consideration is given to legal and/or statutory components of any decision taken by the Board. If in doubt, Directors are expected to ask for clarification.
2. No Director shall commit or condone an unethical or illegal act or instruct another Director, employee, or supplier to do so.
3. Directors have a responsibility to have some familiarity with the regulatory regime in which Northern Health operates. They are expected to recognize potential liabilities and to know when to seek legal advice. If in doubt, Directors are expected to ask for clarification[1].

Northern Health is continually under public scrutiny. Therefore, Directors must not only comply fully with the law, but must also avoid any situation which could be perceived as improper or indicate a casual attitude towards compliance.

Conflicts Of Interest

1. In general, a conflict of interest[2] exists for Directors who use their positions on the Board to:
    a. Benefit themselves, friends, relatives[3], or business associates, or
    b. Benefit other corporations, societies[4], suppliers, unions or partnerships in which they have an interest or hold a position, or
    c. Benefit the interests of a person to whom the Director owes an obligation.

The above are hereafter collectively referred to as "Related Persons[5]".

[1] Throughout this policy, when Directors are requested to seek clarification or make a declaration, unless specific direction is otherwise given, Directors shall consult with either the Board Chair, the CEO, or the Corporate Secretary.
[2] *Conflict of interest* can be real or apparent; direct or indirect.
[3] *Relatives* generally means a spouse, child, parent or sibling of a Director and can include other relatives, direct or through marriage.
[4] Refer to *Schlenker v. Torgrimson 2013 BCCA 9*
[5] Not an exhaustive list, merely representative.

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2. A Director must not take personal advantage of an opportunity available to Northern Health unless the Board or management has clearly and irrevocably decided against pursuing the opportunity, and the opportunity is also available to other Directors or the public.
3. A Director must not use his or her position with Northern Health to solicit clients for the Director's business or Related Persons.
4. Every Director must avoid any situation in which there is, or may appear to be, potential conflict which could appear[6] to interfere with the Director's judgment in making decisions in Northern Health's best interest.
5. There are several situations that could give rise to a conflict of interest. The most common are accepting gifts, favours or kickbacks, or the passing on of confidential information and using privileged information inappropriately.

Disclosure

Northern Health requires full disclosure of all circumstances that could conceivably be construed as conflict of interest.

1. Full disclosure enables Directors to resolve unclear situations before any difficulty can arise.
2. At the beginning of each meeting of the Board, or of one of its Committees or Task Forces, there shall be a standing agenda item requiring each Director present to declare any conflict of interest he/she may have with any item of business on the agenda.
3. Outside of meetings, a Director must, immediately upon becoming aware of a potential conflict of interest situation, disclose the conflict in writing to the Board Chair. This requirement exists even if the Director does not become aware of the conflict until after a transaction is completed.
4. If a Director is in doubt whether a situation involves a conflict, the Director must immediately seek the advice of the Board Chair or the Chair of the Governance and Management Relations Committee (GMR). It may also be appropriate to seek legal advice.
5. Unless a Director is otherwise directed by the Board Chair, a Director must immediately take steps to resolve the conflict or remove the suspicion that it exists.
6. If a Director is concerned that another Director is in a conflict of interest situation, the Director must immediately bring his or her concern to the other Director's attention and request that the conflict be declared. If the other Director refuses to declare the conflict, the Director must immediately bring his or her concern to

[6] *Apparent conflict of interest* means any situation where it would appear to a reasonable person that the Director is in a conflict of interest situation.

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the attention of the Board Chair. If there is a concern with the Board Chair, the issue should be referred to the Chair of GMR.

7. A Director is required to disclose the nature and extent of any conflict at the first meeting of the Board after which the facts leading to the conflict have come to that Director's attention. After disclosing the conflict, the Director:
   a. must not take part in the discussion of the matter or vote on any questions in respect of the matter. However, the Director may be counted in the quorum present at the Board meeting.
   b. may, if the meeting is open to the public, remain in the room, but shall not take part in that portion of the meeting during which the matter giving rise to the conflict is under discussion, and shall leave the room prior to any vote on the matter giving rise to the conflict.
   c. must, if the meeting is not open to the public, immediately leave the meeting and not return until all discussion and voting with respect to the matter giving rise to the conflict is completed.
   d. must not attempt, in any way or at any time, to influence the discussion or the voting of the Board on any question relating to the matter giving rise to the conflict.

Outside Business Interests

1. Directors must declare possible conflicting outside business activities at the time of appointment. Notwithstanding any outside activities, Directors are required to act in the best interest of Northern Health.
2. No Director may hold a significant financial interest, either directly or through a Related Person, or hold or accept a position as an officer or Director in an organization in a relationship with Northern Health, where by virtue of his or her position on the Board, the Director could in any way benefit the other organization by influencing the purchasing, selling or other decisions of Northern Health, unless that interest has been fully disclosed in writing to the Board Chair. A “significant financial interest” in this context is any interest substantial enough that decisions of Northern Health could result in a personal gain for the Director.
3. These restrictions apply equally to interests in companies that may compete with Northern Health in any of its areas of activity.

Confidential Information

1. Confidential information includes personal, proprietary, technical, business, financial, legal, or Director information, which the Board or management treats as confidential.
2. Directors may not disclose such information to any outside person unless authorized.

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3. Similarly, Directors may never disclose or use confidential information gained by virtue of their association with Northern Health for personal gain, or to benefit Related Persons.

Directors are advised to seek guidance from the Board Chair or the President & Chief Executive Officer (the "CEO") with respect to what is considered confidential.

Investment Activity

Directors may not, either directly or through Related Persons, acquire or dispose of any interest, including publicly traded shares, in any company while having undisclosed confidential information obtained in the course of work on the Board, which could reasonably affect the value of such securities.

Outside Employment or Association

A Director, who accepts a position with any organization that could lead to a conflict of interest or situation prejudicial to Northern Health's interests, shall discuss the implications of accepting such a position with the Board Chair, recognizing that acceptance of such a position may require the Director's resignation from the Board.

Public Office

1. No one who holds public elected office[7] is eligible to be a Director of Northern Health.
2. A Director may run for public office while a member of the Board, and shall while campaigning:
    a. Take a paid leave of absence from the Board, or
    b. Attend Board and Board Committee meetings with the proviso that:
        i. At the start of each meeting the Director's candidacy for elected office is declared and minuted, and
        ii. The Director excuses[8] themselves from any discussion/vote that could be viewed as partisan, and
    c. Not speak on behalf of Northern Health, and
    d. Not refer to their work on the Board other than a factual declaration of Board membership in their biography.
3. If elected, the Director must resign immediately.

[7] Public elected office includes: Municipal Council, Band Council, School Board, Regional District/Regional Hospital District, Member of the Legislative Assembly of BC, Member of Parliament.

[8] When a Director excuses themselves from discussion in an in camera meeting they shall leave the room. The Director may remain in the room if during the public session. The minutes of the meeting shall note the Director's actions to excuse themselves from discussion.

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Entertainment, Gifts and Favours

1. It is essential to efficient business practices that all those who associate with Northern Health, as suppliers, contractors or Directors, have access to Northern Health on equal terms.
2. Directors and Related Persons shall not accept entertainment, gifts or favours that create or appear to create a favoured position for doing business with Northern Health. Any firm offering such inducement shall be asked to cease doing so. A sustained business relationship will be conditional on compliance with this code.
3. Similarly, no Director may offer or solicit gifts or favours in order to secure preferential treatment for themselves, Related Persons or Northern Health.
4. Under no circumstances may Directors offer or receive cash, preferred loans, securities, or secret commissions in exchange for preferential treatment. Any Director experiencing or witnessing such an offer must report the incident to the Board Chair immediately.
5. Inappropriate gifts received by a Director shall be returned to the donor and will be accompanied by a copy of this code with full and immediate disclosure to the Board Chair.

Use of the Authority's Property

1. A Director requires Northern Health's approval to use property owned by Northern Health for personal purposes, or to purchase property from Northern Health unless the purchase is made through the usual channels also available to the public.
2. Even then, a Director must not purchase property owned by Northern Health if that Director is involved in an official capacity in some aspect of the sale or purchase.
3. Directors may be entrusted with the care, management and cost-effective use of Northern Health's property and shall not make significant use of these resources for their own personal benefit or purposes. Clarification on this issue should be sought from the Board Chair.
4. Directors shall ensure all Northern Health property which may be assigned to them is maintained in good condition and shall be able to account for such property.
5. Directors may not dispose of Northern Health property except in accordance with the guidelines established by Northern Health.

Responsibility

1. Each Director must adhere to the standards described in this Code of Conduct, and to the standards set out in applicable policies, guidelines or legislation.
2. Integrity, honesty, and trust are essential elements of Northern Health's success. Any Director who knows or suspects a breach of this Code of Conduct and Conflict of Interest Guidelines has a responsibility to report it to the Board Chair.

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3. To demonstrate determination and commitment, Northern Health requires each Director to review and sign the Code annually. The willingness and ability to sign the Code is a requirement of all Directors.

Breach of Code

A Director found to have breached his/her duty by violating the Code of Conduct will be liable to Board censure or a recommendation for dismissal to the Government.

Where to Seek Clarification

The Board Chair or the Chair of GMR will provide guidance on any item in this Code of Conduct and Conflict of Interest Guidelines. The Board Chair may at his/her discretion, or at the request of a Director, seek the advice of outside legal counsel.

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DIRECTOR DECLARATION FORM

I ACKNOWLEDGE that I have read, considered and understood the *Code of Conduct and Conflict of Interest Guidelines for Directors* of Northern Health (BRD210).

A perceived direct or indirect conflict with my duty as a Director of Northern Health may arise because:

a. I hold the following offices or sit on the following Boards (appointed or elected):

☐ None

_____

_____

_____

_____

b. I receive financial remuneration (either for services performed by me, as an owner or part owner, Trustee, Director, employee or otherwise) from the following sources:

☐ None

_____

_____

_____

_____

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Do you have relationships or interests with any of Northern Health's vendors as listed in the annual Statement of Financial Information (SOFI)?

☐ Yes ☐ No

Describe:

_____

_____

_____

_____

Other than disclosed above, do you have any relationships or interests that could compromise, either directly or indirectly, or be perceived to compromise, your ability to exercise judgement with a view to the best interests of Northern Health?

☐ Yes ☐ No

Describe:

_____

_____

_____

_____

I agree to conduct myself in accordance with the Code of Conduct and affirm, to the best of my knowledge, that I have no undeclared Conflict of Interest.

_____
Signature

_____ _____
Print Name Date

_____ _____
Corporate Secretary Date

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COMMUNICATION POLICIES V2 **BRD 220**

This document includes all Board policies that relate to communication:

1. Board Internal Communications
2. Media Relations Protocol
3. Board Meetings

1. BOARD INTERNAL COMMUNICATIONS POLICY

This policy provides a procedure for the Board of Directors of Northern Health (the "Board") to follow regarding communication of information to its members.

Communication to the Board will occur according to the following process:

Critical or Politically Sensitive Information

Information of this type is outside the bounds of normal Northern Health operations. Some of these items will be 'crisis-oriented' while others will generally be non-recurring in nature. This information will be communicated to Directors on an urgent basis:

a. Matters relating to the President & Chief Executive Officer (the "CEO") position that affect the entire region's operations (e.g. appointment, resignation)
b. Major service delivery crisis (e.g. service disruption, adverse event)
c. Matters relating to Directors (appointment, resignation)
d. Other issues deemed extraordinary by the Board Chair

On-going Major Regional Operations Issues Information

Information that updates Directors on Northern Health's major operational issues will be communicated, on an on-going basis, according to a structure and time frame of reporting agreed to by the Board in consultation with the staff.

Duties and Responsibilities

Other than information relating to the CEO position, which will be communicated by the Board Chair or designate if the Chair is absent, it is the CEO's responsibility to ensure that information is communicated to Directors in a timely manner.

Directors are requested and encouraged to bring to the attention of the Chair, CEO, and Director of Communications issues of concern in a community about which they may have information.

Monitoring

The Governance and Management Relations Committee ("GMR" or "the Committee") will monitor the implementation and effectiveness of this policy, and make recommendations to the Board for amendment as deemed necessary.

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2. MEDIA RELATIONS PROTOCOL

The media relations protocol governs how Board decisions are communicated to the public. It is comprised of two sections:

a. Guiding Principles for Directors
b. Communication Roles and Responsibilities – Board Chair, Directors, CEO, Communications Staff

Guiding Principles for Directors (See BRD 140)

a. Directors shall represent the best interests of the entire region, not just their home community.
b. Once the Northern Health Board makes a decision, it is the responsibility of the Directors to abide by and support that decision in all subsequent communication.

Communications Roles and Responsibilities

Board Chair:

The Board Chair is the primary spokesperson for the Board (BRD 120). It is appropriate for the Board Chair to speak on matters such as: governance issues (Board decisions, appointments/departures of Directors); CEO issues (recruitment); and political issues (reactions to government decisions, budgets, elections, appointments of Health Ministers). The Board Chair may also speak on behalf of the CEO if the CEO is unavailable. If the Board Chair is unavailable, the CEO may speak on the Chair's behalf; the Vice-Chair or an alternate Board member can also be designated (BRD 130 & 150).

Directors:

While the Board Chair is the primary spokesperson for the Board, individual members of the Board may be called upon to speak on behalf of the Board in instances where the Board Chair is not available (e.g. at Northern Health events that feature the opening of a new facility) – BRD 140. On such occasions, it is appropriate for the Director present to speak on behalf of the Board according to the following general guidelines:

a. Always keep comments at a strategic level and where possible, use the opportunity to demonstrate alignment with Northern Health's mission, vision and values
b. Abide by the guiding principles as stated above
c. Defer operational questions to the CEO or designate

When the need for a Director to speak is anticipated, Communications staff will provide support as required

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CEO:

The CEO is the primary spokesperson for operational matters of Northern Health. This covers areas such as facility or service changes, staffing issues, crisis communication, labour action, Northern Health financial and management issues. The CEO may appoint a designate from the executive or senior management to speak on specific facility or program issues (BRD 130).

Communications Staff:

The Communications Department is the main contact point for media, and has primary authority to issue press releases on behalf of Northern Health. All media calls should be directed to the Communications Department to help ensure a timely response. Using this protocol as a guide, it is the responsibility of the Communications Department to direct the call to the appropriate spokesperson. Working in cooperation with the Communications Department, Northern Health staff shall endeavour to respond to media inquiries promptly.

If required, the Communications Department can also prepare support material such as key messages to be used by spokespeople in responding to specific issues.

3. BOARD MEETINGS POLICY

The purpose at all Board meetings, whether public or in-camera, is to conduct the business of the Board. See BRD 600.

The Board is scheduled to meet six times a year. The frequency of meetings may be changed at any time at the discretion of the Board.

The schedule of Board Meetings will be available on the Northern Health website.

Every scheduled meeting of the Board will, unless the Board otherwise determines, be a combination of an "open" session and an "in camera" session. Meetings will include consideration for Regional Hospital District engagement as well as community round-table sessions.

Where the Board has determined that all agenda items for a particular meeting are to be addressed in camera there will be no open session of the Board meeting.

Business conducted within Committees of the Board will not be open to the public (BRD 300).

Board Meeting Locations

In each calendar year the Board will normally schedule three meetings outside of Prince George - one meeting within each of the three Health Service Delivery Areas.

Due to the logistical issues of travel, accommodations, and appropriate meeting space, the Board will not normally hold its regular meetings in communities with a population under 4,000. Communities where the Board could hold its meetings include:

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- Fort St. John
- Dawson Creek
- Fort Nelson
- Prince George
- Quesnel
- Vanderhoof
- Smithers
- Terrace
- Prince Rupert
- Kitimat

For exceptional issues, the Board may consider meeting in an individual community other than those listed above.

Each Board meeting held outside of Prince George will be planned with emphasis on the opportunity for Board networking with community leaders. This will include extending an invitation to community leaders in the surrounding communities

In-Camera Board Meeting

In order to protect the personal privacy of individuals, the business interests of individuals and companies, or the public interest, some items of business will not be addressed during the open Board session and will be addressed in an in-camera session of the Board. The Board will determine the items of business that will be conducted in-camera. The Board, in exercising its discretion to address certain items of business in camera, will use the Freedom of Information and Protection of Privacy Act (FIPPA) and the Evidence Act as guides. Similarly, communication of decisions taken by the Board in in-camera meetings will follow these statutes, but may be expanded to include explanatory or background material related to the decisions. (Policy BRD 600)

In preparing the agenda, the GMR Committee will recommend the items of business that should be addressed in camera. The recommendations of the GMR Committee will be circulated to the Directors approximately one week prior to the scheduled meeting. Any Directors who do not endorse the GMR Committee's recommendations will notify the Executive Assistant to the Board within three days of receipt of the proposed agenda for the consideration of the Board Chair in finalizing the Board meeting agenda.

At the beginning of the meeting the Board will, in-camera, pass a motion approving the in-camera agenda.

Open Board Meetings

Open Board sessions are meetings of the Board conducted in public at which the public may attend and observe the meeting. In addition to attendance in person at meetings, members of the public may also attend Board meetings at a distance according to the provisions outlined in Schedule A.

Any person wishing to attend open meetings of the Board is entitled to do so and is welcomed by the Board. Because of space limitations seating is available at the meeting on a first come first served basis, and to comply with fire and other regulations attendance may be restricted to a maximum number.

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The agenda for the open session of the Board meeting will be available to the public on the Northern Health website seven (7) days in advance of the meeting. The full open session meeting package is posted on the Northern Health website the day of the meeting.

Open Board Meeting Procedures

The meeting will be held in accordance with the by-laws of Northern Health (BRD 600) and Roberts Rules of Order (BRD 200).

Participation in the discussion of the Board, except as noted above, is limited to Directors, the CEO, and other management personnel or third parties who may be present at the invitation of the Board.

The Board vests in its Chair or presiding officer the authority to adjourn the meeting prior to the conclusion of Board business if, in the opinion of the Chair, reasonable decorum is not being observed.

The Board vests in its Chair or presiding officer authority to end discussion during the public meeting on any public meeting agenda item and refer the matter to the Board's in-camera meeting if in the opinion of the Chair the discussion is likely to breach the personal privacy of individuals, the business interests of individuals or companies, or the public interest as reflected in previous Board decisions for public or in-camera discussion (BRD 200).

Public Presentations

The Board wishes to consult with the public on the provision of health services. To do this, provision will be made for structured consultations within Health Services Delivery Areas, meetings with Regional Hospital Districts and representatives of municipal government, and through the provision of information on the delivery of health services. In addition to these means, the Board will provide time for public presentations within the agenda of its open meetings. While the Board seeks public consultation on health issues for communities, individuals with very specific concerns may be encouraged to contact Northern Health managers directly in the interest of a timely response.

The Board will schedule opportunities for the public to make presentations to the Board at each meeting. Time for these presentations will be scheduled at the will of the Board before, after or during the Board's regular meeting.

Requests to Address the Board

Persons or groups wishing to make presentations to the Board must submit their request in writing to the Executive Assistant to the Board via a "Request to Address the Board" form indicating the name of the presenter, the group/delegation they represent, the topic, and a brief summary of the presentation.

Instructions shall be posted on the Northern Health website.

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The request and all supporting material must be received at least ten (10) business days in advance of the date of the meeting.

Given the limited number of presentations that the Board is able to hear, individuals or groups who have made presentations to the Board on a similar or related subject within the past year will be given lower priority than individuals or groups who have not yet had the opportunity to present to the Board.

The Chair may decline to hear any presentation, but will report the request for the presentation to the Board at its next meeting.

The Chair may permit an individual or delegation to make a presentation where the individual or delegation has not complied with the requirements of this policy.

Public Presentation Procedures

The time allotted for each presentation is ten (10) minutes. The Chair may extend this time limit if the Board decides that an extension of time is necessary in order to permit the delegation to give a complete outline of its position.

The total time for all public presentations at a particular meeting will be limited to 45 minutes, including time for questions by the Board.

Presenters must be recognized by the Chair and must preface their presentation by an announcement of their name, address and group affiliation.

The Executive Assistant to the Board will advise all parties indicating an interest in making a presentation to the Board that presentations are heard in public meetings and that media, including TV cameras may be present.

The Chair will advise presenters that the Board is there to listen rather than to debate issues.

Questioning will be limited to Directors initially and should be restricted to obtaining clarification of the presentation. After Directors' questions have been dealt with, members of the Northern Health Executive are welcome to ask further clarification questions.

In those instances where errors of fact are presented it may be appropriate for these to be courteously corrected by the Board for the benefit of everyone in attendance.

When presenters voice severe personal problems, it is appropriate for the Chair and CEO to be empathetic. Although presenters may describe important deficiencies in the services provided by Northern Health or the conduct of its affairs, Directors will not respond beyond acknowledging the issue until they have had an opportunity to review background information from staff or review the results of any investigation of the concern raised.

The following considerations will guide the decision to grant a request to make a public presentation to the Northern Health Board:

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1. The Board is the most appropriate audience for the topic and the presenter's intention is to address the Board rather than attempting to reach a broader audience with their issues through the Board public meeting.
2. Northern Health employees generally do not make presentations to the Board during the public presentations portion of the meeting unless requested to do so.
3. Physicians who wish to make a presentation to the Board will be asked to discuss their presentation topic with Medical Administration prior to requesting an opportunity to address the Board. If a discussion with Medical Administration has not occurred, the physician's presentation will not likely be approved to come forward as a public presentation to the Board. If a discussion has occurred, Medical Administration's advice will be sought regarding whether the presentation is appropriate for a public forum or if a different arrangement needs to be made.

The Board Chair has the authority to terminate the presentation of an individual or group that does not adhere to the rules established.

The Board recognizes the great interest and commitment of many citizens to health and health services and recognizes that many different perspectives exist.

The Board Chair has the authority to maintain reasonable decorum at all meetings to enable differing views to be expressed and has the authority to request any individual who chooses not to observe reasonable decorum to leave the meeting.

Follow up to any presentations made to the Board will include:

1. The Board will review the presentations received, and will identify the key issues requiring further follow up by staff.
2. Staff will review the issues identified and provide the Board with the necessary background information.
3. If and when the Board deems it necessary, a full written response will be provided after the Board has obtained further information from staff.
4. Where a proper review of a situation by Staff will take more than two (2) weeks, a letter will be sent thanking the presenter and advising that further information is being sought before responding.
5. A copy of the responses sent to the presenters will be included in the subsequent Board meeting information package.

Regional Hospital District engagement

The Board will provide an opportunity to meet separately with each Regional Hospital District Board on an annual basis. This meeting will normally be arranged when a Board meeting is held within or near the geographic jurisdiction of that Regional Hospital District.

The purpose of this meeting is to offer Regional Hospital Districts an opportunity to directly discuss health issues with the Board.

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Meetings with a Regional Hospital District Board will normally be one hour in length. Format and duration may be changed at the discretion of the Chair.

Northern Health will ask an invited Regional Hospital District to provide topics of discussion in advance of a meeting. This will provide the Board and staff an opportunity to prepare background material to inform discussions.

The Board's meeting with Regional Hospital Districts will be considered closed to media and the public.

Community round table session

The Board ~~will~~ may invite community representatives to a round-table session, particularly when Board meetings are conducted outside of Prince George.

This meeting ~~will~~may:

1. Offer community partners an update on Northern Health services and initiatives in a given community and Health Service Delivery Area; and
2. Provide an opportunity for partners to ask questions with reference to local health issues.

Community partners ~~will~~ may include members of the Legislative Assembly of British Columbia, local government and Regional Hospital District representatives, local First Nations representatives, local health advocates, Chambers of Commerce, and other representatives as the Board deems appropriate.

Round table sessions will generally consist of a presentation by Northern Health followed by group table discussions focusing on topics relevant to the Health Service Delivery Area where the Board meeting is taking place. The table discussions ~~will~~ may be facilitated by a senior executive member and ~~will~~ may include at least one Board member at each table. This discussion will provide participants an opportunity to provide input and feedback to Northern Health.

The community round table session will be approximately 90 minutes in length and light refreshments will be provided to attendees. Format and duration may be changed at the discretion of the Chair.

The Board's community round table will be an invitation-only session. It will be considered closed to media. It is expected that participants will attend the session in the capacity in which they were invited rather than in other roles they may hold within the community.

Media availability

As a significant employer and service provider in northern British Columbia, Northern Health's Board meetings are of particular interest to media outlets.

The Board Chair and CEO will provide reporters attending Board meetings with media availability through a press conference at a scheduled time during the day of the open Board meeting. This media availability will usually occur after the public presentations portion of the meeting and will provide reporters with an opportunity to receive

updates from the Board and ask relevant questions. If facilities permit, the press conference will also include teleconferencing availability for out of town media.

The Communications Department will develop a news release following regular Board meetings with the approval of the Board Chair. As per the direction of the Board Chair, the Communications Department will also assist in arranging contact with regional media unable to attend a regular Board meeting following the meeting.

SCHEDULE A: Distance Access to Northern Health Board Meetings

Northern Health is committed to providing region-wide public access to the Open and Public Presentation sessions of Board meetings.

The provision of distance access to Board meetings will be subject to limitations based on budget and technology infrastructure available in the Northern Health region.

Northern Health and the citizens of the Northern Health region will share in the responsibility of setting up this access efficiently and effectively. Access will be set up on an as-requested basis only.

Telecommunications Access to Northern Health Board Meetings

Using telecommunications technology, Northern Health will provide region-wide public access to the Open Board and Public Presentation sessions of Northern Health Board meetings if and as able depending on availability of the required technology.

a. This access will be provided in response to requests from the public for access.
b. The maximum number of sites that will be connected at any one Board meeting will be a total of three, by video-conference, telephone conference, or a combination of both. This number may be modified at the discretion of the Chair of the Board.
c. Northern Health will inform key stakeholders region-wide of the opportunity to attend the Open and Public Presentation sessions.
d. Northern Health will consider use of third-party video-conferencing capabilities if required but will not be responsible for addressing any compatibility issues impeding the use of third party equipment.

The Board Chair or designate will have the discretion to decide on the applicability of telecommunications access requests.

All by-laws, regulations, and standards of decorum for the Northern Health Board meetings will apply to remote locations linked by telecommunications equipment.

Procedure for Telecommunications Connection

Members of the public who are unable to attend a Northern Health Open Board and/or Public Presentation Session but would like to participate via telecommunications technology may request a link that is most appropriate to their location. Requests for telecommunication links must be forwarded to the Executive Assistant of the Board not less than fourteen (14) days prior to the meeting date.

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a. Placing a request for a presentation via telecommunications link does not guarantee placement on the Public Presentation Session agenda.
b. Presenters will be informed of their position on the agenda as well as the logistics of their telecommunications link no later than five (5) days in advance of the Board meeting.

In the event of technical issues disrupting a telecommunications link, Northern Health will attempt to correct the problem immediately. If a solution cannot be identified, and the telecommunications glitch interrupts the delivery of a presentation, Northern Health will offer a suitable time for the presentation to be delivered at a future Board meeting.

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EXECUTIVE LIMITATIONS V2 **BRD 230**

Purpose and Scope

1. This policy enables the Board of Directors of Northern Health (the "Board") to:
   a. Delegate signing authority to the President and Chief Executive Officer (the "CEO") for the approval of financial transactions within Board approved criteria
   b. Require internal controls to provide assurance that financial transactions are in compliance with Board approved policies and procedures

2. This policy applies to the financial signing authority of the Board and CEO of Northern Health ("NH")

3. This Policy should be read in conjunction with the Terms of Reference for the President and Chief Executive Officer (BRD 130)

Policy Principles

1. The Board has the general and overriding power to enter into all financial transactions that are binding for NH
2. The CEO shall not knowingly cause or allow any organizational practice to occur, which violates legislation, commonly accepted business standards, or professional ethics, and shall only consider formal business relationships[1] that are in the best interest of NH as an independent organization
3. The restrictions to spending authority for the CEO and other personnel who have been delegated authority and responsibility is outlined in Appendix 1
4. The Board may authorize the CEO to approve financial commitments or obligations that are not normally within the authority of the CEO
5. The intentional unbundling of items to reduce the spending threshold is not permitted
6. Financial transactions spread over more than one year shall be valued based on the total contractual commitment for the duration of the contract or commitment
7. Prior to approval, the CEO shall bring to the attention of the Board any financial transactions within the CEO's authority, regardless of value, that have a high risk factor, involve any controversial matter, or that may bring the activities of NH under public scrutiny

[1] Such as a Service Level Agreement or Memorandum of Understanding or any other formal agreement that may indicate an expression of willingness and intent to cooperate for mutually beneficial purposes.

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8. The CEO is not authorized to approve financial transactions where the CEO has a conflict of interest or where there are reasonable grounds to believe that there may be or may be seen to be a potential conflict of interest. The CEO must not approve a transaction that might confer a personal benefit. This includes expenditures such as all expense reimbursement claims, conference fees, educational expenses, travel expenses, advances, membership fees, items that could be used personally, and items that are intended to be located within an individual's home.
9. The CFO, or the CFO's delegate, is authorized to approve financial transactions related to regulatory payments, utilities and payroll deductions without limit
10. The CFO will maintain a listing of all financial transactions greater than $1 million and will report annually to the Audit and Finance Committee of the Board

Designations

The CEO may designate limits of spending authority to the CFO, Chief Operating Officers, Vice Presidents, and other senior management staff with specific areas of responsibility. A Signing Authority Policy[2] outlining any such designated spending authorities will be maintained.

[2] DST 4-4-02-030-P
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APPENDIX 1

Restrictions of Authority

The CEO and any other personnel to whom authority and responsibility has been delegated, are restricted as to signing authority for the following[3]:

1. Borrowing
   1.1. Subject to approval by the Minister of Health, the Board ~~will~~ must authorize any borrowing of funds on behalf of NH

2. Real Property
   2.1. Subject to approval by the Ministry of Health, the Board ~~will~~ must authorize any purchase of real property and/or the mortgage, sale, transfer or change to the use of real property owned or administered by NH

3. Capital Assets
   3.1. Capital assets identified in the Board approved Capital Plan may be purchased

   3.2. Where urgent, to maintain operational services, the CEO may authorize additional capital asset purchases up to a unit cost of $500,000.

      3.2.1. The CEO may consult with the Board Chair and if not available the Board Vice-Chair or Chair of the Audit and Finance Committee before proceeding with approval

      3.2.2. The CEO will report all such purchases, identify the source of funds, and provide the rationale for the purchases to the Audit & Finance Committee or the full Board at its next meeting, whichever comes first

   3.3. Where urgent, to maintain operational services, the Board Chair and Chair of the Audit and Finance Committee may authorize the CEO to approve additional capital asset purchases with a unit cost of $500,000 to $2 million. The CEO will report all such purchases to the full Board at its next meeting.

   3.4. Subject to approval by the Minister of Health, capital leases for equipment used directly in the provision of health services (e.g. CT scanner) will be authorized by the Board. Capital Leases for non-patient care (e.g. photocopiers) do not require Minister of Health approval, but must be included in the Board approved Capital Plan for purchase to occur.

[3] The terms of the *Health Authority Act* and the Health Authority Financial Management Policy Guidelines are considered part of this policy

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4. Operating Expenditures

4.1. Routine operating expenditures within the Board approved Operating Budget may be authorized by the CEO or as designated in the Signing Authority Policy (DST 4-4-02-030-P)

4.2. The CEO is authorized to sign financial transactions subject to:

4.2.1. The financial transaction not exceeding $10 million;
4.2.2. The financial transaction is within Board approved operating budget; and
4.2.3. Compliance with any other applicable policies, procedures or instructions issued by the Board

4.3 Financial transactions in excess of $1 million that are not within the Board approved operating budget must be approved by the Board

4.4 In exceptional circumstances, financial transactions between $1 million and $10 million that are not within the Board approved operating budget but require urgent approval must be:

4.4.1 Reviewed, prior to approval, by the Chief Financial Officer (the "CFO");
4.4.2 Approved by the CEO.
a) The CEO ~~may~~ must consult with the Board Chair and if not available the Vice-Chair or Chair of the Audit and Finance Committee before proceeding with approval; or
b) In the absence of the CEO, approved jointly by the Acting CEO and the CFO. The Acting CEO and CFO must consult with the Board Chair and if not available the Board Vice-Chair or Chair of the Audit and Finance Committee before proceeding with approval.
4.4.3 And in both instances reported to the Audit & Finance Committee or the full Board at its next scheduled meeting, whichever comes first

4.5 Operating leases in excess of $250,000 annually must be authorized by the Board

4.6 Encumbrances on an individual Northern Health real property cumulatively in excess of $250,000 must be authorized by the Board

5 Compensation and Benefit Programs

5.1 The Board reserves the authority to approve:
5.1.1 The CEO's compensation

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5.1.2 The annual compensation plan for non-contract staff and new benefits programs or material changes to existing programs for non-contract staff

5.2 The CEO:

5.2.1 Shall provide to the Board for approval an annual compensation plan that ensures that compensation and benefits for non-contract staff are consistent with HEABC compensation plans

5.2.2 Shall provide to the Board an annual review to ensure compensation and benefits for non-contract staff are consistent with HEABC compensation plans for the skills employed

5.2.3 Shall not promise or imply lifelong employment to anyone

5.2.4 Shall not change his/her own compensation or benefits

6 Collective Agreements

6.1 Only the Board ~~must~~ has the authority to ratify ~~all~~ collective agreements.

7 Banking

7.1 The Board approves the appointment of the banking institution/s and the appointment of the signing officers for banking purposes[4]

8 External Auditor

8.1 The Board will appoint the external auditor

9 Non-Audit Services

9.1 The Board reserves the authority to approve all non-audit services to be undertaken by the external auditor (BRD 315)

10 Shared Services

10.1 The Board will authorize all shared services agreements

10.2 Agreements for shared services shall:

10.2.1 Work to balance the interests of NH with the interests of the overall health care system in British Columbia

10.2.2 Provide mutually beneficial opportunities to accomplish the goals set forth by each organization

10.2.3 Remain in effect until terminated in accordance with the terms of the agreement

[4] See Administration Policy [currently under development]
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10.3 The CEO shall put processes in place to ensure that:

10.3.1 The appropriate Memoranda of Understanding, Service Level Agreements and/or other documentation are in place that provide clarity regarding how business will be conducted between the shared services providers and NH

10.3.2 The agreements established with the shared services providers are in alignment with NH's mission, vision and values and Strategic Plan

10.3.3 The agreements established with the shared services providers are in compliance with NH's administrative and financial policies

10.3.4 The shared services providers understand how they will relate to NH's governance and management structure

10.3.5 Harmonious working relationships are maintained with shared services providers and effective problem solving and conflict resolution processes are in place to ensure continuity of operations

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FACILITY AND FUND NAMING POLICY V1 BRENDA & MARK REVIEWED-NO CHANGE BRD 240

POLICY

Northern Health may recognize outstanding and significant contributions to Northern Health, or Foundations and Auxiliaries affiliated with Northern Health, by naming or attaching the name of a person, company, society or other organization to a particular asset.

The purpose of this policy is to establish criteria for naming assets, an approval process, and the general terms and conditions surrounding naming opportunities. This policy must be used in accordance with the Government of British Columbia's Naming Privileges Policy (Appendix 2).

DEFINITIONS

Approving Agent: person(s) within Northern Health with the delegated level of authority to approve a naming request recommendation (see the Approval by Asset section)

Significant Contribution: may include a gift from a donor (financial or in-kind), sponsorship, or a distinctive achievement in furthering the mission and goals of Northern Health.

PROCEDURE TABLE OF CONTENTS PAGE

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PROCEDURE

Quick Overview

A typical naming request will flow through the following steps, unless otherwise specified:

a. Naming request initiated using NH Nomination Application Form (Appendix 1); completed Application Form forwarded to the appropriate Chief Operating Officer (COO) – 'Executive Sponsor' – see Initial Request - Executive Sponsor.
b. COO forwards NH Nomination Application Form to the Chief Financial Officer (CFO) who is the Office of Record for naming requests.
c. The Chief Financial Officer consults with the President & Chief Executive Officer (CEO) for appropriateness of the nomination and to designate a Naming Committee Chair.
d. If the nomination is deemed eligible to proceed, the Naming Committee is convened (deliberation and recommendation) (Class I – IV) – see Naming Committee Terms of Reference Section
e. Naming Committee forwards recommendation to CEO for review (Class I – III) – see the Approval by Asset Section
f. CEO forwards recommendation to Northern Health's Governance and Management Relations Committee (GMR) for review (Class I – II) – see the Approval by Asset Section
g. GMR Committee forwards recommendation to Board for decision (Class I – II) – see the Approval by Asset Section
h. Board-approved Class I & II naming requests forwarded to the appropriate provincial government Ministry for further approval – See Government Approval section

Initial Request - Executive Sponsor

Initial naming proposals will be directed to the COO of the Health Service Delivery Area (HSDA) in which the applicable asset resides using the NH Nomination Application Form (Appendix 1.)

Process to Initiate/Respond to Request

Unless otherwise specified, all naming proposals must be submitted by an Executive Sponsor to the CFO. To avoid conflict and duplication of effort, Executive Sponsors will inform the CFO, at the earliest opportunity, of any material discussions for a naming opportunity.

If a naming request application clearly does not meet the criteria set out in this policy, the CFO, in consultation with the Executive Sponsor and the CEO, will have the authority to notify the applicant accordingly.

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Naming Committee – Terms of Reference

The naming of health care assets is a sensitive matter. Accordingly, Northern Health will establish a Naming Committee to evaluate naming requests and make recommendations for approval or denial. The Naming Committee will respond to all submissions on a timely basis. The CFO will serve as Office of Record and will formally document and maintain a register of the disposition of all naming requests received by Northern Health.

Standing members of the Naming Committee are:

- Vice President, Financial & Corporate Services/CFO
- Vice President, Human Resources
- COO of applicable HSDA in which asset resides
- Regional Director, Capital Planning and Support Services
- Director, Business Development
- Director, Communications
- Ad hoc members will be appointed to the Naming Committee as set out under the Approval by Asset Section of this policy.

Naming Committee Chair:

- The Chair will usually be selected from among the standing members or as otherwise appointed by the CEO.

The Naming Committee will have the following specific duties and obligations:

a. Assess naming opportunities submitted to the Naming Committee;
b. Make recommendations with respect to pricing, term and any other material conditions that should be tied to the naming right, using the guidelines set out in this policy. For proposals with no financial or in-kind consideration attached, the Naming Committee will determine whether the applicable asset has a high potential for donation and if the naming right to the asset should therefore be reserved for financial or in-kind donor recognition. In this situation, the Naming Committee will recommend to the CEO that the proposal be declined and the CEO will respond accordingly.
c. Ensure consultation takes place with the individuals (NH staff/physicians) most closely associated with the applicable asset. The Naming Committee may wish to include the site manager (or most senior level manager responsible for the applicable asset/program) in the evaluation/approval process.
d. Notify the approving agent (as identified in the Approval by Asset Section) of any reason for deviating from the guidelines set out in this policy respecting pricing and/or term.
e. Endeavour, to the extent reasonably practicable, to balance its responsibility to maintain transparent processes and provide full disclosure to the public, with its responsibility to maintain confidentiality regarding third party interests.
f. Reach agreement, and recommend approval or denial of a naming right to the appropriate approving agent.

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Based on the outcome of the Naming Committee's recommendation, the approving agent will follow the process further described in the Approval by Asset Section.

Naming Opportunities by Asset(s)

(a) Classification

A naming opportunity refers to the official naming of a particular asset, position, or program. Naming opportunities are divided into six broad categories:

Class I: External Facilities (e.g. buildings, roads, parks)

Class II: Internal Facilities (e.g. floors, wings, laboratories)

Class III: Programs (e.g. clinical units, health/wellness programs), rooms, lounges

Class IV: Equipment

Class V: Research/Academic positions

Class VI: Tribute Markers (e.g. plaques, medallions and other markers usually associated with features such as trees, benches or small monuments)

(b) Pricing

The Naming Committee will assess the value of a naming right in accordance with current capital and operating costs of the applicable asset, and/or other factors pertinent to the asset.

(c) Term

The following guidelines will be used to assess the term to be associated with a naming right:

Class I: A defined period of time (normally not to exceed 35 years) or the life of the structure, whichever occurs first

Class II: A defined period of time (normally not to exceed 20 years) or the earlier of the life of the internal facility or the life of the building housing the internal facility, whichever occurs first

Class III: A defined period of time (normally not to exceed 10 years) or commensurate with funding support for the room, lounge or the length of the program, whichever occurs first

Class IV: The length of the equipment's useful life

Class V: A period of time commensurate with funding support

Class VI: Negotiable

Notwithstanding the guidelines set out above, naming opportunities supported through endowment funds may be named in perpetuity.

Exceptions to the above guidelines can be recommended in special circumstances by the GMR Committee for consideration.

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Evaluation Criteria (Applicable to all Naming Requests):

1. The naming of any asset must be compatible with NH's goals, mission, vision and values as articulated in NH's Strategic Plan.
2. No naming opportunity should be approved if it:
   a. Is likely to have a negative impact on the image or reputation of NH or any of its affiliated Foundations and Auxiliaries.
   b. Would call into serious question the public respect for NH or its affiliated Foundations and Auxiliaries.
   c. Is likely to be associated with an unhealthy lifestyle (e.g. alcohol or tobacco usage, obesity etc.)
   d. Implies endorsement of a partisan political, ideological or religious position. This does not preclude use of the name of an individual who has previously held public office.
   e. Implies endorsement of a specific commercial product. This does not preclude using the name of an individual or company that manufactures or distributes commercial products.
3. Naming associated with a particular facility or endowment will not preclude further naming within the facility, program or clinical area.
4. Naming opportunities supported by financial or in-kind gifts may be named after the donor or a third party at the request of the donor.
5. Except where the naming opportunity pertains to the recognition of distinguished service, donations must represent a significant portion of the cost of the facility or activity to be named and/or be critical for the completion of such facility or activity.
6. Where a naming request proposes to honour distinguished service of Board members, staff or physicians, it is recommended that at least three years has passed after the nominee has ended their service with Northern Health or an affiliated Foundation or Auxiliary.
7. Any revenue generated from a naming opportunity that is obtained through a capital campaign organized by a Foundation or Auxiliary affiliated with Northern Health or submitted to the Naming Committee by a Foundation or Auxiliary affiliated with Northern Health will be retained by such Foundation or Auxiliary and used in accordance with the donor's wishes. Final determination of any naming, however, remains with Northern Health. In all other cases, the Naming Committee will make a recommendation as to how revenue should be distributed (including, in the case of Northern Health, which department will receive all or any portion of the proceeds) provided that the donor's wishes will be honoured to the greatest extent possible.

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8. Publicity surrounding the naming of an asset will be handled by Northern Health's Communications Department in conjunction with provincial government, as necessary.
9. When naming recognition has been extended for a gift received, it will be honoured in accordance with the agreement that is made with the donor. In the event of a change in circumstances that would preclude honouring of the donor's wishes, NH reserves the right to determine the form of name recognition in consultation with the donor, or donor's agent, when possible.
10. Where a naming request proposes to honour an individual, it is recommended that the Naming Committee obtain some form of documentation verifying that the person being honoured is in agreement with the proposal, or by a legal representative should the individual be deceased.
11. When the proposed naming of an entire facility would recognize an individual, the complete name of the individual will be used. The surname of the individual so honoured may be used in referring informally to the facility and may be used on a name plaque affixed to the facility.

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Additional Criteria for Distinguished Service Nominations (Without Financial Consideration)

In addition to consideration of criteria set out in the Evaluation Criteria section, the Naming Committee shall use the following criteria to evaluate proposals in recognition of distinguished service:

1. A distinguished service nominee shall have made an extraordinary contribution in terms of a professional or public service nature over a considerable length of time. The contribution must be well documented and broadly acknowledged within the community in which the applicable asset resides. Specifically, the nominee will have achieved distinction in one or more of the following:
   a. While serving the organization in a professional capacity, the individual has demonstrated high professional distinction and/or has earned national or international recognition;
   b. While serving the organization in an important administrative capacity, the individual has rendered distinguished service which warrants recognition of the individual's exceptional contributions to the welfare of the organization; or
   c. The individual has contributed in truly exceptional ways to the welfare of the organization or community in which the applicable asset resides, or has achieved such distinction as to warrant recognition.
2. How the nominee's contribution relates to Northern Health's mission, vision, values and strategic plan.
3. How naming the asset in honour of the nominee will reflect the history, purpose and diversity of the organization.
4. Whether the contribution of the nominee is likely to be recognized two or three decades into the future.
5. The relationship of the applicable asset to the nominee.

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APPROVAL PROCESS

Approval by Asset

The following approval process will be used by Northern Health to all submissions on a timely basis.

Class I**:** External facilities (e.g. buildings, roads, parks), and

Class II: Internal facilities (e.g. floors, wings, laboratories)

Approving agent: Northern Health Board, upon recommendation of the CEO and GMR Committee.

The CEO will consult with, and receive the recommendation of, the Naming Committee prior to submitting a final recommendation to the GMR Committee and the Board. Before submitting a name for approval to the Board preliminary discussions should be held with the provincial government to ensure there will be no government barrier to approval.

The following ad hoc members will be added to the Naming Committee for Class I Naming Opportunities:

a) Health Services Administrator (HSA) for the community where the applicable external facility resides; and
b) Senior representative from the Foundation representing the community where the applicable external facility resides.

Class III: Programs, rooms, lounges

Approving agent: CEO, upon recommendation of the Naming Committee.

The following ad hoc members will be added to the Naming Committee for Class III Naming Opportunities:

a) If applicable, the manager responsible for the program itself or for the clinical area managing the program
b) If the program is site specific, the HSA for the site and a senior representative of the Foundation connected to the site

Class IV: Equipment

Approving agent: The COO responsible for site(s) or clinical area(s) where the equipment will be used, upon recommendation of the Naming Committee.

The following ad hoc members will be added to the Naming Committee for Class IV Naming Opportunities:

a) HSA for the site where the equipment will be used
b) If applicable, the manager responsible for the clinical area utilizing the equipment, and
c) A senior representative of the Foundation connected to the site where the equipment will be used

Class V: Research/Academic positions and

Class VI: Tribute Markers

Approving agent: The Naming Committee will delegate the naming of a tribute marker to the appropriate COO.

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ADDITIONAL PROVINCIAL GOVERNMENT APPROVAL (CLASS I AND II ASSETS)

Where the proposed naming of an entire facility, or significant portion thereof, is to receive Board approval, additional consultation with provincial government is required to ensure compliance with government policy. Refer to "Government of British Columbia Naming Privileges Policy" (Appendix 2.) In some cases, further approval from Cabinet may be required.

1. Prior to submitting recommendation for GMR and Board approval: For Class I and II assets, complete the "Naming Opportunity Request Form" appended to the Government of British Columbia Naming Privileges Policy and submit to the applicable government Ministry.
2. An additional step is required for Class I (entire facility) assets. Upon confirmation that the responsible government Ministry requires no further approval, further application must be made as follows:
    a) Hospital: This type of facility is designated under the *Hospital Act* by way of a Ministerial Order. Any change to an existing facility name requires the Ministry of Health to rescind the original designation and redesignate the facility with the new name.
    b) Residential Care Facility: This type of facility falls under the *Community Care & Assisted Living Act*. The facility is licensed by the Health Authority (therefore a Ministerial Order is not issued by government); the name of the facility is designated by way of the Health Authority's licensing process. As a courtesy, the Ministry of Health should be consulted during the naming process, prior to the facility being licensed.

Upon consultation with the appropriate provincial government bodies, proceed with GMR recommendation/Board approval process.

Process to Revoke Naming Right

A naming right may be revoked at any time by the applicable approving agent upon recommendation of the Naming Committee. Any recommendation put forward by the Naming Committee must provide the applicable approving agent with the following information:

a. Description of the naming right involved, including the value of the naming right and the name of the donor.
b. Reasons for recommending the revocation of the naming right.
c. Names of those members of the Naming Committee who do not support revocation of the naming right and reasons for dissent.
d. Financial impact, if any.

All public communication regarding the revocation of a naming right will be handled by Northern Health's Communications Department in conjunction with provincial government, as necessary.

Policy Review

This policy will be reviewed annually by the GMR Committee.

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Northern Health

APPENDIX 1
NOMINATION APPLICATION FORM

1. Name of donor or sponsoring entity:
2. Proposed Asset to be named:
3. Proposed Name of Asset:
4. Proposed Term of Naming Right:
5. If naming request is to honour an individual, please indicate the individual's:
    a. Full name:
    b. Date of birth:
    c. Date of death (if applicable):
    d. Occupation (or former occupation):
    e. Length of service to Northern Health:
6. Type of consideration to be provided for the naming opportunity (check one)
    - ☐ Financial (describe)
    - ☐ In-kind (describe)
    - ☐ Distinguished Service (no financial or in-kind gift attached)
    - ☐ Other (please describe)

7. If the nomination is for Distinguished Service, have at least three years elapsed since the individual last worked with Northern Health? (Yes/No)
8. Association of proposed name with the asset to be named:
9. Association with and main contribution(s) to NH and/or local community.
10. Include background and/or biographical information demonstrating that the proposed name is of significance to the community.
11. *Optional*: Other reason(s) for choice of name (to reasonably assist Naming Committee's deliberations):
12. Source of above information:

Completed Nomination Application Form to be submitted to Northern Health's COO responsible for the community in which the applicable asset resides.

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APPENDIX 2
Government of British Columbia "Naming Privileges Policy"

See http://www.cio.gov.bc.ca/cio/intellectualproperty/naming_privileges_policy.page for the most current version of the policy.

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CORPORATE CONDUCT V1 NOCHANGES BRD 260

Introduction

The Board of Directors of Northern Health (the "Board") is committed to exemplary standards of corporate conduct, which will inform and guide organizational behaviour and standards of practice. It holds that only by a consistent focus on this goal, and through consistent modelling of expected behaviour by the Board and management, can the organization earn and maintain the trust of those whom it serves.

To this end the Board must establish clear policy objectives for its own conduct, and must also ensure that management, through the President and Chief Executive Officer (the "CEO"), develops, implements and enforces practical, well defined Decision Support Tools (DSTs) for the organization as a whole so that individuals may have clear direction in the discharge of their individual roles and understand their own personal obligation to report known or suspected violations.

Policy Scope

Management shall ensure policies / DSTs are developed for the following corporate issues[1] and such others as deemed prudent and reasonable:

- Code of Conduct/Ethical Behaviour
- Confidentiality
- Conflict of interest
- Respect in the workplace
- Theft, fraud, corruption, and non-compliance

Compliance

The Board expects that management will:

1. Ensure that specific standards are established and clearly communicated to all staff members, and that any updates are communicated to those affected on a timely basis.

2. Inform all staff members as to where they can obtain information needed to interpret these standards in relation to their individual circumstances.

[1] Not an exhaustive list but representative of the areas for which policy / DSTs shall be created and promulgated.

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3. Make it clear that compliance with the approved standards is considered to be a condition of continued association with Northern Health.

4. Maintain established internal and management controls designed to prevent or detect failures to apply corporate standards.

5. Ensure that reports of non-compliance are regarded, except as otherwise dictated by legislation, as confidential and that no penalties are imposed on those reporting alleged violations in good faith.

6. Lead by example and consistently exhibit high standards of personal conduct in dealing with staff and others with whom they may be in contact in the discharge of their duties.

7. Deal with known and proven breaches in an appropriate manner including discipline up to and including discharge where justified.

8. Provide regular reporting regarding the application of this policy to the Governance and Management Relations Committee in accordance with the Committee's work plan.

These guidelines are not intended to abridge statutory rights, rights conferred by a collective agreement, or the obligations arising from a professional designation. The purpose is solely to promote an enterprise-wide commitment to standards of personal conduct that earns Northern Health a reputation for integrity.

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northern health

Board of Directors Schedule

2015

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FEBRUARY

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

Location: Chetwynd

RHD: Peace River RHD

Spring Breaks:
SD 57 February 16-27
Canada Winter Games Feb 16-27

MARCH

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Spring Breaks:
SD 52 March 9 - 20

APRIL

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

Location: Prince Rupert

RHD: North West Regional Hospital District

Spring Meeting with RHDs around the Capital Plan: Date TBD

MAY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

North Central Local Government Association: May (Dates TBA) Prince George

JUNE

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Location: Burns Lake

RHD: Stuart-Nechako RHD

Board Meetings | Board Package Cutoff | Board Planning Session | Board Committee Meetings | Stat Holidays

Board of Directors Schedule

2015

JULY

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Board Teleconference

AUGUST

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

No Board Meeting

SEPTEMBER

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Union of BC Municipalities : (UBCM) Sept 21st – 25th in Vancouver.

OCTOBER

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Location: Prince George

Board Planning Session
Board & RHD Planning Session
Board Meeting

NOVEMBER

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Location: Prince George
RHD: Fraser Fort George

Board Meetings | Board Package Cutoff | Board Planning Session | Board Committee Meetings | Stat Holidays

Northern Health Regional Office
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T: (250) 565-2649, F: (250) 565-2640, www.northernhealth.ca

BOARD BRIEFING NOTE

Date:	**2014 May 04**	
Agenda item	**Regulatory Framework – Legislative Compliance – *Emergency Health Services Act***	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**GMR Committee**	
Prepared by:	**M Leisinger**	
Reviewed by:	**C Ulrich**	

Issue:

To provide an update on the legislative compliance review process.

Background:

1. Current Review

The *Emergency Health Services Act* (*EHS Act* or "the *Act*") was formerly known as the *Emergency and Health Services Act* and was amended in 2013 and renamed the *EHS Act*.

The *Act* was changed to allow for the realignment BC Emergency Health Services[1] (BCEHS) under the Provincial Health Services Authority (PHSA) to better coordinate the delivery of emergency services and urgent health services across the province. BCEHS operates the BC Ambulance Service (BCAS) and the BC Patient Transfer Network[2] (PTN).

The *Act* also allows for the integration of paramedics and other emergency medical assistants into the broader health sector.

The *Act* establishes the Emergency Medical Assistants Licensing Board for the licensing, regulation and discipline of Emergency Medical Assistants.

The *Act* is about pre-hospital care and patient transport, which is related to, but different from, emergency management like the services provided by:

[1] Formerly the Emergency Health Services Commission (EHSC)
[2] Formerly BC Bedline

1. Health Emergency Management BC (HEMBC), which also reports to the PHSA. HEMBC provides support to the health authorities in emergency preparedness, e.g. planning, exercise, training, et cetera. They also connect with local governments, regional offices of government departments like Emergency Management BC (PEP), and others like the BCAS, which also has a small emergency management unit.
2. The Ministry of Health, which operates the Emergency Management Unit (MoH EMU), is responsible for: emergency management for the Ministry of Health; connecting with other government departments; relationships with other provinces, states, and the federal government; and providing policy oversight to the BC health system. They also support the Provincial Health Officer, and have been resourced to play a lead role in pandemic influenza planning. A MoU is currently being drafted between HEMBC and the MoH EMU.

This *Act* imposes no obligations or compliance issues on Northern Health and no Certificates of Compliance are required.

The *Act* and this Legislative Compliance Review were reviewed by the Executive Team.

2. Upcoming Review(s)

Seniors Advocate Act
Laboratory Services Act
Wills, Estates & Succession Act
Health Care Costs Recovery Act

3. Previously reviewed Acts:

24. Emergency Health Services Act – May/Jun 2014
23. Human Rights Code – Mar/Apr 2014
22. Hospital District Act – Jan/Feb 2014
21. Personal Information Protection Act – Nov/Dec 2013
20. School Act (Section 91) - Sep/Oct 2013
19. Hospital Insurance Act – Sep/Oct 2013
18. Gunshot & Stab Wound Disclosure Act – May/Jun 2013
17. Access to Abortion Services; Sec 22.1 of FIPPA (also see Regs of Hosp Ins Act) – Mar/Apr 2013
16. Evidence Act (Section 51) – Jan/Feb 2013
15. Health Care (Consent) and Care Facility (Admission) Act – Nov/Dec 2012
14. Health Professions – Sep/Oct 2012
13. Adult Guardianship Act – May/Jun 2012
12. Patients Property Act – May/Jun 2012
11. Coroners Act – Mar/Apr 2012
10. Ombudsperson Act – Mar/Apr 2012
09. PCQRB Act – Mar/Apr 2012
08. Ministry of Health Act – Mar/Apr 2012
07. Mental Health Act – Jan/Feb 2012
06. CCALA – Nov/Dec 2011
05. E-Health (Personal Health Information Access and Protection of Privacy) Act – Sep/Oct 2011
04. Public Health Act – May/Jun 2011

03. Hospital Act – Mar/Apr 2011
02. FIPPA – Jan/Feb 2011
01. Health Authorities Act – Nov/Dec 2010 (Refreshed: Jan/Feb 2014)

Recommendation(s):

That the Board receives this briefing note for information.