Meeting of the Northern Health Authority Board of Directors Public Session

Burns Lake, British Columbia

Monday, June 15, 2015

1:15pm - 3:00pm

College of New Caledonia - Room 007

(545 Highway 16 West)

northern health

the northern way of caring

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Public Session

AGENDA

June 15, 2015
College of New Caledonia – Room 007
545 Highway 16 West, Burns Lake, 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	Discussion		
4. **Approval of Agenda**	Chairman Jago	Motion		1
5. **Approval of Previous Minutes:** April 20, 2015	Chairman Jago	Motion		3
6. **Business Arising from Previous Minutes**	Chairman Jago			
7. **CEO Report** 7.1 Human Resources Report	C Ulrich D Williams	Information Information		8 11
8. **Audit & Finance Committee** 8.1 Public Comments Fiscal Y/E 2014-15 8.2 Major Capital Projects Summary (Period 13)	 M De Croos M De Croos	 Information Information		 19 20
9. **Performance, Planning & Priorities Committee** 9.1 Annual School Medical Health Officer Appointments 9.2 Seniors' Advocate Report and Actions	 S Allison K Gunn	 Motion Information		 22 24
10. **Governance & Management Relations Committee** 10.1 Northern Health Violence Strategy 10.2Policy Manual BRD 200 Series 10.3 Policy Manual BRD 315 External Auditor Independence 10.4 2016 Board Meeting Calendar 10.5 Community Consultation Strategy 10.6 Carbon Neutral Action Report 10.7 Regulatory Framework – Legislative Compliance 10.7.1. Financial Administration Act 10.7.2. Financial Information Act 10.7.3. Public Sector Employers Act	 D Williams / M McMillan C Jago C Jago C Ulrich S Raper M De Croos C Ulrich	 Information Motion Motion Motion Motion Information Information		 32 48 85 93 97 99 101
Adjourned			3:00pm	

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Public Motions

Meeting Date:
June 15, 2015

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 June 15, 2015 public agenda as presented	☐	☐
5.	Approval of Minutes	The Northern Health Board approves the April 20, 2015 public minutes as presented	☐	☐
9.1	Annual School Medical Officer Appointments	The Northern Health Board approves the appointment of Drs. Sandra Allison, Charl Badenhorst, and Raina Fumerton as School Medical Officers as per Section 89 of the *School Act* for the school districts within the geography of Northern Health.	☐	☐
10.2	Policy Manual BRD 200 Series	The Northern Health Board approves the revised BRD 200 series.	☐	☐
10.3	Policy Manual BRD 315 External Auditor Independence	The Northern Health Board approves the revised BRD 315 policy.	☐	☐
10.4	2016 Board Meeting Calendar	The Northern Health Board approves the revised 2016 Board Calendar.	☐	☐
10.5	Community Consultation Strategy	The Northern Health Board approves the recommendation that the 2016 Consultation focus on Child Health.	☐	☐

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Board Meeting

Date: April 20, 2015
Location: British Columbia Room
Prince Rupert, BC

Chair: Dr. Charles Jago

Recorder: Desa Chipman

Board:
- Sharon Hartwell
- Gary Townsend
- Ben Sander
- Maurice Squires
- Edward Stanford
- Rosemary Landry
- Gaurav Parmar

Regrets:
- Stephanie Killam

Executive:
- Cathy Ulrich
- Fraser Bell
- Kirsten Thomson
- Kelly Gunn
- Mark De Croos
- David Williams
- Dr. Ronald Chapman
- Penny Anguish
- Dr. Sandra Allison
- Steve Raper

Public Minutes

1. **Call to Order Public Session**

   The Open Board session was called to order at 1:25pm

2. **Opening Remarks**

   Chairman Jago expressed pleasure in being back in Prince Rupert and thanked members of the public for attending.

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 20, 2015 public agenda.

4. **Approval of Agenda**

   Moved by S Hartwell seconded by G Parmar
   The Northern Health Board approves the April 20, 2015 public agenda as presented

5. **Approval of Board Minutes**

   Moved by R Landry seconded by G Parmar
   The Northern Health Board approves the February 16, 2015 public minutes as presented

6. **Business Arising from Previous Minutes**

   There was no business arising from the previous minutes.

7. CEO Report

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

- The Canada Winter Games recently hosted in Prince George were a success for the North. The Games were supported by an incredible group of volunteers from Prince George and across the north which included many Northern Health staff and physicians.
- Northern Health completed an accreditation process in 2014 and received accredited status. As part of this process, Northern Health submitted the "STOP HIV AIDS" initiative as a Leading Practice for innovative approaches to quality improvement in health care which met all required criteria and was accepted as a Leading Practice.
- David Williams was introduced as the newly appointed Vice President, Human Resources with Northern Health.
- Updates on the capital projects in the North West were highlighted for information.
  - The Village of Queen Charlotte/Haida Gwaii General Hospital Replacement project is well underway and anticipated completion is in early 2016.
  - The visiting specialist Clinic at Mills Memorial Hospital has recently been completed at a cost of $820,000.
  - The CT Suite upgrade at the Prince Rupert Regional Hospital has been completed and the CT has been relocated back into the CT Suite. This was a $1M project.

7.1. Human Resources Report

D Williams provided an overview of the Human Resources Report and highlighted the following;

- The Strategies to support Violence Prevention continues to be a focus at both the Health Authority and the Provincial Level.
- WorkSafeBC Short Term duration (STD) continues to decrease in Northern Health and Northern Health experiences the lowest rates of STD when compared to all BC Health Authorities.
- As of March 4th the number of external vacancies has dropped slightly (8%), reducing the number of vacancies from 122 to 112.
- The number of excluded vacancies has trended upwards over the past four months, which includes 14 Nurse Practitioner vacancies. In an effort to solicit advice and input for designing recruitment strategies specific to attracting Nurse Practitioners, recruitment connected with the existing Nurse Practitioner cohort. A number of innovative ideas were identified which recruitment staff will explore further for potential implementation.

8. Audit and Finance Committee

8.1. Period 11 Public Financial Statements

- M De Croos provided an overview of the year-to-date Period 11, and advised that revenues exceeded expenses by $5,209,000.
- Revenues are favourable to budget by $2.9 million or 0.5%. Expenses are favourable to budget by $2.2 million or 0.4%.
- Better than expected patient revenues and Medical Services Plan revenues are contributing to the favourable variance in revenues. The favourable variance in expenses is due to vacant positions in Community Care, Mental Health, and Population Health and Wellness. Acute Care is experiencing an unfavourable variance to budget due to higher than usual patient activity.
- At this time, Northern Health is forecasting a balanced position at yearend.

Moved by B Sander seconded by G Townsend
The Northern Health Board approves the Period 11 financial statement, as presented

8.2. Period 11 Major Capital Projects

- An overview was provided of the Northern Health Project Summary report for the fiscal period 11 ending January 29, 2015. Additional information was provided to explain projects that are identified as delayed.

9. Performance Planning and Priorities Committee

9.1. Programs – Critical Care

- An update and overview was provide on the Critical Care Program which provided information on the 3 program goals which are:
  1. All patients presenting to Northern Health Emergency Departments will have a complete set of vitals done to improve rates of early detection of sepsis symptoms to improve patient outcomes.
  2. Northern Health physicians and staff will have access to standardized critical care education with a focus on emergency department and trauma education.
  3. All patient transfers from emergency departments will be executed with complete Transfer of Care Documentation.
- Information was also provided about the BC Emergency Health Services' Project which is underway to develop a standardized process for the repatriation of patients to NH facilities and to review the 2010 Life, Limb, and Threatened Organ policies. The intent is to review the five existing policies and amalgamate them into one regional policy.
- The BC Patient Transfer Network (PTN) replaced BC Bedline to improve coordination for inter-facility transfers and support better communication between sending/receiving sites to ensure patients throughout B.C. receive appropriate care at the appropriate facility in a more timely and efficient way. The Critical Care program is collaborating with UNBC professor Dr Waqar Haque to produce a dynamic dashboard that can facilitate the repatriation of a patient to a site closer to home.
  - The Ministry of Health has agreed to provide funding to allow development of this tool for use by all Health Authorities. The Northern Health Critical Care Program is leading this provincial project.

9.2. Communications Strategy & Policies

- An overview of the Communications Strategy was provided with additional information being provided on the four significant categories of work, which are:
  - Media Relations and issues management
  - Health Promotions which includes the social media and web interface with the public
  - Internal Communications and change management support
  - External Relations which includes HEMBC, Foundations, government relations and industry relations.
- Four awards have been recently presented to the Communications portfolio which are:
  - From Canadian Public Relations Society
    - Community Relations Campaign of the Year (silver)
    - Canadian Marketing Communications Campaign of the Year (bronze)
    - Canadian Advocacy and Social Marketing Campaign of the Year (bronze)
  - From the International Association of Business Communicators
    - Communications Management, Social Media Programs (award of merit)
- One of the highlights from the Canada Winter Games was introducing the Northern Health mascot "Spirit" who was available and interactive throughout many venues during the games celebrations and events.

10. PRISM Clinic Presentation

Angenita Gerbracht, Manager Rehabilitation Services joined the meeting to present on PRISM, Prince Rupert Interprofessional Student-led Clinic:

- The PRISM Clinic is a partnership with Northern Health and the UBC Department of Physical Therapy and aligns with:
  - The Northern Health Strategic Plan through utilizing a model which will increase access to services which are integral to positive health outcomes and quality of life for community members.
  - The strategic commitment of the UBC Faculty of Medicine, Department of Physical Therapy to be responsive to current and emerging health issues through a focus on the needs of rural communities, primary health care and inter-professional education and collaborative practice.
- The mission of the Clinic is to provide patient/family-centered rehabilitation services using an innovative primary health care approach and model of clinical education for health care professional students.

11. Governance and Management Relations Committee

11.1. Policy Manual BRD 100 Series

- The revised BRD 100 policies were presented to the Board for discussion and approval.

Moved by S Hartwell seconded by R Landry
The Northern Health Board approves the revised BRD 100 series

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

- The declaration forms were circulated to the Board members who are to sign and return to management to place on file.

11.3. Policy BRD 260 Corporate Conduct

- The revised BRD 260 Corporate Conduct policy was circulated to the Board for discussion and approval.

Moved by R Landry seconded by G Parmar
The Northern Health Board approves revised BRD 260 policy.

11.4. Board Development & Education Session Topics 2015

- The revised 2015 Board Development and Education plan was presented for review and discussion of the proposed changes which include adding a second workshop on the Strategic Planning process at the June 2015 Board meeting and moving the Role of Governance in Quality Session to December 2015.
- Medication Management would be moved to occur in the 2016 education plan.

Moved by R Landry seconded by G Parmar
The Northern Health Board approves the revised Board Development & Education Session Topics for 2015.

11.5. Regulatory Framework – Legislative Compliance

11.5.1. Workers Compensation Act

- An update on the Legislative Compliance Process was provided for information with the current review focusing on The Workers Compensation Act.

- The Act and this Legislative Compliance Review were reviewed by the Executive Team from a governance-level viewpoint.
- NH is compliant with respect to awareness of obligations and implementation of policy to address the Act and applicable Regulations at a Senior Leadership Level.
- Senior Leadership acknowledges that there is ongoing work to support the full implementation of policy, the Act, and the Regulations throughout all levels of the organization.
- This Act imposes no obligations or compliance issues on Northern Health.

Moved by G Townsend
The public session was adjourned at 2:51pm

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Dr Charles Jago, Chair Desa Chipman, Recording Secretary

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

CEO REPORT

Meeting: Northern Health Board Meeting Date: June 2, 2015

Agenda Item: CEO Report

Purpose: Information

Prepared by: Cathy Ulrich

Canada Winter Games - Canadian Public Relations Society Award:

Northern Health was recognized by the Canadian Public Relations Society (CPRS) on June 2, 2015 with a 2015 Gold Award in the Best Special Events category for its preparation work for the 2015 Canada Winter Games. The award is part of the CPRS Awards of Excellence program that recognizes outstanding projects in public relations and communications.

The project team focused on health needs for the Games and was led by Northern Health with input from key stakeholders including the Games host society. The project focused on NH's key categories of activities:

- Health services and operations;
- Medical services for the Games;
- Health promotion, education, and training; and
- Public health and preventative services planning.

A focus for Northern Health was leaving a legacy that would benefit northern B.C. residents after the Games concluded. An example of legacy work included partnering with Wellness in Northern B.C. (WINBC) and PacificSport Northern B.C. to use the opportunity to train health care professionals for sport specific skills. Injury prevention and concussion management training sessions were held in 15 communities across Northern Health including Dawson Creek, Terrace, Valemount, Quesnel, and McBride under the leadership of Dr. Anne Pousette

The public health team was engaged in the Games as well, providing surveillance reports to ensure a proactive approach could be taken to prevent outbreaks or spread of disease. They partnered with the B.C. Centre for Disease Control and Public Health Agency of Canada who have helped with large scale events in the past.

North Central Local Government Association 2015

On May 6th, 2015 Dr Charles Jago and I attended the North Central Local Government Association conference where we had the opportunity to meet with local government representatives from 16 different communities to discuss health care concerns.

Northern Health had the opportunity to organize a panel discussion at this conference. The panel was focused on population health topics including;

1. Impacts of natural resource development - Dr. Sandra Allison, NH and Dr. Margo Parkes, UNBC
2. Partnering for Healthier Communities - Sabrina Dosanjh and Theresa Healy,
3. NH First Nations Health: Partnership between Northern Health and the First Nations Health Authority - Dr. Margo Greenwood, NH and Nicole Cross, First Nations Health Authority

Dr. Charles Jago, NH Board Chair moderated the panel discussion on behalf of Northern Health. Approximately 75 local government representatives attended the session.

Regional Hospital District Spring Meeting

The six Northern Regional Hospital Districts met with Northern Health on May 11, 2015 in Prince George. The meeting provided an opportunity for newly elected Hospital District members to learn about Northern Health, capital planning processes, and the status of capital planning and projects currently underway.

Collaborative Baccalaureate Nursing Program 2015 Graduation

I had opportunity to speak at the Pinning Ceremony for the nurses graduating from UNBC on May 30. It was an opportunity to learn about the immediate and future plans of the nurses graduating in 2015. Many of these nurses have pursued employment in Northern BC and have aspirations for specialty nursing and pursuing further education in the future.

NH and UNBC Brown Bag Lunch Research Webinar

Northern Health's Innovation and Development Commons organizes a brown bag lunch once per month with a focus on a research initiative underway in the region. In May, Dr. Martha MacLeod, Chair, Nursing Program, Co-Chair, Health Research Institute at UNBC and I presented on our partnered research, "Partnering for Change: Engaging Municipal Leaders in Primary Health Care Transformation". Dr. MacLeod is the Lead Investigator and I am the Lead Knowledge User for this research initiative funded by the Canadian Institutes for Health Research.

Primary and Community Care Forum - Ministry of Health

On June 1 and 2, two teams of community service providers, Northern Health managers, physicians and staff from the Divisions of Family Practice in Vanderhoof and Prince George attended a forum organized by the Ministry of Health focused on improving community based services for seniors with complex health needs. The forum also included patient representatives from across the province. This was a good opportunity to learn from other parts of the province and to further develop our integrated model of primary and community care focused on the needs of seniors in these communities. Further work will be undertaken over the summer to continue the implementation of an interprofessional approach to services.

Northern Interior Health Service Delivery Area Highlights:

Diagnostic Spect CT Scanner Unveiling: On May 20, 2015, the Spirit of the North Healthcare Foundation and Northern Health officially unveiled the new Diagnostic Spect CT Scanner. The scanner was purchased for $1.4 million thanks to the generosity of donors, including a $200,000 donation from the UHNBC Hospital Auxiliary! The equipment was purchased and officially installed in late 2014, with the first patient using this new service on December 9, 2014.

Learning & Development Centre: The grand opening of the Learning & Development Centre, located on the UHNBC campus, took place on Monday June 8, 2015. This capital project is the final component of the infrastructure development to support the Northern Medical Program. The building includes meeting and educational rooms, patient simulation and library space. This new space will support Northern Health's partnership in education and research with post-secondary institutions including the University of Northern B.C., the UBC Faculty of Medicine, the College of New Caledonia and other partners in the region.

This new facility includes a couple of key features which are:

- The patient simulation centre in Prince George is one of four across the Northern Health region. The other centres are located in Quesnel, Fort St John, and Terrace. Some of this patient simulation equipment can also be transported to other communities to support learning and skill development. This is an important enabler of continuous learning within Northern Health, as it allows staff and physicians to practice their skills in a safe environment, and receive feedback as appropriate.
- The Northern Health Library supports Northern Health through its information and knowledge management services, which are available to allied health, nursing, medical, administrative, support staff, and students in all Northern Health sites.

Human Resources Board Report

June 2015

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Workplace Health, Safety and Prevention

Strategic Directions

Utilizing the Canadian Standards Association (CSA) Z1000-06 and Z1003; a gap analysis of the Violence Prevention Program was completed. An action plan to address identified gaps and support a sustainable approach has been developed, including identifying roles and responsibilities of all workplace parties.

A monthly report is being developed to identify key indicators that leaders are familiar with. These indicators also include WorksafeBC's (WSBCs) high risk strategy. Examples of key indicators include time loss, medical aid and report only incident rates, and claim duration. WSBCs key focus priorities are violence prevention and supervisory responsibilities. Work is underway to further develop a database that captures health and safety activity (non-employee specific) that cannot be captured by the existing Workplace Health Indicator Tracking & Evaluation (WHITE.net). Examples of activity that could be tracked include workplace inspections, violence prevention risk assessments, and violence de-escalation (Code White) response reports. This database would allow leaders to electronically keep track of their site-based health and safety information.

The Employee Absence Reporting Line (EARL) system is continuing to be extremely beneficial to leaders, as well as NH as a whole in allowing workers to have a single access point to call when they are ill. Work is underway to develop compliancy reports as well as a 5 day report for entry into the Disability Management Program.

Disability Management

Returning employees with permanent disability to meaningful work is a legal obligation (Duty to Accommodate) and is a challenge for all employers. With the establishment of the Duty to Accommodate (DTA) Team in 2013, we have been able to focus on improved collaboration, due diligence and standardization in working with our Human Resources Team and Operations Managers. The team had notable success in retaining employees in their owned occupation, eliminating indirect costs such as staff replacement, orientation/training and overtime while also avoiding direct costs of sick leave, WorkSafe BC and/or Long Term Disability benefits. This project has been announced as the winner of the 2015 BC Excellence in Healthcare *Award of Merit* in the category of Workplace Innovation.

Health, Safety and Prevention

Historically, less than 25% of all new hires consistently reported their immunization status upon hire. As such the Immunization Status reporting project was launched on April 1, 2015. This project focuses on all newly hired employees, requiring them to report their current immunization status to the Provincial Workplace Health Call Centre within 2 weeks of hire. To assist in facilitating this requirement, newly hired employees are emailed a reminder letter at day 5 and day 10 post hire. In addition, managers are also copied on these emails. Since the initiation of this project we have seen an increase in reporting of immunization

status for newly hired employees. In turn, this provides better information to managers during an outbreak situation, allowing safe scheduling practices.

With an increased offering of immunization services through Workplace Health and Safety there has been a significant increase of employees being immunized at these clinics. Since January 1st, the Northern Health Occupational Health Nurses have seen 273 employees in immunization clinics whereby they have provided 303 immunizations such as Measles, Mumps, Rubella (MMR); Varicella, Hepatitis B, etc. to employees of Northern Health.

Violence Prevention continues to be a focus for Northern Health. The Health, Safety and Prevention portfolio has assisted the organization with the following activities:

- Updated procedures for our on-site team response plans.
- In progress - update of the current Violence Risk Assessment (VRA) resources. This update is based on feedback received from managers and WorkSafeBC. These guidelines have been modified to better assist managers through the process of completing a Violence Risk Assessment. The finalized VRA resources will be completed and communicated in June. As part of this communication plan, webinars will also be developed and available for managers.

Annually, WorkSafeBC releases their high risk strategy which identifies sectors and sub-sectors within healthcare with a high risk of serious workplace injury and significant contribution to the serious injury rate. Northern Health has 9 sites that have been identified in this strategy and WorkSafeBC officers will be visiting these sites at least twice during this calendar year. A webinar was developed for managers, providing them with the necessary information to assist in preparing sites for the WorkSafe BC site inspection process.

HR Planning & Design

Recruitment

As of May 13th, there are 111 vacancies which represents a reduction in the vacancy rate to 2.10% from 2.31% in April 2015. Since December 2014, the total number of new hires overall is trending upwards with 106 new hires reported in April 2015 [*see Chart: Trending Total New Hires*].

New to the "Hot Spots" list [*those professions that have more than 4 active Open postings*] are Licensed Practical Nurse (4), Nursing Unit Clerk (5), Community Care Nurse (5), and ICU Registered Nurse (5).

Currently, the difficult-to-fill professions include Nurse Practitioners (13) and Physiotherapists (4). As of May 26th, a Physiotherapist position has been filled in Dawson Creek. Strategies to recruit for this difficult-to-fill profession include attending the UBC Rehab Program Career Event on June 1st and the Canadian Physiotherapy Association Conference on June 18th.

The Northwest has experienced success recruiting nurses for Masset. Masset will have all full-time nursing lines filled by mid-June.

Recruitment Strategies Updates

Grow Our Own

At each "Grow Our Own" event, Recruitment staff facilitates an interactive presentation to Grades 10, 11 and 12 students showcasing 35 diverse health care careers. Staff have already presented in Prince George, Quesnel and Fort St John, and presentations are confirmed in Vanderhoof and Terrace in June. We are confirming presentations in Prince Rupert and Kitimat.

The presentation specifically addresses each career's educational requirements and specifics such as pay and responsibilities. The objectives include:

- Introducing the many diverse health care careers to high school students.
- Targeting the students at a point in time when they have the ability to align their educational pathway with a health care career of choice.

Northern Health professionals are invited to each presentation and provide a first-hand account of their career paths including sharing how they became interested in their career, why they love their work, and what keeps them engaged.

Interactive Clinical Simulations

To complement the "Grow Our Own" strategy, Recruitment staff are collaborating with staff from the Innovation & Development Commons (IDC) to facilitate and host interactive simulation lab sessions geared to introducing youth to a spectrum of health care careers in a simulated practice environment. The first session occurred April 24th for a group of Carrier Sekani youth. A simulated stroke patient scenario was staged and a variety of health care professionals showcased their profession for the students.

Representatives from the following Northern Health Medical Professions were involved:

- Emergency Nursing
- Respiratory Therapist
- Speech Pathologist
- Biomed
- Physical Therapy
- Occupational Therapist
- Care Aide

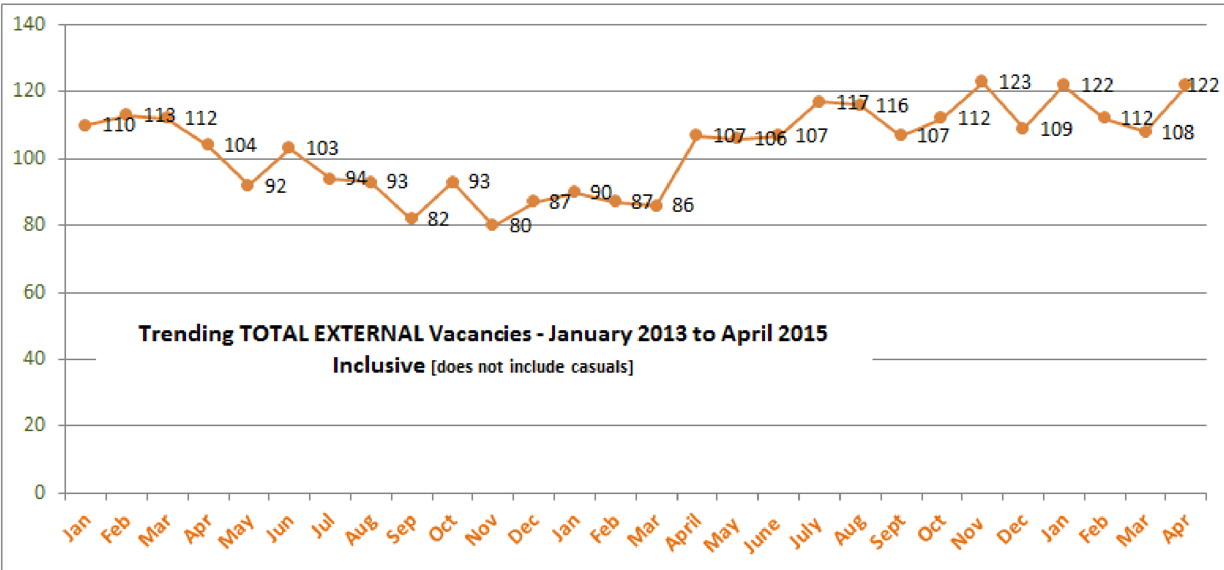
After the simulation, the students paired up with medical professions for a tour of their respective departments. On average, there were two students to a professional. Following the tour, Recruitment provided the students with a pizza lunch and facilitated the "Grow Our Own" presentation.

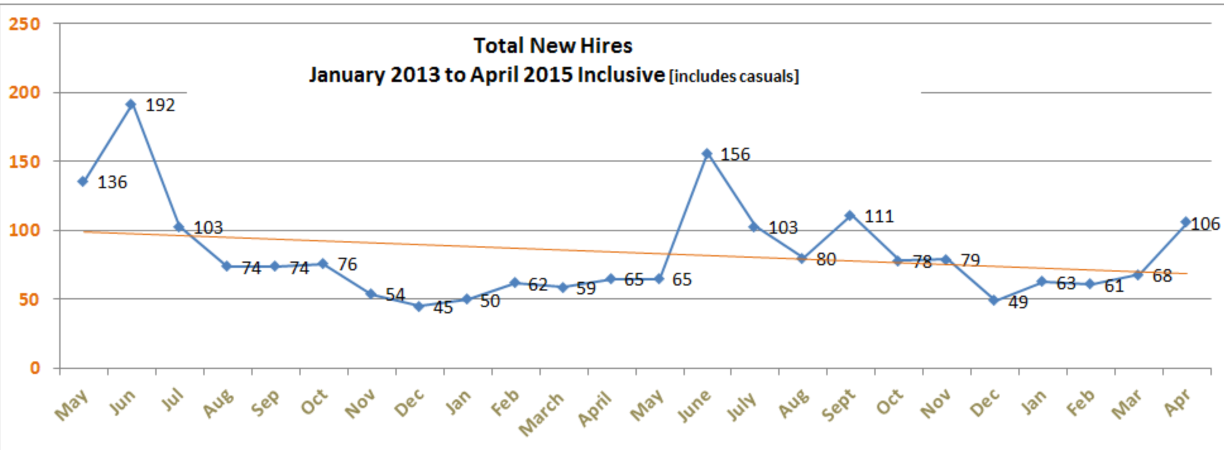
International Recruiting

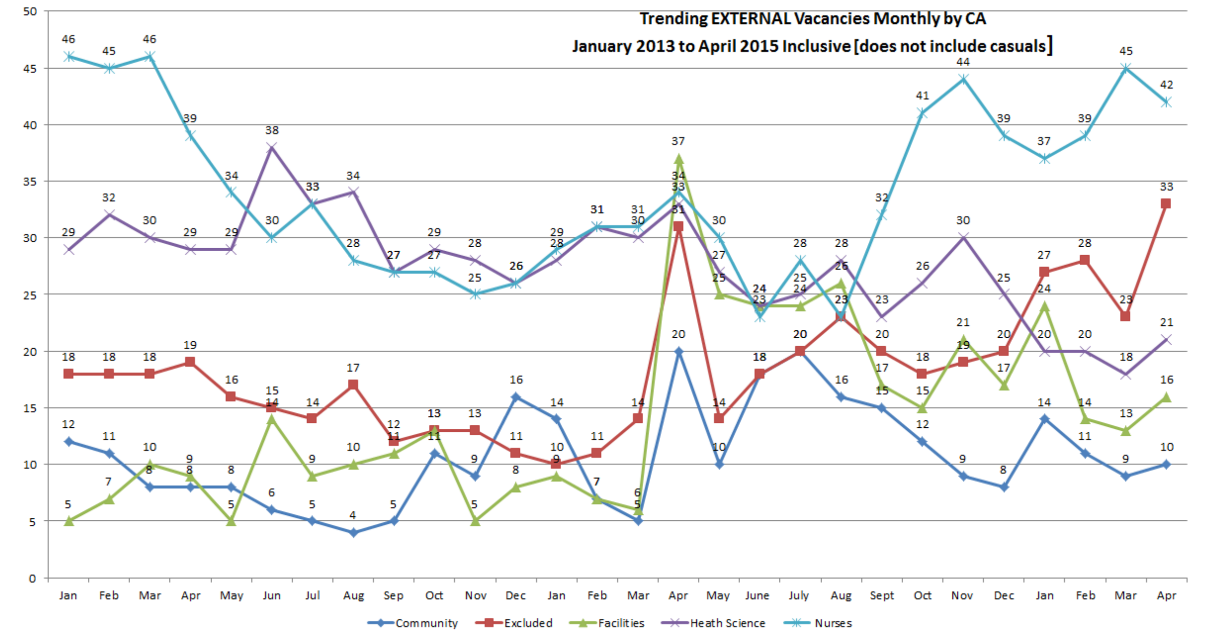
Over the past few months, hiring managers have expressed a renewed interest in interviewing internationally trained nurses, who have critical care or emergency experience. One international recruit received a full-time offer at the Mackenzie & District hospital and is currently beginning the immigration process and a nurse from Jamaica was interviewed for the Dawson Creek & District Hospital.

Career Fairs / Conferences

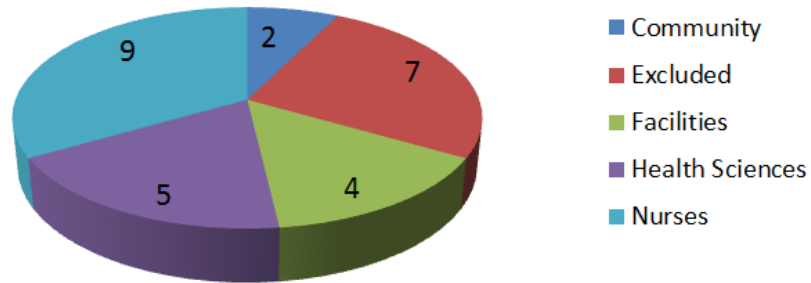
- Northworks – UNBC Career Fair (April 8)
- National Emergency Nurses Association Conference – Edmonton AB. (May 1 &2)
- Operating Room Nurses Association of Canada – Edmonton AB (May 3-5)
- Think Big Career Fair – Fort St. James (May 13)
- Quesnel Job Fair – Quesnel (May 14)
- Canadian Society of Diagnostic Sonographers Conference – Moncton (May 21- 23)
- UBC Rehabilitation Fair – Vancouver (June 1)
- American Association of Nurse Practitioners – New Orleans (June 9-12)
- British Columbia Nurse Practitioner Association Conference- Vancouver (June 12-14)
- Canadian Physiotherapy Association National Congress- Halifax (June 17-20)


Trending TOTAL EXTERNAL Vacancies - January 2013 to April 2015
Inclusive [does not include casuals]
140
120
100
80
60
40
20
0
110 113 112 104 92 103 94 93 82 93 80 87 90 87 86 107 106 107 117 116 107 112 123 109 122 112 108 122
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar April May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr

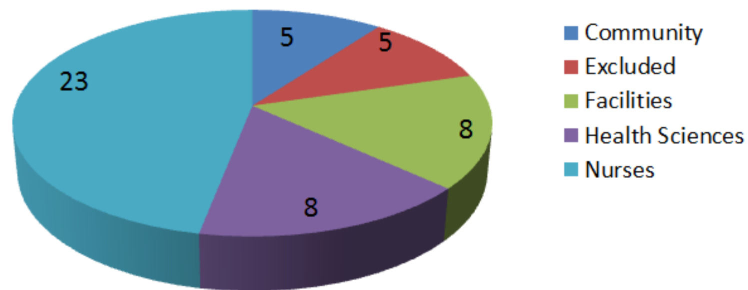

Total New Hires
January 2013 to April 2015 Inclusive [includes casuals]
250
200
150
100
50
0
136 192 103 74 74 76 54 45 50 62 59 65 65 156 103 80 111 78 79 49 63 61 68 106
May Jun Jul Aug Sep Oct Nov Dec Jan Feb March April May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr


Trending EXTERNAL Vacancies Monthly by CA
January 2013 to April 2015 Inclusive [does not include casuals]
50
45
40
35
30
25
20
15
10
5
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr
Community
Excluded
Facilities
Heath Science
Nurses

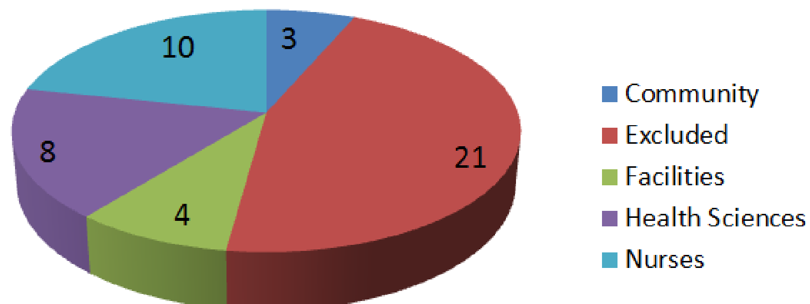
(27) - External Vacancies - NORTHWEST
April 2015[*does not include casuals*]



(49) External Vacancies - NORTHEAST
April 2015 [*does not include casuals*]



(46) External Vacancies - NORTHERN INTERIOR
April 2015 [*does not include casuals*]

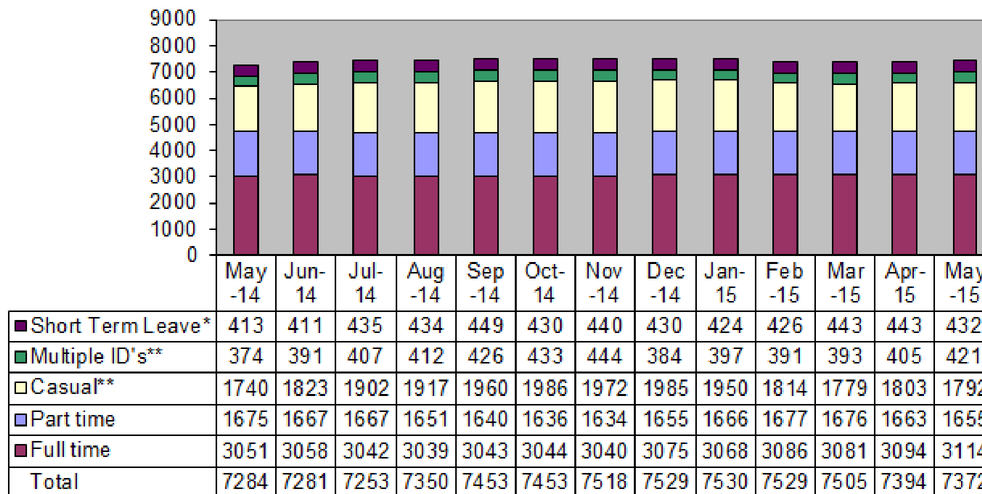


HRIS/Staffing

Employee and FTE Counts

Northern Health Employee Counts by Month

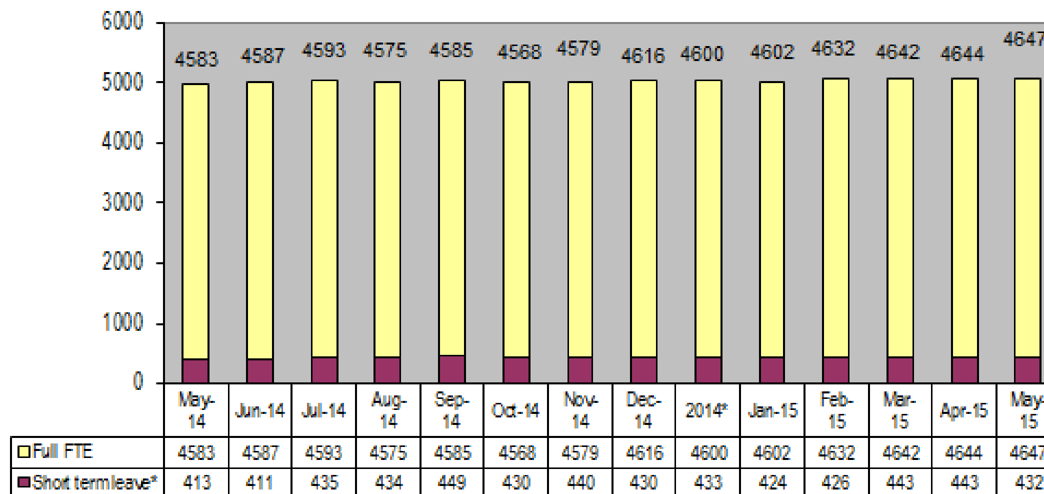
Displays the total # of employees, regardless of their status. Employee is based on unique SIN.



	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Short Term Leave*	413	411	435	434	449	430	440	430	424	426	443	443	432
Multiple ID's**	374	391	407	412	426	433	444	384	397	391	393	405	421
Casual**	1740	1823	1902	1917	1960	1986	1972	1985	1950	1814	1779	1803	1792
Part time	1675	1667	1667	1651	1640	1636	1634	1655	1666	1677	1676	1663	1655
Full time	3051	3058	3042	3039	3043	3044	3040	3075	3068	3086	3081	3094	3114
Total	7284	7281	7253	7350	7453	7453	7518	7529	7530	7529	7505	7394	7372

Northern Health FTE counts by Month

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



	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	2014*	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Full FTE	4583	4587	4593	4575	4585	4568	4579	4616	4600	4602	4632	4642	4644	4647
Short term leave*	413	411	435	434	449	430	440	430	433	424	426	443	443	432

<u>Chart notes:</u>

*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 14, 2015**	
Agenda item	**2014-15 Year End Financial Statements (June Public Meeting)**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Audit & Finance Committee / NH Board of Directors**	
Prepared by:	**Mark De Croos - VP, Finance & Chief Financial Officer**	

Issue:

To provide an update on the status of the audit of Northern Health's 2014-15 financial statements and Government's requirements regarding disclosure of the audited financial statements to the general public.

Background:

Northern Health ended fiscal year 2014-15 on March 31, 2015. 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 2014-15 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-15**

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 Control System Upgrade CNCP	Y		Y		Y	
2	NI - DPL Energy Conservation Measures CNCP	Y		Y		Y	
3	NE - FNH DDC System Upgrade CNCP	Y		Y		Y	
4	NE - FNH Morgue Renovation	Y		Y	19-Dec-14	Y	19-Dec-14
5	NE - FNH Tub Room Renovation	Y		Y	19-Dec-14	Y	19-Dec-14
6	NE - FNH Roof Replacement II	Y		Y		Y	
7	NE - FSH Planning - Old Fort St John Hospital Asset Retirement	Y		Y		Y	
8	NI - BLH Lakes District Hospital & Health Centre Replacement	Y		Y		Y	12-Sep-13
9	NI - GTW 3rd Floor Conversion	Y		Y		Y	
10	NI - STH Stuart Lake Hospital Sprinkler System	Y		N	1-Dec-14	Y	9-Jul-14
11	NI - UHN Learning & Development Commons	Y		Y	10-Oct-13	Y	10-Oct-13
11	NW - ACM Acropolis Manor/ Summit Residence Floor Elevation Moveme	Y		Y		Y	
12	NW - BVH Boiler and Controls CNCP	Y		Y		Y	
13	NW - BVH Nurse Call System Replacement	Y		Y	4-Mar-15	Y	
14	NW - MAH Roof Condensation Issue	Y		Y		N	4-Mar-15
15	NW - MMH Outpatient Clinic Renovaton	Y		Y	29-Oct-14	Y	29-Oct-14
16	NW - PRR Building Automation System DDC Upgrade	Y		Y		Y	
17	NW - PRR Electrical Power System	Y		Y		Y	
18	NW - QCI Hospital Replacement	Y		N	15-Oct-14	N	12-Sep-13
19	NW - WRI Sprinkler System Install	Y		N	1-Dec-14	Y	9-Jul-14
20	NW - STC Energy Conservation Measures CNCP	Y		Y		Y	
21	NW - STE Ventilation Isolation CNCP	Y		Y		Y	
22	IT - NHR Data Centre Transition (STMS)	N	2-Jul-13	N	3-Jan-13	Y	
23	IT - NHR Enterprise Master Person Index (EMPI) Active Integration	N	2-Jan-14	N	22-May-14	Y	31-Mar-14
24	IT - NHR Regional Nutrition Systems Project (CBORD)	Y	7-Mar-14	N	14-Aug-14	N	7-Mar-14
25	IT - NHR Voice Recognition Electronic Documentation	Y		Y	15-Jan-15	Y	

*** Yes denotes green health indicator**

**** 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**

#	Comment
10	Project is now behind schedule due to issues related to unknown water connection; additional engineering was required to establish water requirements which delayed finalizing design
13	Contract delay due to vehicle accident for crew and material damaged.
14	Tender closed, price very over budget. Currently reviewing cost and scope. Approval received from Board April 20th to award.
18	Contractor submitted delay claims are currently under review
19	Project schedule has been impacted due to a delay in being able to start civil work; the interior work has commenced within the facility, however the civil work has to be pushed out until frost is gone which will delay the schedule by a few months
22	Delays on infrastructure preparation
23	Schedule at risk due to Cerner delivery of enhancement to VIHA and NH and due to the integration software coming from CGI (MOH Tech Support)
24	Network and printing issues have impacted CBORD implementation. Focused effort to resolve the issues is underway

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COMPLETED PROJECT SUMMARY REPORT (Note 1) | Fiscal Period End Date **31-Mar-15**

Projects completed during period P13

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*

Construction completed - Projects under financial review (Note 2)

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*
NI - Baker Lodge Deconstruction-Quesnel	Y	Y	Y
NI - UHN Chiller Replacement	Y	Y	Y
NE - FNH Roof Replacement	Y	Y	Y
NI - GRB Pharmacy - Sterile Processing Room	Y	Y	Y
NW - KIT Observation (Secure) Room	Y	Y	Y
NI - SJH Outpatient Services Renovation	Y	Y	Y
NI - UHN NCCS Patient Care Services - Renovation	Y	Y	Y
NI - UHN Mat-Child Entrance & MM Exit	Y	Y	Y
NI - FLC Heating System	Y	Y	Y
NI - UHN Nechako Centre Deconstruction	Y	Y	Y
NI - UHN Parking Enhancements	Y	Y	N
NE - CGH Ventilation Control Upgrade	Y	Y	Y
NI - GTW Nurse Call System Replacement	Y	Y	Y
NI - UHN Control System Upgrade	Y	Y	Y
NW - KIT Nurse Call System Replacement	Y	Y	Y

Projects completed during Fiscal Year 14/15

Project	*Scope *Yes/No*	*Schedule On Time: *Yes/No*	*Budget On Budget: *Yes/No*
IT - UHN SurgiNet (OR Booking & Care Documentation)	Y	N	N
PSECA 3 Projects	Y	Y	Y
NW - MMH Planning - Facility Renewal	Y	Y	Y
NE - DCH Parking Resurfacing	Y	Y	Y
NE - RMC Parking Resurfacing (Rotary Manor)	Y	Y	Y
NW - PRR CT Suite	Y	Y	Y
NE - DCH Nurse Call Replacement	Y	Y	Y
NW - MMH Electrical Switchgear Replacement	Y	Y	Y
NI - DPL Sprinkler System	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 &

Note 2

Financial Review is underway to assess final financial project closure related to expenses and funding sources in order to enable amortization

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

BOARD BRIEFING NOTE

Date:	May 26, 2015	
Agenda item	**School Medical Officers**	
Purpose:	☐ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	**3P Committee**	
Prepared by:	**S. Allison, Chief Medical Health Officer**	
Reviewed by:	**C. Ulrich, President & CEO**	

Issue:

School Medical Officers under the *School Act* require designation by the Board of Directors of Northern Health.

Background:

The *School Act* requires the Northern Health Board of Directors to designate a School Medical Officer for each school district within its region:

> *School Act*
> **87.1 "school medical officer"** means a medical health officer under the *Public Health Act* who is designated as a school medical officer under section 89 (1) of this Act.
> **89** (1) Each regional health board under the *Health Authorities Act* must designate a school medical officer for each school district.

With the departure of Dr. William Osei at the end of May 2015, the Board's enduring motion regarding School Medical Officers must be renewed.

Drs. Sandra Allison, Charl Badenhorst, and Raina Fumerton will carry out the duties and functions of School Medical Officers for the school districts within the geography of Northern Health in accordance with the following table:

Sept 2015			
HSDA	**SCHOOL DISTRICT**	School Medical Officer/ Contact Info	
NW	**#50 - Haida Gwaii/ Queen Charlottes** **#52 - Prince Rupert** **#54 - Bulkley Valley** **#82 - Coast Mountains** **#87 - Stikine** **#92 - Nisga'a** **#93 - Conseil Scolaire Francophone** **Re: Jack Cook Elementary, Terrace BC**	**Dr. Raina Fumerton**	**O: 250-631-4261** **C: 250-641-1758**
NE	**#59 - Peace River South** **#60 - Peace River North** **#81 - Peace River Fort Nelson**	**Dr. Charl Badenhorst**	**O: 250-263-6067** **C: 250-793-2780**
NI	**#28 - Quesnel** **#57 - Prince George** **#91 - Vanderhoof** **#93 - Conseil Scolaire Francophone** **Re: Duchess Park Secondary** **and Ecole Franco-Nord**	**Dr. Sandra Allison**	**O: 250-565-7424** **C: 250-612-2582**

Recommendation(s):

It is recommended that the 3P Committee request the following motion be passed by the Board at its June meeting:

The Board of Directors of Northern Health appoint Drs. Sandra Allison, Charl Badenhorst, and Raina Fumerton, as School Medical Officers as per Section 89 of the *School Act* for the school districts within the geography of Northern Health.

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Executive Lead - Elder Program
543 Front Street, Quesnel, BC, V2J 2K7
(P) 250-985-5883

BOARD BRIEFING NOTE

Date:	May 26, 2015	
Agenda item	Office of the Seniors' Advocate – Seniors' Housing Paper	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Performance, Planning and Priorities Committee**	
Prepared by:	**Stacey Patchett, Executive Lead, Elder Program**	
Reviewed by:	**Kelly Gunn, VP Primary & Community Care & Clinical Programs**	

Issue:

The Office of the Seniors Advocate released a paper 'Seniors' *Housing: Affordable, Appropriate, Available'* to the public at the end of May, 2015. The Board is provided with an overview of the key recommendations of the report as they relate to the public consultation on seniors wellness and Northern Health's Seniors' Strategy. The Executive Summary of the Seniors' Advocate's report and recommendations are appended for information.

Background:

The Seniors Advocate's recommendations are consistent with the views and perspectives gained from the 2013 Northern Health public consultation *Let's Talk about Health Aging and Seniors' Wellness* and Northern Health's *Seniors' Strategy.*

In 2013, Northern Health's public consultation on healthy aging and seniors' wellness provided an opportunity to engage citizens in Northern BC in conversations about what it means to be healthy and well as one ages. Consultation themes included:

- A need for a range of supports to allow seniors to stay home longer and more options to allow a smoother transition from home into supported care.
- More supports in the home including timely service, more frequent home support visits and better consistency and continuity in home care staff.
- Integration of clinical services and community based services.
- Attention to seniors living in poverty in northern communities.

Northern Health's Seniors' Strategy focuses on:

- Supporting healthy aging in community;
- Supporting frail seniors living in community with a strong emphasis on integrated primary care and community services; and

- Preventing and/or limiting time spent in acute care and ensuring the provision of quality of life for seniors living in Residential Care.

The findings of the consultation process and the focus of the Seniors' Strategy are consistent with the recommendations of the Seniors Advocate's paper that focuses on three areas of seniors' housing with a view to improved housing accessibility, security, affordability for seniors living in:

1) Independent housing;
2) Assisted Living; and
3) Residential Care.

<u>An overview of the Seniors Advocate's Key Recommendations</u>

Independent Housing:

- This section of the report focuses on the ability for seniors to live as independently as possible in their own homes, for as long as possible. It recommends revisions to the *Shelter Aid for Elderly Renters* (SAFER) program offered through BC Housing, creation of a *Homeowner Expense Deferral Account* program as well as amendments to the *Residential Tenancy Act*, the *Strata Property Act*, the *Home Adaptations to Independent Living* program and the *Manufactured Homes Act*. There are also recommendations for the provincial government to work with BC Housing to develop a strategy for affordable seniors housing in rural and remote BC and to work with the Office of the Seniors Advocate to raise awareness of all subsidy and grant programs available to seniors. Further, there are recommendations for the province to work with the federal government to address the needs of homeless seniors.

This set of recommendations addresses the consultation feedback from seniors calling for a range of supports to allow them to stay home longer and supports the first area of focus in Northern Health's Seniors' Strategy: Supporting Health Aging in Community. While there is a role for Northern Health to assist communities' efforts to be age friendly and to be aware of housing and other socioeconomic factors that affect the health and wellbeing of seniors (and address these concerns in care planning processes), many factors affecting seniors' ability to live independently in community fall outside the jurisdiction of health. The legislative and programmatic amendments proposed by the Seniors Advocate have the potential to address many factors that enable independent living such as deferring the expenses of owning a home and allowing for the home renovations and adaptations needed to accommodate the changing needs of seniors (widening doorways, adding stairway chair lifts, outfitting bathrooms with support rails, etc.). A key role for Northern Health will be to ensure seniors and communities are aware of the available housing programs and grants available to them.

Assisted Living:

- The Seniors' Advocate calls for the '*Registered Assisted Living*' program to be re-designed. The current eligibility criteria for assisted living is very narrow and excludes many seniors who would be able to maintain a good degree of independence if more supports were available to them or if supports were delivered using a more flexible approach.

This recommendation is consistent with what we heard from seniors across the north and with Northern Health's Seniors' Strategy that contemplates a series of actions to support frail seniors living in community. Guided by *Care Plans* established with the senior and their family in the Primary Care Home and with the support of interprofessional teams, seniors should receive a wide range of supports that are designed to meet the seniors' specific needs whether they are living independently at home or in assisted living environments.

Residential Care:

- This section of the Seniors Advocate's report seeks to reduce the likelihood of a person being admitted to residential care when other community or assisted living arrangements would be more appropriate. The report recommends the expanded use of the InterRAI assessment tool[i] to ensure that care options are appropriately calibrated to the seniors' needs and only those who meet the eligibility criteria for Residential Care are admitted.

Assessment protocols are important to guide care decisions. Part of Northern Health's Seniors Strategy focuses on expanding the use of the RAI assessment tool by training all members of Interprofessional Teams to use the tool to ensure seniors receive the services most appropriate for their care needs. Among other things, this approach will assist with early identification of frailty and early intervention to slow or halt the need for higher levels of care, such as admission to Residential Care.

The Seniors Advocate also calls for the reassessment of people currently living in Residential Care who do not need the level of care provided in this setting and who may prefer to receive care in an alternative setting, to explore whether they can transition back to community with the appropriate supports in place. This recommendation is consistent with the research conducted by Dr. Shannon Freeman from UNBC[ii]. Dr. Freeman reviewed Northern Health RAI data and determined that a percentage of people in residential care either did not meet the eligibility criteria at the time of admission or who met the criteria at the time of admission but no longer meet the criteria because their condition has improved while in care.

In summary, the intent of the Seniors Advocate's report is to produce a series of recommendations that are workable, realistic and will make an appreciable difference in the quality of life of seniors. The report recommendations are consistent with the views expressed in the seniors' consultationsenior are consistent with the key elements of Northern Health's Seniors' Strategy.

Recommendation(s):

This information is presented to the Board for information and discussion purposes. The Executive Summary of the Seniors Advocate's report and summary of the recommendations are appended.

Seniors' Housing in B.C. Affordable • Appropriate • Available
Executive Summary

May, 2015
Report #4
www.seniorsadvocatebc.ca

In the past year, the Seniors Advocate has met with thousands of seniors and their families in every region of the province. Among the many issues and concerns these seniors have raised and brought forward for discussion, they expressed a deep concern around the affordability, availability and appropriateness of seniors' housing in the province.

Seniors expressed clearly that they want to age as independently as possible in their own homes and in their local communities. However, low incomes and high living costs have a profound impact on the affordability of independent housing options for seniors, and on their ability to freely choose their living arrangements.

Many seniors accept that, as they age, changes to their health and mobility may necessitate a move to housing that incorporates a support or care component. However, many feel frustrated that their housing options are limited by the availability of appropriate housing in their communities and by the policies, practices and regulations currently in place that determine eligibility for particular types of housing. They fear they will be forced into assisted living or residential care prematurely, or need to move to faraway communities where there is no support system of friends and family.

Given the breadth and depth of the concern, the Seniors Advocate sought to undertake a review to identify issues across the continuum of independent housing, assisted living, and residential care settings that might limit seniors' ability to make choices about their housing. At each step along this housing continuum, the Advocate asked:

1. Have we done everything we can do to make this housing affordable?
2. Have we done everything we can to ensure this is the most appropriate place for seniors to live?
3. Have we done everything we can to make this housing option available to seniors?

The goal of this report is to emphasize some of the most pressing housing priorities facing seniors living in British Columbia. It is focused on recommendations that are practical, realistic and have the potential to leverage significant change.

The context of where and how B.C. seniors are currently living is necessary to appreciate the magnitude of the issues. The data indicate that, while many seniors are doing fine, some are not and require help to ensure their housing is affordable, appropriate and available.

A snapshot of how B.C. seniors are living shows that:

- 93% live independently in houses/townhouses/apartments/condominiums
- 80% are homeowners, of which 22% carry a mortgage
- 20% are renters, with 20% receiving some rent subsidy
- 26% live alone
- 4% live independently but receive provincially subsidized home care services
- 3% live in assisted living, with 20% receiving a subsidy
- 4% live in residential care, with 95% receiving a subsidy

The financial circumstances of B.C. seniors show that:

- The median income for seniors is $24,000
- 35% of seniors who rent live on a household income of $20,000 or less

- Average rents for a one-bedroom apartment vary from a high of $1,038 in Vancouver to a low of $547 in Quesnel
- While the average house price varies greatly in the province, the average annual costs of homeownership net of any mortgage payments is about the same regardless of where a senior lives, averaging around $1,000 per month
- 36% of seniors with household incomes less than $30,000 believe they will need to move in the future due to affordability

Independent Housing

Independent housing options for seniors include both home ownership and rental situations.
Independent housing is a choice that is appropriate for most seniors if it is affordable, if there is housing available that can provide accessibility to services and supports, and if it allows for design features to make the environment safe and accessible. There are data to support that, if seniors choose to, they can be cared for in their own home to very high care levels. Where the housing is located, whether or not there is a co-residing caregiver, and the degree of risk that a senior chooses to live with are all factors that will influence this choice, and different people will make different choices. However, should a senior choose to live independently, evidence supports this can be an appropriate choice.

The affordability of independent housing for low and moderate income seniors, both renters and homeowners, is challenging. Data support that many seniors who rent, particularly those in the Lower Mainland and Greater Victoria, are in genuine need of more support to cover their rental costs. The data also support that some low to moderate income seniors who are homeowners need to find cost relief for either their ongoing home ownership costs, or the extraordinary costs of major repairs.

The availability of suitable housing for seniors is lacking most in rural and remote areas of the province. This presents a particular challenge for those seniors who are isolated and may need to move into the nearest town once they are either widowed, lose the ability to drive, or require daily home support services if they want to continue to live independently and optimize their safety. In response to these issues, this report makes a number of recommendations including changes and amendments to existing programs designed to help seniors financially. For homeowners, a bold new initiative is proposed that would allow for some, or all, of seniors' household expenses to be deferred.

Assisted Living

Assisted living in British Columbia takes various forms: publicly-subsidized Registered Assisted Living, private-pay Registered Assisted Living, and private-market assisted living residences.
Assisted living is a housing choice for many seniors who wish to live in a community with others and have hospitality services like cooking and cleaning provided by the facility. It is also appropriate housing for seniors who require care but have a level of cognitive function that allows them to engage with the community of seniors they live with while maintaining their independence.

The data reviewed in this report support that, for many of the people living in Registered Assisted Living, it is an appropriate setting. However, the data also clearly indicate there are other seniors for whom subsidized Registered Assisted Living would be appropriate, but they are not eligible for this type of housing and care as a result of the current regulations. These seniors would appear to instead go prematurely to residential care.

The affordability of subsidized assisted living appears to be adequately regulated by the current rate structure whereby seniors pay 70% of their net income, with a Temporary Rate Reduction available to

those who need it. For seniors with very low incomes, however, these fees can leave very little disposable income for costs not covered by the fees.

The availability of assisted living overall appears to be sufficient given there is an estimated 10% vacancy rate. However, the availability in smaller, more remote communities may be a challenge. In general, the availability of subsidized assisted living is difficult to assess as there is no standardized method used for tracking vacancies either within or between health authorities. Based on these issues, this report makes recommendations related to several aspects of the current regulatory framework for assisted living.

Residential Care

Sometimes called long-term care, facility care or a nursing home, residential care provides 24-hour professional supervision and care in a protective, secure environment for people who have complex care needs and can no longer be cared for in their own homes or in assisted living settings. Seniors with Alzheimer's or other forms of dementia, those with significant physical incapacity, and those who require unscheduled and frequent higher level nursing care are all suited to live in residential care.

The data reviewed in this report suggests that residential care is the appropriate setting for the majority of seniors who live there, although some seniors are not in the appropriate location or their preferred facility. However, these data also suggest that some seniors in residential care, perhaps 5 to 15% of current residents, could be living in the community either with home care services or in assisted living.

The availability of residential care varies throughout the province. Waiting times for placement are greater in the north than in the Lower Mainland and waiting times are greatest for those who require highly specialized care such as a secure dementia unit. While it is difficult to assess accurately the sufficiency of beds overall, there is definitely a lack of availability of the bed of choice, or 'preferred bed'.

The affordability of residential care is assured by charging residents a percentage of their net income and by the availability of a Temporary Rate Reduction (TRR) in the case of undue financial hardship. However, awareness of the TRR and uniform application are lacking. This report recommends changes to how residential care clients are assessed in order to ensure that all possible options for care and support in the community, either via home care or assisted living, have been exhausted before a senior is admitted to a residential care facility. It also recommends changes to admission processes to ensure that seniors' admission to residential care is carried out in a fair and appropriate way that respects seniors' needs and preferences. Finally, the report calls upon the provincial government to commit to a higher standard of accommodation in residential care facilities, including the provision of single room occupancy with ensuite baths for 95% of beds by 2025.

Conclusion

We all want to do better for our seniors. This report highlights some of the systemic issues that seniors face as they strive to achieve housing that is appropriate, affordable, and available. It is clear that many low and middle income seniors, both renters and homeowners, need to have more financial help in meeting their basic needs. It is also clear that we need to do a better job in respecting the desire of seniors to live as independently as possible for as long as possible. Changes to the regulatory framework for Registered Assisted Living, along with more comprehensive screening for residential care admissions, are required to ensure our seniors are given all possible supports to live as independently as possible for as long as possible. Lastly, for those seniors with significant cognitive or

physical disability who require the level of care provided in residential care, we must do all we can to get them to a place they want to call home that offers the privacy and dignity they deserve.
Together, we can build a strong foundation of appropriate, affordable and available housing options for the seniors of British Columbia.

Independent Housing Recommendations

1. Revise the Shelter Aid for Elderly Renters Program (SAFER) to align with the subsidized housing model of tenants paying no more than 30% of their income for shelter costs, by:
   a. adjusting the maximum level of subsidy entitlement from the 90% currently indicated in the SAFER regulations to 100%; and
   b. replacing the current maximum rent levels used in the SAFER subsidy calculations with the average market rents for one-bedroom units in B.C.'s communities as reported annually by Canada Mortgage and Housing Corporation.

2. Create a Homeowner Expense Deferral Account type program, as outlined in this report, to allow senior homeowners with low or moderate income to use the equity in their home to offset the costs of housing by deferring some or all of the major ongoing and exceptional expenses associated with home ownership until their house is sold.

3. Amend the Residential Tenancy Act and Strata Property Act to protect tenants and owners who require non-structural modifications to their unit (i.e. grab bars, flooring) from either eviction, fine or denial and protect their right to access grant money from the Home Adaptions for Independence (HAFI) program.

4. Amend both the Residential Tenancy Act and the Strata Property Act to ensure that tenants/owners cannot be evicted or fined under bylaw for the occupancy of their unit by a live-in caregiver.

5. Amend the Home Adaptations for Independence (HAFI) program to: exclude the value of the home as a criterion; graduate the grant on a decreasing scale relative to income; decrease complexity for landlord applications; and allow for applications from strata corporations and co-ops.

6. Amend the Strata Property Act and the Manufactured Home Act to ensure seniors who are placed either in residential care or subsidized Registered Assisted Living are able to rent their homes while they are listed for sale.

7. The Provincial Government consult with the Active Manufactured Home Owners Association, the Manufactured Home Park Owners Alliance of British Columbia and regional manufactured home owners associations to revise the Manufactured Home Act so that fair and equitable compensation is provided to manufactured home owners who are required to leave their home due to sale or development of the property.

8. The Provincial Government, BC Housing and the Office of the Seniors Advocate work together to develop a strategy for affordable and appropriate seniors housing in rural and remote British Columbia.

9. The Provincial Government work with the Federal Government on the issue of seniors who are homeless as a discrete population within the homeless community.

10. The Provincial Government works with the Office of the Seniors Advocate to raise awareness of all subsidy and grant programs available to seniors.

Assisted Living Recommendations

11. Registered Assisted Living be fundamentally redesigned and regulations changed, to allow for a greater range of seniors to be accommodated and age in place as much as possible including palliative care. This should reduce: the number of discharges from Registered Assisted Living to Residential Care; the number of admissions to residential care of higher functioning seniors; and the number of seniors admitted directly to residential care from home with no home care.

12. Amend section 26(6) of the Community Care and Assisted Living Act to:
   a. allow that section 26(3) of the Act does not apply to a resident of assisted living if that person is housed in the assisted living facility with a person who is the spouse of the resident or anyone in the classes listed in section 16(1) of the Health Care (Consent) and Care Facility (Admission) Act and that person is able to make decisions on behalf of the resident.
   b. provide that the meaning of "spouse" should extend to a person who has lived in a marriage like relationship with the resident in addition to a person legally married to the resident.

13. The minimum amount of income with which a resident of subsidized assisted living is left be raised to $500 from the current $325 to recognize the costs that are not covered under Registered Assisted Living that are covered under Residential Care.

Residential Care Recommendations

14. All health authorities adopt a policy that everyone assessed for admission to residential care who scores lower than three on either of the ADL Hierarchy or Cognitive Performance Scale on the InterRAI-HC or MDS 2.0 must receive an additional assessment to ensure all possible options for support in the community, either through home care or assisted living, have been exhausted.

15. All current residents in residential care whose latest InterRAI assessment indicates a desire to return to the community be re-assessed to ensure all possible options for support in the community, including additional supports for their caregiver and potential placement in assisted living are exhausted.

16. All health authorities immediately adopt a policy that any vacancies in residential care will be filled first from the preferred facility transfer list, and only after that has been exhausted will the bed be filled from the assessed and awaiting placement (AAP) list. Residents, if they choose, should be permitted to be placed on the transfer list for their preferred facility immediately upon admission to their first available bed. Residents and their family members should be regularly advised of:
   a. How many people are ahead of them on the waiting list for a preferred bed; and
   b. How many vacancies on average occur in the preferred facility.

17. The resident co-payment amount charged to residents who do not enjoy a single room must have a portion of their rate adjusted to reflect their lower grade accommodation.

18. The government commit that by 2025, 95% of all residential care beds in the province will be single room occupancy with ensuite bath and any newly built or renovated units meet the additional standard of shower in the ensuite washroom.

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[i] InterRAI assessment refers to a series of Clinical Assessment Protocols designed to help clinicians focus on key issues identified during the assessment process so that decisions about what kinds of supports will best meet the individual's needs can be explored with the person and their family.

[ii] "Caring for older adults in their preferred location of care: An evidence based intervention study to support safe transition from residential care facilities back to rural and remote northern communities"

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Workplace Health and Safety
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(P) 250-645-6408 (F) 250-565-2015

BRIEFING NOTE

Date:	June 5 2015	
Agenda item	Northern Health Violence Strategy	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	The Northern Health Board of Directors	
Prepared by:	Frank Talarico, Director, Workplace Health and Safety	
Reviewed by:	David Williams, Vice President, Human Resources Cathy Ulrich, CEO	

Issue:

Extensive efforts have been directed to the Violence Prevention Program (VPP) at Northern Health over a number of years and significant progress has been made. However, program implementation has limitations when not supported by a systems approach; for example, variations in uptake, effectiveness and sustainability may occur. Provincially, attention is being focused on the effectiveness and consistency of current VPP implementation:

1. WorkSafeBC statistics show that healthcare disproportionally represents time loss claims due to acts of violence with 57% of all violence related time loss claims arising out of the health care and social services subsector. WorkSafeBC's 2015 Healthcare High Risk Strategy focuses on violence prevention and the occupational health and safety responsibilities of supervisors*. This WorkSafeBC inspection activity may result in orders related to VPP implementation.
2. The Ministry of Health is focusing on the issue of violence in the workplace and recently requested Violence Prevention Program Activities Audits from all health authorities.

**WorkSafeBC definition of supervisor*: A person, who instructs, directs and controls workers in the performance of their duties.

Background:

Employers are required under the Workers Compensation Act Section 115 to ensure the health and safety of all workers. The Violence Prevention Program is mandated in the BC Occupational Health and Safety (OHS) Regulation Sections 4.27-4.31 and Policy R4.29-2 when violence is identified as a workplace hazard.

Building an effective occupational health and safety management system will contribute to reducing injuries to workers, improving the workplace environment for all, and achieving the Northern Health vision.

At the May 2015 meeting, the Executive Team approved the following recommendations:

1. Ensure all Northern Health Operations implement and sustain effective systems for preventing violence in the workplace.
2. Ensure all leaders understand and act on their occupational health and safety responsibilities as outlined in the Workers Compensation Act.

To support these recommendations, the attached document outlines roles and responsibilities of workplace parties based on the BC Workers Compensation Act and CSA Standard Z1000-06: Occupational Health and Safety Management[1], as required for implementation and sustainability of an effective and comprehensive Violence Prevention Program.

References:

1. CAN/CSA-Z1000-06 Occupational Health and Safety Management, Canadian Standards Association (CSA), 2006.

Recommendation:

The Board of Directors receive the following for information only.

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VIOLENCE PREVENTION PROGRAM – June 2015

Employers are required under the Workers Compensation Act Section 115 to ensure the health and safety of all workers. The Violence Prevention Program (VPP) is mandated in the Occupational Health and Safety Regulation of BC, Sections 4.27 – 4.31 and Policy R4.29-2 as part of an employer's OHS program when violence is identified as a workplace hazard. The following table outlines healthcare-specific requirements for the violence prevention program (VPP).

Northern Health leaders are committed to a safe and healthy workplace for all NH staff. In NH, our workers are our most valuable asset and resource. Our goal is to have each and every staff member leave work in the same condition that they arrived, that is, safe and healthy.

Despite the many local and provincial efforts thus far, violence continues to occur in healthcare workplaces. NH is committed to building on these efforts in order to provide the safest and healthiest environment possible. Although violence prevention initiatives are largely driven by the Worker's Compensation Act, NH is taking a step further in recognizing that a safe and healthy working environment for all will support the organization's goal of providing quality client centered care.

As an immediate plan, NH will commit to:

- *An increase in reporting on violence and near misses*
- *Appropriately educating staff in the high risk areas so they know what the processes are and what steps to follow.*

It is through the dedicated work of leadership, staff and physicians that NH continues to further enhance the safety and health of its workplaces.

GOAL: To create a culture of safety for staff and patients.

Executive Commitment:

- That participation in violence prevention education for employees will be mandatory.
- That site violence prevention risk assessments for potential violence will be completed or updated and recommendations will be acted upon.
- That support will be provided for patient/client risk assessments and appropriate recommendations will be implemented.
- That Code White Response Plans for each site will be comprehensive and based upon the level of risk, and will be reviewed for resource requirements.
- That violent incidents will be investigated and corrective actions implemented to prevent recurrence.
- That roles and responsibilities of the employer, supervisor and worker under the act will be defined and committed to.

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ROLES AND RESPONSIBILITIES FOR IMPLEMENTING AND SUSTAINING VIOLENCE PREVENTION PROGRAM

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
Provide Leadership	Endorse Violence Prevention Policy and establish as a priority Lead communication in portfolio Monitor progress in portfolio Approve appropriate resources required	Receive and review the current state, gap analysis, and work plan. Establish as a priority in management work plans Violence prevention program implementation is included in all leader performance plans Communicate VPP as a focus area to JOHSC committees Use Management Rounds to follow up on VPP implementation Understand and execute supervisory responsibilities at all	Communicate and review (with all staff) the violence prevention elements at management / supervisory rounds Include VPP as a standing agenda item Establish process to communicate and review VP items at regular intervals (e.g. supervisory rounds; for topics such as VB screening, alerts, care plans, incident reporting, investigation results/follow up, etc.) Understand and execute supervisory responsibilities at all levels including the	Create a tool for use in conducting a gap analysis on violence prevention program implementation across NH. Collate gap analysis results received from sites. Support leadership and JOHSC in addressing findings of the gap analysis; sourcing content expertise where required. Assist with developing a framework/process for management rounds	JOHSC members to complete VPP modules if have not already. Communicate to co-workers the importance of the violence prevention program, attendance as scheduled at education programs, and the importance of participating in all relevant processes both preventative and responsive. Participate in completion of the actions identified in the work plan.	Communicate the importance of violence prevention and management in quality care Ensure understanding and integration of worker and patient safety in clinical care.	Understand and act upon responsibilities under the Workers Compensation Act and as outlined in the NH VPP policies.	Become familiar with and understand the NH VPP policies and program elements. Support organizational VPP efforts by communicating and promoting NH VPP initiatives and providing constructive feedback as required.

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ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
		levels including the provision of adequate supervision as per WorkSafeBC definition.	provision of adequate supervision as per WorkSafeBC definition. All leaders with supervisory responsibility to complete the violence prevention modules. All leaders with supervisory responsibility to complete the Managing Safety in Healthcare and OHS for Leaders modules.					

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
Complete Site Violence Prevention Risk Assessments	Review results of risk assessments, approve plans and required resources	Inventory sites and high risk departments re: completion of risk assessments Make plans to complete site risk assessments as required and/or support frontline leaderships in completing, reviewing and following up on outcomes of the risk assessments. Monitor site and high risk department progress re completion of risk assessments Monitor site and high risk department progress re action plans to address findings of the risk assessment	Arrange, participate and engage staff in site risk assessment processes Review and update the most recent site risk assessment, in consultation with site JOHSC (all new builds will require new site risk assessments) All sites and high risk departments to have a recent violence prevention risk assessment. (Recent is defined as the risk assessment that contains the most recent structural description on the site as well as an annual review). The risk assessment team involves JOHSC worker rep(s) and all staff who are	Provide support to site leadership and JOHSC for each site in the updating or completing the site risk assessment, assisting with the identification of gaps, and providing guidance on control measures	Participate in completion, review and updating of site risk assessment with site leadership. Provide input and consultation to site leadership in developing action plans to address identified gaps.		Participate in feedback opportunities and provide suggestions for improvement during risk assessments	Participate on risk assessment team and provide constructive feedback and suggestions for improvement during risk assessment processes

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ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
			interested in being part of this team. All staff invited to participate in the worker feedback process via the online survey. Develop action plans to address identified gaps, in consultation with site JOSHC An action plan is developed for each site/high risk department address all findings of the risk assessment(s).					
Complete Patient/Client Risk Assessments	Establish requirement for patient risk assessment processes (i.e. Violent Behaviour Alert Notification policy and procedures) and the intent to review	Support the process review led by Professional Practice, sending delegates as requested and ensuring current process information is shared Ensure full support	Implement and communicate site processes in alignment with regional DST for completion of Violent Behaviour screening, assessment, and behavioural care	Provide content expertise as needed	Annually review Violent Behaviour Alert Notification processes for patient/client risk assessments. Receive and review the progress reports	Understand the regulatory requirements for this aspect of violence prevention and support the integration of worker and patient safety in	Understand and follow procedures for assessment, behavioural care planning, alerts, and appropriate communication of alerts and related information required to	Become familiar with and understand NH policy and procedures for Violent Behaviour Alerts. Support implementation

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
	these processes Provide commitment to promote any recommended changes, and communicate with appropriate groups including medical staff	and actions necessary to fully implement the recommendations from the process review. Monitor site progress on process review led by Professional Practice. Monitor site progress on implementation of Patient/Client Risk Assessments (i.e. Violent Behaviour Alert Notification procedures).	planning, including clinical responsibility and documentation. Site processes are established for communicating violent behaviour risk and associated safety plans to all workers who may be exposed to the risk in the course of their work. Site processes are established for communicating violent behaviour alert status when patients are transferred to different services, programs, facilities. All patients/clients have a violent alert behaviour screening documented on admission		of the process review by Professional Practice for patient/client risk assessments. Provide feedback on the material received to the process review team. Reinforce to co-workers the importance of behavioural care planning, charting and communication of violent behaviour.	clinical care. (Violent Behaviour Alert Notification) Lead a process review for patient violence risk assessments, charting, behavioural care planning, and communication of risk between providers and across settings	maintain staff safety	and ongoing sustainability of alert processes by communicating and promoting their use. Provide constructive feedback and suggestions for improvement during annual review processes.

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ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
			All patients who meet the screening criteria have an alert placed on their file For patients with alerts placed on their files, behavioural care plans identifying safety procedures are in place.					
Education and training	Establish requirement for violence prevention education and training curriculum which includes provincial e-learning modules, classroom personal safety and code white training	Prioritize mandatory education for sites with ER, Inpatient Mental Health, and residential/community sites providing dementia care or mental health client services Ensure e-learning modules are accessible by staff and that staff complete the modules prior to classroom sessions Support attendance at the mandatory classroom education	Establish site plan for VPP education and training based on risk. Ensure e-learning modules are accessible by staff All staff identified as needing to complete VPP modules have done so. Ensure that staff complete applicable VPP modules prior to classroom sessions.	Provide the education program appropriate to the varying degrees of risk. Provide the instructors (as applicable)and materials/ Provide classroom session attendance list to site leadership for review. Provide site trainer workshops and mentoring.	Promote the e-learning modules and classroom education sessions to increase attendance at the site.	Ensure an education plan forms part of the implementation of any change to current processes for all providers, both employees and medical staff. Ensure current medical staff participate in violence prevention education	Attend, and actively participate in VPP education and training. Apply and implement VPP practices.	Support implementation and ongoing sustainability of VPP education by communicating and promoting it at the site. Attend, and actively participate in VPP education and training. Apply and implement VPP practices in the workplace.

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
		programs, including backfill where required Support development of internal/site trainers to sustain training requirements for all high risk staff Monitor site progress re VPP education and training of staff Monitor site progress re development and support for internal /site trainers (training, time and scheduling).	Staff requiring mandatory classroom education are identified. Plans are in place to ensure all required staff attend required education sessions on paid time, including relief/backfill as needed. Support development of internal/site trainers to sustain training requirements for all high risk staff Staff are identified as internal trainers (in consultation with WHS) Internal trainers are supported re time and scheduling to carry out their duties	Provide train the trainer workshops and mentoring for site trainers.				Provide constructive feedback and suggestions for improvement during annual review processes.

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
New and young worker orientation	Establish requirement for new and young worker OHS orientation which includes VPP	Ensure implementation and tracking of new and young worker OHS orientation (includes VPP) Monitor site progress re completion and documentation of new and young worker OHS orientation	Ensure all new and young workers receive OHS orientation (includes VPP) Documentation indicates that every new and young worker receives OHS orientation including VPP.	Provide resources for new and young worker OHS orientation	Promote the need for new and young worker OHS orientation, communicate resources, and follow up to ensure site based implementation and tracking	Ensure new medical staff participate in violence prevention orientation	New workers complete required OHS orientation.	Participate with site management in promotion and monitoring of new worker OHS orientation implementation and sustainability. Provide suggestions for improvement during annual review processes.
Code White Response Plans	Establish requirement for all sites to have a written Code White Response Plan in place	Monitor site progress re site Code White response plan (CWRP) documentation and education of all staff Monitor implementation and sustainability (at the site level) for the Code White Response Plan including Code White drills and practice sessions	Ensure written site-based Code White response plans include: i. Code White response (based on levels) including roles and supports required ii. Code White drill or practice session plans iii. Education of all site staff in the site Code White Response Plan	Provide site-specific Code White Response Plan template Provide support to the sites in the development of a Code White Response Plan, identifying potential gaps and providing recommendations as appropriate	Review (at least annually) site Code White Response Plan and provide feedback input to site leadership as needed.	Understand the requirements for appropriate safe Code White Response and support the integration of worker and patient safety in this aspect of clinical care.	Demonstrate ability to carry out their responsibilities for Code White Response in the workplace. Participate in Code White Response as appropriate.	Be familiar with responsibilities for Code White Response in the workplace. Understand the requirements for appropriate safe Code White Response and participate in development and annual review of the site Code White Response Plan.

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
			Documentation indicates that all staff have been educated in the site Code White Response Plan including: i. how and when to call for assistance in case of violent incidents ii. Code White response (based on levels) including their role and responsibility Ensure that Code White drills are regularly held. Code White Team practice sessions are regularly held (Code White Level 3 sites) The written site-based Code White response plan includes the required elements.					

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ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
			Documentation indicates that all staff are educated in the site CWRP					
Working Alone or In Isolation	Establish the requirement to have Working Alone or In Isolation plans in place	Ensure working alone risk assessments and site/program specific working alone procedures are completed as required. Monitor site progress re • site working alone risk assessments • site/program specific working alone procedures	Complete working alone risk assessments All departments /sites where working alone or in isolation applies have conducted and documented a working alone risk assessment. Complete site/program specific working alone procedures as required. All departments /sites where working alone or in isolation applies have site/program specific working alone procedures based on	Finalize the working alone guidelines document (revision from 2007) Provide support and templates for working alone program risk assessments and site/program specific working alone procedures	Review and provide feedback on site/program/ department working alone procedures	Understand the requirements for working alone	Know policies, procedures and responsibilities when working alone or in isolation. Comply with risk assessment and check in procedures as required.	Review and provide feedback on site/program/ department working alone procedures Provide constructive feedback and suggestions for improvement during annual review processes.

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
			risk assessment In all departments /sites where working alone or in isolation applies, staff have been educated in: i. Risk assessment procedures ii. Control measures to decrease risk including Check-in/Check Out procedures iii. Safe travel procedures iv. Right to refuse visit policy (community)					
Incident reporting	Establish the requirement for reporting of violent incidents and near misses	Ensure all leaders understand reporting requirements for violent incidents	Ensure all workers understand reporting requirements for violent incidents including near misses Review reporting requirements for the Workplace Health Call Centre (WHCC)	Provide reports from WHITE database	Promote incident reporting	Understand the Workers Compensation Act requirements for incident reporting	Report all violent incidents and near misses to the Workplace Health Call Centre.	Communicate and promote incident reporting.

ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
			and violent incidents and clarify Patient Safety Learning System (PSLS) and WHCC reporting. (Review with all staff) All workers understand reporting requirements for violent incidents, hazards and near misses. Number of incidents and near misses reported to the WHCC					
Incident Investigation	Establish the requirement for investigation of violent incidents and near misses	Ensure all managers understand their responsibility for incident investigation and implementation of corrective actions Ensure all violent incidents are investigated	Investigate all violent incidents and implement corrective actions. All incidents and near misses are investigated. All investigations are	Provide resources and support/ guidance as requested Support site based investigation process	Follow up to ensure violent incidents and near misses are investigated and corrective actions are implemented	Understand the requirements for incident investigation as per the Workers Compensation Act	Participate in incident investigations as required.	Participate in incident investigations as required. Review incident investigations at JOHSC meetings and follow up with managers on

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ACTION	SENIOR LEADERSHIP	REGIONAL LEADERSHIP	SITE/FRONTLINE LEADERSHIP	WHS	JOHSC	PROFESSIONAL PRACTICE/MEDICAL AFFAIRS	WORKERS	UNION OHS REPRESENTATIVES
			conducted with an investigation team as per process.					effectiveness of corrective actions as required.
Data Gathering and Progress Reporting	Establish the requirement for data gathering and progress reporting Identify what data metrics and progress reports are required	Complete progress reporting Senior Leadership at identified frequency. Support the data gathering and progress reporting for all leaders Identify resource requirements to Executive for approval Review reports for areas of improvement	Participate in data gathering and progress reporting Review reports for areas of improvement Use of reporting tool at frequency identified by leadership	Develop a reporting template which includes all aspects of violence prevention program progress reporting (all aspects of the program as per WSBC regulations). Provide senior leadership with available data metrics related to violence prevention	Review progress on all aspects of the site specific implementation of the VPP at each meeting and report out to employees, WSBC and unions			

BOARD ROLE AND GOVERNANCE OVERVIEW V.1 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 Minister of Health, 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 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 9, 2014 (R)

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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 budget management. 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 or with the Board as a whole. Refer to Policy BRD300, which outlines terms of reference and guidelines for Board committees.

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Task Forces

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 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)

5.6. A consent agent package will be provided with materials for the interest of the Board members for information only. This information will not be discussed during the Board meeting; however, there will be opportunity at the beginning of each Board meeting to review the consent agenda material and move items to the regular agenda for discussion.

6.7. 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.

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

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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. 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 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

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

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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

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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COMMUNICATION POLICIES V.1 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 may invite community representatives to a round-table session, particularly when Board meetings are conducted outside of Prince George.

This meeting 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 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 may be facilitated by a senior executive member and 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

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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 V.1 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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~~7.~~8. The Board authorizes the CEO to set travel expense reimbursement rates for excluded employee expenses, including but not limited to travel costs, per diem meal claims and mileage. Limitations should be set in consideration of Ministry of Finance Policy 10.0 Travel[2]. ~~The~~ The Audit and Finance Committee is to be provided, as information, the NH Travel Expense Reimbursement policy at minimum annually or when a revision has been made.

~~8.~~9. 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.~~10. The CFO, or the CFO's delegate, is authorized to approve financial transactions related to regulatory payments, utilities and payroll deductions without limit

~~10.~~11. 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[3] outlining any such designated spending authorities will be maintained.

[2] http://www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/10_Travel.htm#103
[3] 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[4]:

1. Borrowing
   1.1. Subject to approval by the Minister of Health, the Board 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 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.

[4] 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 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 has the authority to ratify 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[5]

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

[5] See ~~Administration Policy [currently under development]~~Banking Policy 4-4-6-040

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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 V.1 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).

The naming of physical assets in recognition of financial or in-kind contributions must be submitted to the Intellectual Property Program by way of a Naming Opportunity Request Form (Appendix 3), regardless of the size of the asset.

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

Quick Overview 2
Initial Request - Executive Sponsor 2
Process to Initiate/Respond to Request 2
Naming Committee – Terms of Reference 3
Naming Opportunities by Asset(s) 4
(a) Classification
(b) Pricing
(c) Term
Evaluation Criteria (Applicable To All Naming Requests) 5
Additional Criteria for Distinguished Service Nominations 7
(Without Financial Consideration)
Approval Process
Approval by Asset 8
Additional Provincial Government Approval (Class I and II Assets) 9
Process to Revoke Naming Right 9
Policy Review 9
Appendix I – NH Nomination Application Form 10
Appendix II - Government of British Columbia "Naming Privileges Policy" 10

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 9th 2014 (r)

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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.

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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
- Regional Director, Business Development
- Regional Director, External Relations/ Chief Communications Officer
- 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:

Assess naming opportunities submitted to the Naming Committee;

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.

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.

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.

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.

Reach agreement, and recommend approval or denial of a naming right to the appropriate approving agent.

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.

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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. May be inconsistent with Northern Health's legal obligations
   b. Is likely to result in an employee of a public sector body or an elected official receiving any benefit or personal gain
   c. Is likely to have a negative impact on the image or reputation of or damage public respect for NH or any of its affiliated Foundations and Auxiliaries.
   ~~a.~~d. Conveys a message that might be deemed to be prejudicial to race, religion, gender, or sexual orientation, or cause offence to a community group.
   ~~a. Would call into serious question the public respect for NH or its affiliated Foundations and Auxiliaries.~~
   ~~b.~~e. Is likely to be associated with an unhealthy lifestyle (e.g. alcohol or tobacco usage, obesity etc.)
   ~~c.~~f. Implies endorsement of a partisan political, ideological or religious position. This includes use of the name of an elected official currently in office but does not preclude use of the name of an individual who has previously held public office.
   ~~d.~~g. 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

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any portion of the proceeds) provided that the donor's wishes will be honoured to the greatest extent possible.

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. If the naming opportunity is accompanied by a financial or in-kind contribution, regardless of the class of asset, the additional process of provincial government approval must be followed.

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

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

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~~naming opportunities for all classes of asset that are accompanied by a financial or in-kind contribution, 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.

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Policy Review
This policy will be reviewed annually by the GMR Committee.

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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APPENDIX 3 – Naming Opportunity Request Form

NAMING OPPORTUNITY REQUEST FORM

This form is used by government bodies to submit proposals to Cabinet (either directly or indirectly through the Naming Committee) pursuant to the Naming Privileges Policy

PART 1 - NAMING REQUEST

1. Proposed Name of Asset (plus former name of asset, if any):

2. Term of the Naming Opportunity (how long will the naming opportunity apply to the asset):

3. Description of the public asset to be named (including location, and whether the proposal applies to an entire asset such as a building or to a portion of the asset):

4. a) Dollar value of the donation to be associated with the naming opportunity:

   b) Has the donation been received?

   c) Date and amount paid for each received payment:

   d) Anticipated date and amount to be paid for each future payment:

   e) If the donation was not received in cash (in-kind contribution, shares, etc.) please provide a description of the donation and how it was valued.

PART 2 - BENEFACTOR INFORMATION

1. Benefactor profile: (Name, philanthropic and business history, community activities, public offices held, etc.):

2. If the asset is to be named in honour of individual(s) other than the benefactor listed above, please provide any relevant information pertaining to that person:

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3. If the financial contribution is provided by a commercial benefactor, please provide details of the process used to select the benefactor:
PART 3 - OTHER
1. Any additional information that the Naming Committee should be aware of:
2. Entity submitting the request, such as Health Authorities, Foundations, Institutions etc. (please include contact name and title, address, telephone and email address):
Please attach the formal letter of commitment or contractual arrangement with the benefactor.

SIGNATURE OF REQUESTOR

Name & Title Date

Intellectual Property Program
Ministry of Technology, Innovation and Citizens' Services
Attn: Pamela Ness
563 Superior Street, 3rrd Floor
PO BOX 9452 STN PROIV GOVT
Victoria, British Columbia V8W 9V7
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2. Term of the Naming Opportunity (how long will the naming opportunity apply to the asset):

3. Description of the public asset to be named (including location, and whether the proposal applies to an entire asset such as a building or to a portion of the asset):

4. a) Dollar value of the donation to be associated with the naming opportunity:

   b) Has the donation been received?

   c) Date and amount paid for each received payment:

   d) Anticipated date and amount to be paid for each future payment:

   e) If the donation was not received in cash (in-kind contribution, shares, etc.) please provide a description of the donation and how it was valued.

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1. Benefactor profile: (Name, philanthropic and business history, community activities, public offices held, etc.):

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PART 3 - OTHER
1. Any additional information that the Naming Committee should be aware of:
2. Entity submitting the request, such as Health Authorities, Foundations, Institutions etc. (please include contact name and title, address, telephone and email address):
Please attach the formal letter of commitment or contractual arrangement with the benefactor.

SIGNATURE OF REQUESTOR

________________________________ ____________________

Name & Title Date

Intellectual Property Program
Ministry of Technology, Innovation and Citizens' Services
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563 Superior Street, 3rrd Floor
PO BOX 9452 STN PROIV GOVT
Victoria, British Columbia V8W 9V7
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Fax: 250 356-6036

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BOARD BRIEFING NOTE

Date:	May 14, 2015	
Agenda item	BRD 315 External Auditor Independence	
Purpose:	☐ Information	☐ Discussion
	☐ Seeking direction	☒ Decision
Prepared for:	Board of Directors	
Prepared by:	Mark De Croos - VP, Finance & Chief Financial Officer	

Issue:

To review and update the policy BRD 315 External Auditor Independence.

Background:

KMPG, NH's external auditor, has expressed concern that Board BRD 315 External Auditor Independence limits their ability to bid on non-audit services to the Northern Health.

The specific wording that is of concern is as follows:

7. Except for those services set out in #5 above, management may arrange the provision of non-audit services by the external auditor provided that:
   a. The costs of such services do not exceed an amount equal to 25% of the regular external audit fee for the year as approved by the Board
   b. The costs of the service to be provided, combined with the cost of any other non-audit or internal audit services provided by the external auditor in the same year do not exceed an amount equal to 50% of the regular audit fee
   c. All such services are reported to the Committee at the next scheduled meeting along with the reasons therefore

A review of related polices of the other Health Authorities was conducted and summary was presented to the Committee in March 2015.

It is proposed to revise section 7 the following item to the section above:

7. Except for those services set out in #5 above, management may arrange the provision of non-audit services by the external auditor provided that:
   a. A formal procurement process is followed in accordance with NH procurement policies
   b. The costs of such services do not exceed an amount equal to 25% of the regular external audit fee for the year as approved by the Board
   c. The costs of the service to be provided, combined with the cost of any other non-audit or internal audit services provided by the external auditor in the same year do not exceed an amount equal to 50% of the regular audit fee
   d. All such services are reported to the Committee at the next scheduled meeting along with the reasons therefore
   e. Any proposal to engage the external auditor for the provision of non-audit services, the costs of which will exceed the limits set out in 7(b) and (c), must have the prior approval of the Committee. Where the need for such services is time sensitive, the CFO may request the Chair of the Committee to convene a special meeting of the Committee.

Recommendation(s):
The Northern Health Board approves the revised BRD315 External Auditor Independence Policy.

EXTERNAL AUDITOR INDEPENDENCE BRD 315

PURPOSE

Policy BRD 310, *Terms of Reference for the Audit & Finance Committee* (the "Committee"), assigns to the Committee the responsibility of reviewing the planning and results of external audit activities, and for overseeing the ongoing relationship with the external auditor.

The Committee recommends engagement of the external auditor to the Board of Directors of Northern Health (the "Board"). As specified in the section entitled "External Audit", it is also required to:

- *review and receive assurances on the independence of the external auditor; and*
- *review the non-audit services to be provided by the external auditor's firm or its affiliates (including estimated fees) and consider the impact on the independence of the external audit*

The objectivity and integrity of the external auditor is fundamental to the public confidence in the reliability of the external auditor's report and hence the public accountability of Northern Health.

Since the external auditor is required to have a relationship with the client, absolute independence is not possible. The significance of economic, financial and other relationships must therefore be evaluated in the light of what a reasonable and informed third party would conclude as acceptable.

The purpose of this policy is to establish principles and controls designed to provide reasonable assurance that the external auditor maintains an adequate degree of independence to ensure objectivity and integrity.

The principles and controls set out below concern the engagement of the external auditor, the justification of non-audit services, and the hiring of audit staff.

ENGAGEMENT OF THE EXTERNAL AUDITOR

1. The external auditor's independence can be influenced by a number of threats including, but not limited to:
    a. Self-review threats that occur when an external auditor provides assurance on his or her own work

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b. Self-interest threats that occur when an external auditor could benefit from a financial interest in a client or when there is an undue dependence on an assurance[1] client
c. Advocacy threats that occur when an external auditor promotes a client's position or opinion
d. Familiarity threats which occur when an external auditor becomes too sympathetic to a client's interests
e. Intimidation threats which occur when an external auditor is deterred from acting objectively by actual or perceived threats from a client

2. It is expected that the external auditor will maintain a quality control system which recognizes these and other threats and provides reasonable assurance that his or her independence is not impaired.
3. The external auditor is required to give the Committee annual assurances concerning independence.
4. The external auditor is expected to adhere to a rotation policy that provides a balance between effectiveness, efficiency and independence. This rotation must be at intervals of no more than seven years for the lead partner responsible for the audit.

   An exemption on an annual basis from these requirements can be granted by the Committee if circumstances require such an exemption. Where there is only one partner engaged, the Committee may request that a partner from another location of the same firm be utilized in at least one year.
5. The external auditor should not hire and involve any of the following individuals to participate in the audit within twelve months of the cessation of their employment with Northern Health:
   a. Individuals who were previously employed as senior management of Northern Health, or
   b. Individuals who were previously employed as participants in processes or areas subject to external audit procedures.
6. Once the Committee is satisfied that the external auditor recognizes and accepts these principles and responsibilities it will authorize the Board Chair and the President and Chief Executive Officer (the "CEO) to jointly co-sign the letter of engagement.
7. The Committee will annually provide the Board with a summary of any internal audit and non-audit services undertaken by the external auditor and the associated fees.

[1] An 'assurance client' is a client who is receiving external audit services

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INTERNAL AUDIT SERVICES

1. Internal audit services encompass assurance and consulting activities undertaken by the Internal Audit department of Northern Health. Internal Audit may, during the course of the year, seek assistance on projects through contract relationships with qualified individuals or firms.
2. The Institute of Chartered Accountants of British Columbia (ICABC) Rules of Professional Conduct[2] specifically prohibit performance of an external audit engagement if:

   "… during either the period covered by the financial statements subject to audit or the engagement period, …the licensed firm… provides an internal audit service to the client or a related entity, that relates to the client's, or the related entity's, internal accounting controls, financial systems or financial statements unless it is reasonable to conclude that the results of that service will not be subject to audit procedures during the audit of the financial statements. In determining whether such a conclusion is reasonable, there is a rebuttable presumption that the results of the internal audit service will be subject to audit procedures."
3. The external auditor should not provide internal audit services where the services comprise a significant portion of the internal audit activities.
4. Certain internal audit activities may impair the independence of the external auditor and should not be undertaken by the external auditor:
   a. Performing ongoing monitoring or quality control activities that relate to the execution, accounting for, or approval of transactions
   b. Determining which, if any, recommendations for improving the internal control system should be implemented
   c. Reporting to the Board or the Committee on behalf of management or Internal Audit
   d. Approving or being responsible for the overall internal audit work plan, including the determination of the internal audit risk and scope, project priorities, and frequency of performance of audit procedures
5. The licensed firm is required to identify threats to its independence and either apply safeguards to reduce the threats to an acceptable level or refuse to accept the external audit engagement.[3]

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[2] *Rules of Professional Conduct*. Institute of Chartered Accountants of British Columbia: s.204.4 (27) – Mar/2012.
[3] Ibid, 204.2.

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6. A proposal by Internal Audit to engage the external auditor for any internal audit services must be approved in advance by the Committee. The proposal will provide an estimate of fees and a description of safeguards to ensure independence of the external auditor is maintained. The proposal must be accompanied by a statement by the external auditor that such services:
    a. Will not be provided by external audit staff members participating in an external audit of Northern Health within twelve months of the provision of internal audit services
    b. Will be supervised and reviewed by an external audit partner other than that responsible for the provision of external audit services
    c. Will exclude audit items covered in the annual external audit
    d. Will exclude activities outlined in #4 above
7. The total fees incurred in the provision of internal audit services by the external auditor will not exceed 25% of the regular external audit fee for the year as approved by the Board.

NON-AUDIT SERVICES

1. External audit services are those related to the formulation of an opinion on financial statements prepared by management and include advice on accounting policies. Non-audit services are those services other than external or internal audit services.
2. Non-audit services undertaken by the external auditor create actual and/or perceived self-review, self-interest or advocacy threats to the independence of the external auditor. The degree of the threat depends on the nature, scale and scope of the non-audit services.
3. In relation to the provision of non-audit services, the term external auditor shall be interpreted as meaning the external auditor and any of its affiliates. The term affiliates will be interpreted by reference to the substance of a relationship with the audit firm but will generally include any entity controlled by the audit firm or under common control, ownership or management.
4. The external auditor may be engaged to provide non-audit services where there are good reasons and the services to be provided do not create a material threat to the independence of the external auditor. Good reasons for the external auditor to be appointed to perform non-audit services include:

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   a. It is economical in terms of skill and effort for the external auditor to provide such services as a result of his or her intimate and specialised knowledge of the business
   b. The information required is a by-product of the audit process
   c. The services are required by legislation or regulation
5. Certain categories of non-audit services are considered to be potentially incompatible with the independence of the external auditor and should normally be avoided. These categories include:
   a. Performance of management functions or making management decisions
   b. Financial statement preparation services and bookkeeping services
   c. Valuation services
   d. Actuarial services
   e. Designing or implementing a hardware or software system
   f. Designing or implementing internal controls over financial reporting
   g. Legal services
   h. Recruiting services
   i. Certain corporate finance activities that create an unacceptable advocacy or self-review threat including making investment decisions or having custody of assets such as securities
6. A proposal by Northern Health management to engage the external auditor for any services in the categories set-out in #5 above must be approved in advance by the Committee. In the review of such proposals the Committee will, where further detailed guidance is considered necessary, refer to standards and guidelines issued by the Canadian Institute of Chartered Accountants and the Institute of Chartered Accountants of British Columbia.
7. Except for those services set out in #5 above, management may arrange the provision of non-audit services by the external auditor provided that:
   a. A formal procurement is followed in accordance with NH procurement policies
   ~~a.~~b. The costs of such services do not exceed an amount equal to 25% of the regular external audit fee for the year as approved by the Board
   ~~b.~~c. The costs of the service to be provided, combined with the cost of any other non-audit or internal audit services provided by the external auditor in the same year do not exceed an amount equal to 50% of the regular audit fee
   d. All such services are reported to the Committee at the next scheduled meeting along with the reasons therefore

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e. Any proposal to engage the external auditor for the provision of non-audit services, the costs of which will exceed the limits set out in 7(b) and (c), must have the prior approval of the Committee. Where the need for such services is time sensitive, the CFO may request the Chair of the Committee to convene a special meeting of the Committee.

8. Taxation services comprise a broad range of services, including compliance, planning, provision of formal taxation opinions and assistance in the resolution of tax disputes. Such assignments are generally not seen to create threats to external auditor independence.

HIRING OF EXTERNAL AUDIT STAFF

1. Any individual that was employed by the external audit firm and participated in the external audit within the last three months will not be hired to a position at the Regional Director level or above.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): October 22, 2014 (r)

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BOARD BRIEFING NOTE

Date:	May 12, 2015	
Agenda item	2016 Board Calendar	
Purpose:	☐ Information	☐ Discussion
	☐ Seeking direction	☒ Decision
Prepared for:	Board of Directors	
Prepared by:	D Chipman, Executive Assistant	
Reviewed by:	C Ulrich, Chief Executive Officer	

Issue:

To finalize (1) dates for Board meetings in 2016 and (2) to select the locations of out of town Board meetings.

Background:

It has been normal practice for the Board to meet the 3rd Monday (full day) and Tuesday (half-day) of the month as follows:

- October[1] and December in Prince George,
- Out of town in February, April and June in each of the 3 HSDAs[2], and
- Via a brief video/teleconference in July[3] or August.

The exact dates may vary from the Mon/Tues/3rd week norm depending on statutory holidays, the timing of school breaks, and other factors deemed important by Directors, which is why a schedule is developed well in advance.

Appended to the end of this briefing note is a proposed calendar for 2015.

The following table shows when and where the Board has met since 2005, with a proposal for the meeting locations in 2016.

It is recommended that the GMR Committee provide guidance to management regarding meeting dates and locations for Board Meetings in 2016.

[1] including a 3rd day for Board planning and meetings with the RHDs
[2] Health Service Delivery Areas (Northwest, Northern Interior and Northeast)
[3] Usually a 2-hour meeting in July for urgent business

Year	NI	NW	NE
2016 *proposed*	**Quesnel(Apr)**	**Haida Gwaii(Jun)**	**Fort St John(Feb)**
2015	Burns Lake(Jun)	Prince Rupert(Apr)	Chetwynd(Feb)
2014	Valemount (Feb)	Terrace/Kitimat (Apr)	Fort Nelson (Jun)
2013	Vanderhoof (Feb)	Smithers (Apr)	Dawson Creek (Jun)
2012	Quesnel (Feb)	Terrace (Apr)	Fort St John (Jun)
2011	Burns Lake (Feb)	Prince Rupert (Jun)	Dawson Creek (Apr)
2010	Valemount (Feb)	Smithers (Jun)	Fort St John (Apr)
2009	Quesnel (Apr)	Terrace/New Aiyansh (Jun)	Fort Nelson (Oct)
2008	Prince George (Jan)	Kitimat (Jul)	Dawson Creek (Sep)
2007	Vanderhoof (Nov)	nil	Fort St John (Sep)
2006	Valemount (May)	Terrace (Jul)	Fort Nelson (Sep)
2005	Quesnel (May)	Smithers (Sep)	nil

***Recommendation(s)*:**

The Northern Health Board approves the revised 2016 Board Calendar.

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2016

No Board Meeting

January

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						

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: Fort St John

RHD: Peace River Regional District

Spring Breaks:
SD 52 March 14 - 29
SD 57 March 14 - 28

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		

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: Quesnel

RHD: Cariboo

Spring Meeting
with RHDs around the Capital
Plan: Date TBD

North Central Local Government Association: May 4 - 6
Dawson Creek

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				

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: Haida Gwaii

RHD: North West RHD

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

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2016

Board Teleconference

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						

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

Union of BC Municipalities :
(UBCM) Sept 26 – 30
Victoria

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	

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

Day 1 - Board & RHD Planning Session
Day 2 - Board Planning Session
Day 3 - 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 Committee Meetings | Stat Holidays

BRIEFING NOTE

Date:	May 28, 2015	
Agenda item	Community Consultation Update	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	Board of Directors	
Prepared by:	Steve Raper, Director of Communications	
Reviewed by:	Cathy Ulrich, CEO	

Issue:

An update on the 2013-2014 'Healthy Aging & Seniors Wellness' Community Consultation, the Strategic Planning consultative process, and the 2016 Board Consultation topic.

Background:

In May 5, 2014, a press conference was held releasing the 'Healthy Aging & Seniors Wellness' Community Consultation board report to the public. A strategy is still being developed for implementation across the region based on the recommendations and information gathered through the consultative process.

In March of 2015, we began the consultative work related to the Board Strategic Plan. While this is not a formal board community consultation, there will be a large consultative process that includes external community members and leaders. This process is focused on bringing our health region's Vision, Mission and Values up to date as well as defining clear and updated organizational directions.

Our Board developed these original guiding statements to provide direction to our management and staff, as well as organizational directions that have guided us well over the past five years. Since then, we have matured as an organization and the issues we face today are different than those of five years ago. It is important that we take the time to get input to ensure that the next five years plan continues to be meaningful to our stakeholders, and something that we can work on together in partnership.

The next formal Board Community Consultation is expected to begin in the fall of 2016, and the topic will be child health. It is still too early to definitively articulate the breadth and description of the topic beyond child health, but there is an expectation that this will be

refined over the course of 2015 in coordination with Dr. Allison's health status report focused on child health.

Recommendation:

The Northern Health Board of Directors approve the recommendation that the 2016 Consultation focus on Child Health.

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BOARD BRIEFING NOTE

Date:	*June 2, 2015*	
Agenda item	**2014 Carbon Neutral Action Results**	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	NH Board Meeting - Public Session	
Prepared by:	Michael Hoefer, Regional Director, Capital Planning and Support Services	
Reviewed by:	Mark De Croos, Vice President, Financial and Corporate Services/CFO	

Issue:

Northern Health is pleased to submit our 2014 Carbon Action Neutral Program Results. Once again Northern Health has been able to reap the rewards of previous years' work, as the Health Authority has further reduced natural gas consumption year over year (3% last year, 7% since the baseline year 2009). In addition electricity consumption was reduced in 2014 by more than 2% from the previous year, a slight increase over electrical consumption in 2009.

The increase in electricity consumption since the baseline year of 2009 is attributed to a 15% increase in conditioned floor area including additional electrical load related to new diagnostic/clinical equipment. These accomplishments combined resulted in an overall cost avoidance of $3.9M over 4 years in energy consumption (electricity, natural gas and propane).

This report highlights key actions taken to reduce greenhouse gas emissions over this past year and describes future plans.

Background:

Energy conservation projects were implemented at six facilities (Chetwynd, Dawson Creek, Fort Nelson, GR Baker, Prince Rupert Regional, and University Hospital of Northern BC) across the North with an expected energy saving of 3% ($257,000) of actual 2014-15 costs.

Funding for these projects was provided through a provincial initiative known as the Carbon Neutral Capital Program combined with financial support with our Regional Hospital District (RHD) partners across the region. Once completed, incentive contributions (where applicable) are recouped through FortisBC and BC Hydro, and are applied against future energy saving

projects. These incentives are typically the result of replacing/ upgrading a facility's inefficient systems (e.g. heating, ventilation, control systems, lighting, etc.) with higher efficiency equipment or technology that will deliver yearly energy savings for years to come.

As we move forward into 2015, we're continuing our efforts to identify the best available opportunities to reduce carbon emissions. Already four energy conservation projects are in early stages of implementation - Dunrovin Park Lodge, Bulkley Valley District Hospital, Stikine Health Centre and Stewart Health Centre for 2015/16.

Although it is easy to conceptualize energy conservation projects as they relate to gas and electricity consumption there are numerous pathways that contribute to an overall reduction.

For example, NH is continuing its participation in BC Hydro's Energy Behavioural Awareness program - a five site pilot project targeting energy saving behaviour by staff. Out-of pocket costs are covered by BC Hydro and FortisBC. Anticipated savings are in the order of 1% of the site's utility costs. In short, it is an awareness building campaign aimed at energy reduction.

Several other activities are also underway:

Energy Audits & Retro Commissioning: BC Hydro operates several programs that provide partial funding for energy audits/retrofit studies at various NH facilities, including many smaller facilities not previously considered. Providing that opportunities meeting the program criteria are implemented at each facility, BC Hydro will provide funding up to 100% of the audit cost and (potentially) additional incentive payments upon completion. Similarly, FortisBC operates a Commercial Custom Design Program aimed at reducing natural gas consumption in their service area (about 50% of our natural gas use). Unfortunately, Pacific Northern Gas, a significant NH supplier, offers no incentives.

New Construction Incentives: BC Hydro is currently working to finalize incentive payments for the new Lakes District Hospital (estimated $138,000). Similar incentives will result from completion of the Queen Charlotte facility (currently under construction, estimated $62,000), expected next year.

Environmental Sustainability (ES):
The primary benefits of ES are cost reductions from energy reduction, improved public profile, and improved employee recruitment and retention as people look for an environmentally responsible employer.

Northern Health is committed to sustainable actions and supporting a healthy environment for future populations of northern British Columbia.

Recommendation(s):

For information

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BOARD BRIEFING NOTE

Date:	2015 May 29	
Agenda item	Regulatory Framework - Legislative Compliance • *Financial Administration Act* • *Financial Information Act* • *Public Sector Employers Act*	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	Northern Health Board of Directors	
Prepared by:	Kirsten Thomson, Regional Director, Risk and Compliance	
Reviewed by:	Cathy Ulrich, CEO	

Issue:

To provide an update on the legislative compliance review process.

Background:

1. Current Review
   a. *Financial Administration Act*

   The *Financial Administration Act* regulates financial management within government proper, describing how government collects revenue, authorizes expenditures, manages assets and liabilities, and enforces accountability of public money.

   There are no direct applications to or obligations of the health authority within the Act. The Act describes the relationship between the Treasury Board and the Comptroller General and the health authority, where the health authority has obligation to comply with directives or other requirements issued by either party.

   Northern Health is fully compliant with any directives issued to date, noting that a health authority exemption was made to Treasury Board Directive 3/11, regarding Board remuneration, to which the health authority is compliant.

b. *Financial Information Act*

The *Financial Administration Act* describes the health authority obligations for preparation of financial statements, which are to be made available to the Minister of Finance and the public, upon request.

Northern Health is fully compliant with all obligations under this Act.

c. *Public Sector Employers Act*

The *Public Sector Employers Act* regulates the coordination of human resource and labour relations policies and practices among public sector employers. It describes the requirements for membership in an employers association and the association membership in the Public Sector Employers Council.

Part 3 of the Act describes the health authority obligations for excluded employee contracts, compensation, benefits, termination standards and human resource practices.

Northern Health is fully compliant with all obligations under this Act.

These *Acts* and Legislative Compliance Reviews were reviewed by the Executive Team.

These *Acts* impose no outstanding obligations or compliance issues on Northern Health.

2. **Upcoming Review(s)**

Adult Guardianship Act update
Food and Drug Act (Canada) Bill C-17 amendment (Vanessa's Law)

3. **Acts Reviewed for Legislative Compliance:**

32. Workers Compensation Act Feb/Mar 2015
31. Tobacco Control Act Dec/Jan 2015
30. Budget Transparency and Accountability Act Nov/Dec 2014
29. Medicare Protection Act – Nov/Dec 2014
28. Apology Act – Nov/Dec 2014
27. Seniors Advocate Act – Nov/Dec 2014
26. Adult Guardianship Act changes – Nov/Dec 2014
25. Laboratory Services Act – Sep/Oct 2014
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.