Meeting of the Northern Health Board
Public Meeting
9:15am – 10:45am

Monday, June 20, 2016

St. Peter's Anglican Church Army Hall

4390 Government Street

Hazelton, BC

northern health

the northern way of caring

northern health

Public Session

AGENDA

June 20, 2016
St. Peter's Anglican Church
Hazelton, BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Open Board Session	Chairman Jago		**9:15am**	
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 18, 2016	Chairman Jago	Motion		**3**
6. Business Arising from Previous Minutes	Chairman Jago			**-**
7. CEO Report	C Ulrich	Information		**9**
7.1 Human Resources Report	D Williams	Information		**14**
8. Audit & Finance Committee				
8.1 Public Comments Fiscal Y/E 2015-16	M De Croos	Information		**23**
8.2 Capital Projects Report	M De Croos	Information		**24**
9. Performance, Planning & Priorities Committee				
9.1 Strategic Priority: Healthy People in Healthy Communities				
9.1.1. Partnering for Healthy Communities	Dr S Allison	Information		**28**
10. Presentation – Healthy Communities Partnerships in Prince Rupert and Haida Gwaii	P Anguish	Information		**-**
Presenter: Michael Melia, Health Service Administrator				
11. Governance & Management Relations Committee				
11.1 Policy Manual BRD 200 Series	C Ulrich	Motion		**35**
11.2 2017 & 2018 Board Meeting Calendar	C Ulrich	Motion		**81**
11.3 2015 Carbon Neutral Report	M De Croos	Information		**85**
11.4 Regulatory Framework – Legislative Compliance	C Ulrich	Information		
11.4.1. Controlled Drug & Substance Act				**87**
Adjourned			**10:45am**	

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Public Motions *Meeting Date: June 20, 2016*				
Agenda Item		**Motion**	**Approved**	**Not Approved**
3.	Conflict of Interest Declaration	Does any Director present have a conflict of interest they wish to declare regarding any business before the Northern Health Board at this meeting?	☐	☐
4.	Approval of Agenda	The Northern Health Board approves the public agenda as presented		
5.	Approval of Minutes	The Northern Health Board approves the April 18, 2016 public minutes as presented	☐	☐
11.1	Policy Manual Board 200 Series	The Northern Health Board approves the revised BRD 200 policy series as presented.	☐	☐
11.2	2017 & 2018 Board Meeting Calendars	The Northern Health Board approves the Board Calendars for the years 2017 and 2018 as submitted.	☐	☐

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Date: April 18, 2016

Board Meeting

Location: Fort St John, BC

Chair: Dr. Charles Jago

Recorder: Desa Chipman

Board:
- Sharon Hartwell
- Gary Townsend
- Ben Sander
- Maurice Squires
- Edward Stanford
- Rosemary Landry
- Colleen Nyce
- Stephanie Killam

Regrets:
- Gaurav Parmar

Executive:
- Cathy Ulrich
- Fraser Bell
- Kirsten Thomson
- Kelly Gunn
- Mark De Croos
- Angela De Smit
- David Williams
- Dr. Ronald Chapman
- Michael McMillan
- Dr. Sandra Allison
- Jonathon Dyck
- Dr. Jaco Fourie

Public Minutes

1. Call to Order Public Session

The Open Board session was called to order at 9:14am

2. Opening Remarks

Chairman Jago welcomed members of the public to the meeting. Executive and Board members introduced themselves to the gallery. Chairman Jago expressed delight to be back in Fort St John to hold the Northern Health Board meeting and expressed appreciation to see Jean Leahy from the Save Our Northern Seniors in attendance.

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 18, 2016 Public agenda.

4. Approval of Agenda

Moved by S Killam seconded by R Landry
The Northern Health Board approves the April 18, 2016 public agenda as presented.

5. Approval of Board Minutes

Moved by G Townsend seconded by E Stanford
The Northern Health Board approves the February 15, 2016 public minutes as presented.

6. Business arising from Previous Minutes

There was no business arising.

7. CEO Report

- C Ulrich provided an overview of the CEO report and highlighted the following:
  - Northern Health 2016 – 2021 Strategic Plan – Looking to 2021: The Northern Health Board approved the 2016-2021 Strategic Plan in February 2016. Northern Health management and staff are in the process of using this new Strategic Plan to guide planning of services for the 2016/17 to 2018/19 operational plan.
  - Primary care and Community Services: Northern Health has been working in partnership with Divisions of Family Practice across the region to implement changes to the way community services and primary care providers work together to provide services to people and their families. These changes are intended to provide increased continuity of services and enable people and their families to be part of developing their plan of care with their health care providers.
  - BC Quality Forum: Growing Ideas for Action: the fifth annual provincial Quality Forum organized by the BC Patient Safety and Quality Council was held on February 24 to 28 in Vancouver. Michael McMillan, Chief Operating Officer, Northern Interior participated in Health Talks and provided a PechaKucha 20X20 presentation regarding his hopes for health care.
  - Chronic Disease Prevention Alliance of Canada (DCPAC) 2016 Conference: Dr. Margo Greenwood, Vice President, Aboriginal Health and Academic Lead, National Collaborating Centre for Aboriginal Health and Cathy Ulrich had the opportunity to participate in a panel presentation at the 2016 CDPAC conference on February 24, 2016 along with Dr. Evan Adams, Chief Medical Officer, First Nations Health Authority.
  - Collaboration with Northern Lights College regarding Health Human Resources Workforce Planning: Northern Health identified persistent challenges with vacant Residential Care and Community Care Aide vacancies primarily in Fort St John and Dawson Creek. As a result of a successful partnership in 2014, Northern Health approached Northern Lights College to consider offering a second Health Care Aide course. NLC was agreeable to pursue and has opened enrollment for a May course which will be offered on both the Fort Nelson and Fort St John campuses.
  - Enhanced Prenatal Care: Northern Health partnered with the North Peace Division of Family Practice in January 2014 to establish a Prenatal Clinic to offer primary care services at the Fort St John hospital due to the increasing number of prenatal women with no family physician. There are now twelve General Practitioners working in the Prenatal Clinic.
  - Collaboration with First Nations Communities: Northern Health entered into a Partnership Accord with the First Nations Health Council: Northern Regional Health Caucus and the First Nations Health Authority (FNHA) in 2012. In Fort St John are, Northern Health, FNHA and five of the seven local First Nations communities have collaborated to create a new team who will provide a continuum of mental health and substance use services in the First Nations Communities.
  - Nurse Practitioners: Northern Health recently hired 5 Nurse Practitioners on Provisional Licensure. This means that these Nurse Practitioners were practice ready upon hire but not eligible to be fully licensed until completion of a final OSCE exam (Objective, Structured Clinical Examination). In early March, all 5 of the new hired Nurse Practitioners completed and passed their examination to achieve full licensure.

7.1. Human Resources Report

- Disability Management's main focus over the next 6-12 months will be on Long Term Disability (LTD) Claims Activity. Including the following goals:
    - Reducing LTD claims through proactive utilization of Great West Life's Early Referral Services in the pre-LTD phase.
    - Claim reduction through disability case management which focuses on employee's functional abilities and creating opportunities for early and safe return to work (RTW) accommodation.
- NH facilities continue to complete site violence risk assessments. Many facilities, which had completed their assessments in 2015, are approaching their annual reviews.
- The Learning Management System is a secure web-based system that houses learning materials for all health care staff and is managed by the Provincial Health Services Authority. This allows standardized, high-quality learning for all our staff which is accessible from any NH or home computer.
- Grow our Own: following obtaining feedback from past students regarding meaningful program design and hosting world café events, Northern Health has received enough data to move forward with a redesign of the Grow our Own program collaboratively with the Simulation Centre. Details of the program were outlined in the report.
- NH continues to collaborate with the Ministry of Health and British Columbia Nurses Union (BCNU) in recruiting nurses to the region. Strategies to fill vacancies include:
    - Advance hiring of new grads to allow current staff to undergo training in speciality areas
    - Incentive program for return of services agreements in rural and remote communities
    - Continuing to work with post-secondary institutions to recruit graduates to stay in the north
    - Collaborating with BCNU on recruitment activities including their "Hire a Nurse" campaign designed to encourage casual nurses to explore regular positions.

8. Audit and Finance Committee

8.1. Financial Summary – Operations

- Year-to-date Period 12, revenues exceeded expenses by $2,192, 000.
- Revenues are unfavourable to budget $2.4 million or 0.3%. Expenses are favourable to budget by $4.6 million or 0.7%
- Delays in approval of targeted funding for a few budgeted programs have resulted in a delay in program expenditures and recognition of related funding. It was budgeted that $4.3M of targeted funding and matching expenditures would have been realized to the end of Period 12. As a result, revenues are showing an unfavourable variance to budget, while expenditures are showing a corresponding favourable variance to budget.
- At this time, Northern health is forecasting to be in a balanced position on base operations at yearend. Not factored into the yearend forecast is the confirmation of the actuarial valuation of the Healthcare Benefit Trust benefits. It is anticipated that the actuarial confirmation will be provided sometime in April 2016.

Moved by B Sander seconded by S Killam
The Northern Health Board approves Northern Health's Period 12 financial Statement, as presented.

8.2. Capital Projects Report

- The Northern Health Board approved the 2015-16 capital expenditure plan in February 2015, with minor amendments throughout the year. The updated plan approves total expenditures of $59.5M, with funding support from the Ministry of Health ($27.5M, 46%), Six Regional Hospital Districts ($17.0M, 29%), Foundations and Auxiliaries ($1.6M, 3%), Northern Health ($8.5M, 14%), and funding received in prior years ($4.5M, 8%).

- Year-to-date Period 12 (February 23, 2016), $45M has been spent towards the execution of the Plan and was summarized in detail in the report.

Moved by B Sander seconded by G Townsend
The Northern Health Board approves Northern Health's Period 12 Capital Project update, as presented.

9. Performance Planning and Priorities Committee

9.1. Clinical Quality Priorities

- An update on the Northern Health's Programmatic approach to the strategic advancement of clinical quality in the organization was provided for information.
- There are six Clinical Programs in Northern Health with a regional responsibility to stimulate quality in the organization, support the organization's pursuit of quality improvement goals and ensure we sustain gains made in our efforts to deliver high quality services for northerners.
- Over the last two years, Clinical Quality Programs have matured and identified five functions that enable front line staff and physicians to work in a culture that promotes quality care and patient safety and deliver care that meets or exceeds quality and safety standards. These functions are to:
  - Activate the front line
  - Develop Program Service Plans and support the implementation of these Plans
  - Develop clinical, service and learning pathways and quality standards
  - Identify and provide leadership for regional quality improvement priorities
  - Evaluation and measurement through the provision of data and analysis
- Next steps include further refinement of the Clinical Quality Programs Process Map for review and validation by the Executive team. This work will inform part of the executive review of the various ways Northern Health pursues quality under the Northern Health Quality Framework.
- Attention is also being given to the role of Programs in supporting Primary Care Homes, inclusive of the Interprofessional Teams (e.g. best practice support for preventive/population health measures such as well baby/child health immunizations, developmental assessments, etc)

9.2. Child Health Report

- An overview of the Chief Medical Health Officer's Health Status Report on Child Health was presented to the Board for approval.
- The report is intended to:
  - Provide an overview of the current state of knowledge on healthy child development in Northern BC;
  - Make recommendations on how to improve the health of Northern BC children;
  - Fosters conversations and stimulate further ideas around how to improve the health of children; and
  - Strengthen partnerships with key stakeholders playing a role in the health and well-being of Northern BC children and families.
- Management is seeking approval from the Board that the next public consultation be focused on Child Health.

Moved by E Stanford seconded by C Nyce
The Northern Health Board approves the Chief Medical Health Officer's Health Status Report on Child Health and directs management to complete the planning of the 2016/17 public consultation process with a focus on child health.

10. Presentation: Rapid Mobilization in Fort St John

Sherry Sawka, NP Manager Community Services presented on Rapid Mobilization which is a process that provides rapid access to assessment and clinical support to manage acute episodes for individuals identified in the Primary Care Home, Acute Care and Community Care.

- The presentation included details on the identified problems, learning and challenges, what does the data show, and what development has transpired since rapid mobilization was established.
- The next steps are to look into the use of Community MOIS Information System for documentation
- Direct Access to the Patients' Interprofessional Team (through the Primary Care Nurse) to identify patients in the Primary Care Home who require the service and to support post-discharge care plans.
- Chairman Jago thanked Sherry Sawka for her presentation and commented that the hard work of management and the relationship with members of the community has helped with the success of rapid mobilization.

11. Governance and Management Relations Committee

11.1. Policy Manual BRD 100 Series

- The revised Policy Manual BRD 100 Series was presented to the Board for their approval. The minor revisions and edits were highlighted to ensure the Board Directors were aware of where changes occurred. In particular the changes made to BRD100 were highlighted as this policy relates to the Mission, Vision, Values and Priorities.

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

11.2. Code of Conduct Signing – BRD 210

- Board policy BRD 210-Code of Conduct and Conflict of Interest Guidelines for Directors stipulates that each Director shall annually sign a declaration that they have read and considered the policy and agree to conduct him or herself in accordance with the policy.
- The Director Declaration Form was provided to each Director for signing.

11.3. Regulatory Framework – Legislative Compliance

11.3.1. Health Authorities Act

- The Health Authorities Act describes how health authorities are created by the Minister of Health, how health authority boards function, how multiple boards can amalgamated, and how health sector labour relations are managed.
- The structure and activities of the board, described in Part 2 of the Act, are fully reflected in Northern Health board policies and bylaws.
- The Act does not impose outstanding obligations or compliance issues on Northern Health.

11.4. Board Development & Education Plan

- The Board Development & Education plan has been updated to align with the redevelopment of the Northern Health Strategic Plan. The draft plan was provided for discussion and approval by the Board.

Moved by M Squires seconded by C Nyce
That Northern Health Board approves the Board Education and Development plan as presented for the 2016 board meetings.

11.5. Designation of School Medical Officers

- School Medical Officers under the School Act requires designation by the Board of Directors of Northern Health.
- The briefing note contained a table which outlined which medical health officer will be designated for each school district within the geography of Northern Health, as well as an alternate designate, should the first not be available.

Moved by S Hartwell seconded by R Landry
The Northern Health Board designates Dr. Sandra Allison and Dr. Raina Fumerton as School Medical Officers for the school districts as described.

The Public Meeting was adjourned at 10:57am

Dr Charles Jago, Chair

Desa Chipman, Recording Secretary

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

CEO REPORT

Meeting:	Northern Health Board Meeting	Date:	June 6, 2016
Agenda Item:	CEO Report		
Purpose:	Information		
Prepared by:	Cathy Ulrich		

Regional:

Dr. Geoff Appleton, Medical Director North West
Dr. Geoff Appleton will be retiring at the end of June. Dr. Appleton has worked as the North West Medical Director for a number of years and has served in the Terrace medical community for over 40 years. His leadership and medical expertise and care for the patients in his primary care practice will be missed. On behalf of Northern Health, we would like to thank Dr. Appleton for his years of service and wish him the very best in this next phase of life.

Dr. Jaco Fourie who is a family physician in Terrace as well the Medical Lead, Northern Cancer Care and Chair of Northern Health Medical Advisory Committee will be replacing Dr. Appleton as the Medical Director for the North West starting in July 2016.

Aboriginal Health Improvement Committee Gathering
Northern Health has established eight Aboriginal Health Improvement Committees across the North. These committees are led by the Health Services Administrator and bring together representatives from Northern Health management and staff, the First Nations Health Authority Community Engagement Coordinator, representatives from First Nations Communities in the catchment area, and representatives from Aboriginal Serving Organizations such as Friendship Centres.

In May, the Aboriginal Health Improvement Committees gathered in Prince George for a learning and networking opportunity. At this gathering, each of the Aboriginal Health Improvement Committees had an opportunity to share work they have undertaken to increase the cultural safety of the health care services in their area. Actions have included:

- Visits to First Nations Communities to learn about the community and develop relationships
- Inclusion of art in health facilities that is representative of the culture in the area
- Development of scared spaces and gathering places in health care facilities
- Learning sessions about the culture, history, and traditions of First Nations
- Development of resources such as videos and other resources focused on cultural practices e.g. birth, critical illness and death, discharge planning, and protocols for health research
- Development of indigenous language signage at several facilities

In addition, a half day Building Cultural Safety interactive learning session was held with Rose LeMay, Director, Northern and Indigenous Health at the Canadian Foundation of Health Improvement. There was opportunity to hear from the First Nations Health Authority regarding the priorities and areas of innovation occurring. Finally, the participants had opportunity to learn about some practical tools for story telling as a way to develop relationships.

Transfer of Wrinch Memorial Hospital services from the United Church Health Services Society to Northern Health

The United Church has been committed to the delivery of health services in the Upper Skeena area for over 115 years. These services were most recently provided through the United Church Health Services Society. Over the last year, the United Church Health Services Society reached the decision that they would transfer the majority of their health services to Northern Health.

Over the last number of months, Northern Health has been working with the United Church Health Services Society to complete this transfer. As of April 1st, Wrinch Memorial Hospital, the primary care clinic and the dental clinic were transitioned to Northern Health. Over the past two months, Northern Health has been establishing a local leadership team, learning about the services in the Upper Skeena area, and providing opportunities for staff to learn about the broader supports available in Northern Health.

In addition, a Community Health Improvement Committee has been established to enable a better understanding of the health needs of communities in the Upper Skeena area. Two meetings of this committee have occurred.

On behalf of Northern Health, I would like to take this opportunity to thank the members of the Steering Committee and the Working group for their diligent work in planning for a smooth transition of services from an operational, human resources, and financial perspective. In addition, we have appreciated the collaborative relationship with the United Church Health Services Society leadership and Board throughout the transition process.

North Central Local Government Association Convention – Dawson Creek, May 3 – 6, 2016

The North Central Local Government Association Convention was held in Dawson Creek in May. Dr. Jago, Northern Health Board Chair and I attended these meetings. We met with representatives from twelve Regional Districts and municipalities across the North. These meetings are valuable opportunities to learn about the issues that are important to communities across the region.

On May 3, a *Partnering for Healthy Communities* pre-conference forum was held in Dawson Creek. This workshop was co-sponsored by Northern Health, BC Healthy Communities, and Plan H. There were 60 to 70 representatives from Northern Health and local governments in attendance. The forum provided an opportunity to learn about building healthy communities and to share initiatives underway in northern communities. Focused table sessions were held on healthy aging, active communities, mental wellness, child health and wellness, industrial resource development, food security, and drinking water.

In the North West, there were three initiatives profiled at this event. The initiative in Haida Gwaii will be presented later in the public session of the Board meeting. The other two initiatives were:

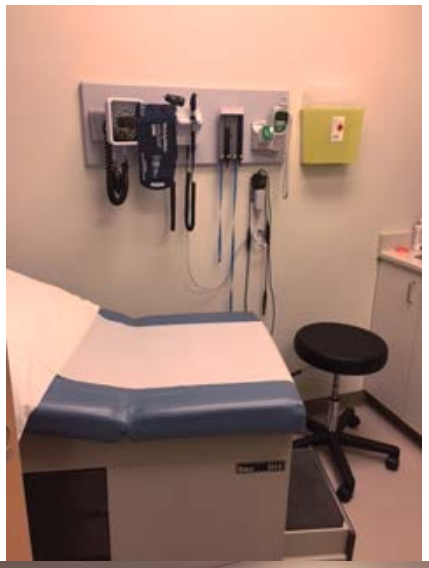
1. ***Terrace and Area:*** The Greater Terrace Healthy Communities Committee (GTHCC), co-chaired by the Mayor of Terrace and the Health Services Administrator for Terrace, has successfully advanced a youth project. After surveying approximately 300 high school students on their perspectives regarding health and the challenges they face in living a healthy lifestyle, the committee partnered with local RCMP to develop a 'youth summit'. This summit included several hundred grade eight students who met at the Terrace Campus of NW Community College in late April**.** During the two-day event, students heard inspiring keynote speakers and participated in breakout sessions on coping with peer pressure, confidence building, managing the social media landscape, eating

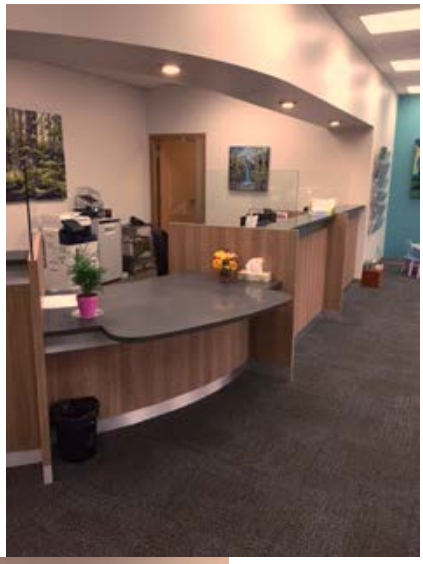
healthy, staying active, and so on. The event was viewed as a success and discussions are underway to plan a similar event in 2017.

2. ***Houston:*** The Houston ACT (*Action Changes Things)* Committee was established in 2012 with grant funding from the Healthy Communities initiative and is focused on promoting healthy living and active lifestyles in Houston while allowing increased activity and wellbeing to be accessible, affordable, and fun. The activities have included the Houston Winterfest, a Guns and Hoses Hockey Game (between the RCMP and Fire Department), a Mothers Day Walk/Run, and a Canada Day Bike Parade. This initiative has received three consecutive Community Spirit Awards from the community as a whole.

Quesnel Primary Care Clinic Opening

On May 2, the Quesnel Primary Care Clinic celebrated their official opening. Services will be provided by physicians, nurse practitioners and members of an interprofessional team of health providers in this Primary Care Clinic. This clinic space was made possible through collaboration with the City of Quesnel, the Cariboo Regional District, and the office of MLA Coralee Oakes.





Northwest

Addictions Dialogue in Terrace

In response to a Coroner's inquest held on October 19-21, 2015 where a young woman died as a result of complications from detoxing, the Chief Operating Officer in the North West organized an Addictions Dialogue in the community of Terrace. The initial meeting included Northern Health staff including medical staff representation, FNHA, City of Terrace, RCMP, and BC Ambulance Services. As a result of this initial meeting, there was agreement to engage a broader group and that the City of Terrace would co-lead the process.

Further dialogues have been held on April 8 and May 13 and have focused on:

- understanding each organizations' mandate, resources and role with people living with addiction issues,
- patient journey mapping, and
- ways to improve information sharing to enable shared care planning.

Future sessions will focus on clarifying the legislation impacting information sharing and hosting a session with patient advisors to revisit the patient journey mapping process in order to identify areas for collaborative action. This work in Terrace is a prototype for similar types of dialogues that could occur in other communities across the North.

Partnership with the FNHA

Northern Health, the First Nations Health Authority and First Nations Communities have been working to implement some service improvements in the areas of primary care and mental wellness. Two of these initiatives are currently in development in collaboration with each initiative's project advisory committee.

1. ***Coastal Primary Care Team*** **-** The Project Advisory Committee (PAC) continues to meet bi-weekly to work through the details of implementing the Primary Care Team serving the Coastal Tsimshian First Nations communities. The focus is on ensuring the continuity of care for people across providers and creating linkages to Primary Care Homes in Prince Rupert. Current work underway includes the development of team member role descriptions, logistical planning related to travel and accommodation, and connections to other services currently available.

2. ***Mental Health and Addictions Mobile Support Team (MST) for Dease Lake/Iskut Area*** **-** The MST Project Advisory Committee (PAC) continues to meet as needed to plan the service delivery approach and work through the details of implementation to serve the communities of: Tahltan, Isket, Dease River, Telegraph Creek, and Good Hope. A schedule for services to each community has been proposed and office space and equipment in the Stikine Health Centre has been secured. Job descriptions have been completed and recruitment to positions is underway. Planning is also underway to develop a local orientation process for each community for the MST staff as they are hired.

Haida Gwaii Hospital and Health Centre Replacement Project

The Haida Gwaii Hospital and Health Centre replacement project is progressing well. The hospital is scheduled to be complete in the fall 2016. The majority of community, primary care, and acute care programs will be located on this new site.

Photographs of the new construction from a site visit that occurred in early June are included below:

Human Resources Board Report

June 2016

Workplace Health & Safety (WHS)

Disability Management

Disability Management continues to focus on Long-Term Disability (LTD) claims activity, both provincially and at the health authority level. In May, a provincial meeting occurred with senior leaders from Great West Life (GWL), Health Employer Association of BC, the Healthcare Benefit Trust (HBT), and representatives from all the BC Health Authorities. Areas of focus included:

- enhancing services available to support employees who are struggling to remain at work with a medical condition
- offering resources to provide greater flexibility to assist employees struggling with medical/non-medical barriers
- developing a preferred provider network for mental health claims
- improving proactive communication and information sharing between Health Authorities and Great West Life to improve efficiencies
- provision of statistics on "six-month claims closure by disability type" in the HBT LTD Activity Report which will enable the Health Authorities to understand which claims are closing sooner than others
- providing a monthly activity report on the "Referral Acceptance Rates for GWL's Early Intervention Services" in order to evaluate the program
- HBT providing a monthly LTD Activity Report (versus current quarterly report) to the Health Authorities

Over the next year and a half, a provincial committee with all Health Authorities represented will continue to meet with a focus on the above noted expectations and outcomes. The goal is to reduce LTD claims throughout the province by 20 percent over the next 18 months, focusing on all LTD claims in the active and maintenance phases, as well as those in the pre-qualification period prior to LTD acceptance.

Violence Prevention (VP)

Northern Health facilities continue to complete site violence-risk assessments and implement VP program elements such as violent behaviour response plans (code white), violent behaviour alert notification, violent incident reporting and investigation, and violence prevention education and training.

To date, WHS has two violence prevention trainers, five certified site trainers, and is working with another 23 Northern Health employees to further our capacity to complete provincial violence prevention curriculum (PVPC) education and training. WorkSafeBC's high-risk strategy requires employees who work in areas considered to be high risk for violent acts (e.g. emergency departments, psychiatry, mental health and addictions (MHA), and residential care) to attend PVPC education and training. Approximately 30% of Northern Health residential care employees, 67% of psychiatry and MHA employees, and 31% of emergency care employees have attended PVPC classes. In total 38% of Northern Health employees who work in high-risk facilities are been trained in PVPC. The goal is to train the remaining 62% of Northern Health employees from high-risk areas in PVPC over the next two years.

Human Resources Planning & Design, Education & Training

HR Planning

Health Human Resource (HHR) Planning is occurring at a Provincial and Health Authority level. At Northern Health, our HR Planning and Design team is working in collaboration with other departments, including Planning, Quality, and Information Management, Finance, HR Operations, Recruitment and other operational leaders across Northern Health so that we can leverage expertise and share learnings.

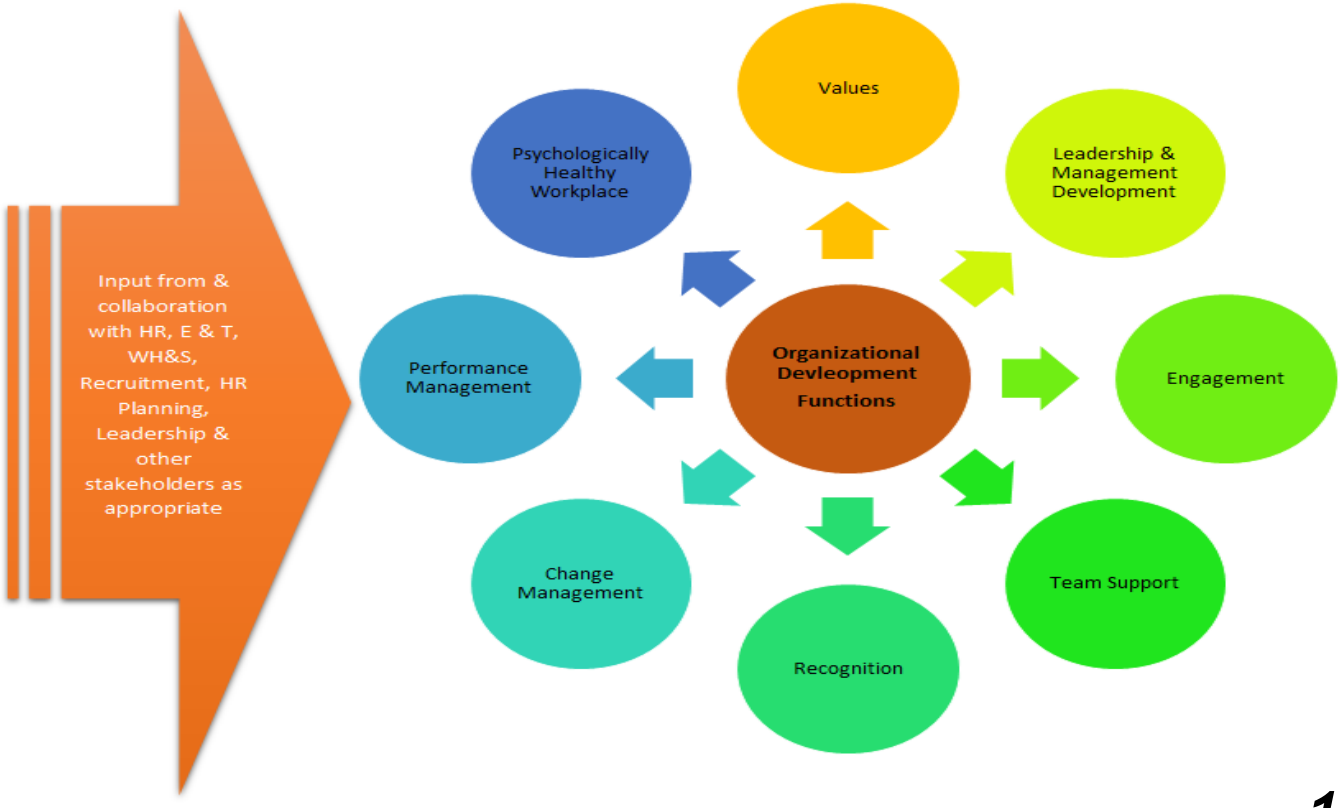
The HR Planning and Design team is currently developing an Integrated Health Human Resources Plan (IHHRP). This plan will identify our forecasted gaps in nursing and allied health professions and will identify what strategies will be implemented in order to close these gaps.

The expected outcomes of the Integrated HHR Planning Project are that Northern Health will have:

- The ability to set recruitment/development priorities based on the identification of HHR gaps across Northern Health
- Effective planning to accommodate Northern and rural populations in terms of adequate and well-staffed service delivery
- Integrated HHR Planning focused on the professions of physicians, nursing, and allied health
- Effective partnerships with other HHR planning in health authorities across the province to share best practices and benchmarking

Organization Development

Organization Development planning is underway and the focus will be to develop tools, methods, frameworks, technologies, and processes that enable Northern Health to be more efficient, effective, collaborative, and innovative in support of its strategic goals.
The functions of Organization Development are represented in the diagram below.



LearningHub

The LearningHub launched in April and there has been an enthusiastic response to this resource. Single log in/log off using Northern Health employee log in information is being tested and the learning histories of Northern Health employees – some 40,000 course records – are being transferred to the LearningHub. Manager reports will be developed and operational by the end of this calendar year. Our eLearning Advisor is working with regional program leads to develop and modify online curricula to meet the needs of Northern Health staff and to support the development and implementation of learning pathways.

Clinical Placements

Health Sciences Placement Network (HSPnet), software to manage student placements, is currently being used for clinical placement of nursing students across Northern Health. The system will be expanded for all non-nursing health care disciplines this summer with the exception of medical students.

Learning Pathways

The Primary Care Assistant pathway is complete, a Medical Office Information System curriculum is being created, and other curriculum development opportunities to complete the pathway have been identified. The Medical Device Reprocessing (department responsible for cleaning, assembling, sterilizing and distributing surgical instruments) pathway awaits final validation and the Housekeeping Pathway is nearly complete. Laboratory Technology, Health Information Management, and Human Resource Advisor pathways will be developed next. The Primary Care Nurse pathway has created an orientation outline for nurses entering these new positions in September. Further work to consolidate and refine the entirety of this complex pathway is also underway.

Leadership Development

Northern Health has taken the lead in the development of a Management 101 series of learning opportunities to assist new frontline leaders to grasp the transactional aspects of their new role. This should be ready for staff by September.

The provincial pilot of the blended (online and face-to-face) frontline leadership development program, Core LINX, will begin in early June with Coaching LINX which uses Coaching out of the Box curriculum. This pilot is being offered in collaboration with Provincial Heath Services Authority and all face-to-face learning opportunities will involve staff from both agencies learning together. The Education Division will also be working collaboratively with operational leaders to schedule management and leadership learning opportunities for the balance of the year.

Recruitment

Grow Our Own

Sessions were held on May 12 and May 19 at College Heights Secondary in Prince George and at Caledonia Senior Secondary in Terrace. Sessions were presented using a new format that includes:

- An introduction to a diverse group of medical professionals
- A talk by each medical professional about their career paths
- A lesson in applying Cardiopulmonary Resuscitation (CPR) correctly and an opportunity to practice on a full patient simulator
- The medical professionals running a code (anaphylaxis to cardiac arrest) in the simulator scenario and using CPR to demonstrate to the students the actual use of CPR in a medical situation

- Students completing a questionnaire based on the events of the simulation
- A conclusive Q&A session and a prize awarded for the most accurately answered questionnaire

When asked at the start of the sessions, the majority of the students identified only Nursing and Physicians as health care roles. At the end of the sessions students were more informed about the diverse roles within health care.

The outcomes from these sessions included familiarizing students with a spectrum of health care roles. An informative handout called "Health Care Careers – What's out there for me? – How do I start?" was mailed directly to the students' homes following the presentations to assist parents in starting a conversation with their children about moving towards a health care career.

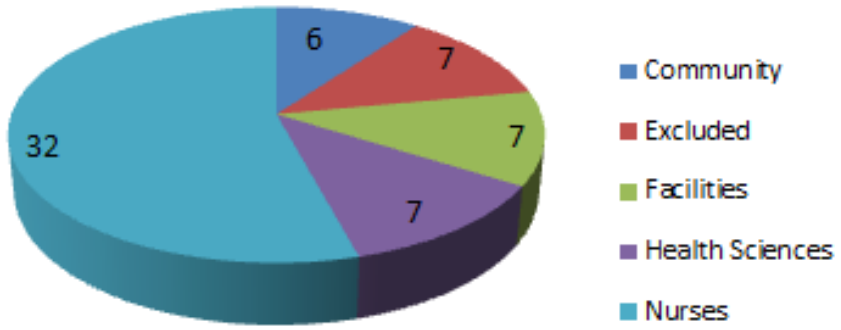
Partnership with Northern Lights College (NLC)
Northern Health Recruitment has partnered with NLC to offer a Health Care Assistant (HCA) session with an intake date of May 2016. They also collaborated to host public events in Fort St. John and Dawson Creek. The purpose of the public events was to provide information to interested participants to grow awareness of the HCA program offered through NLC. Interested participants were invited to the events via posters which were strategically placed throughout both communities.

Career Fairs/Recruitment Conferences:

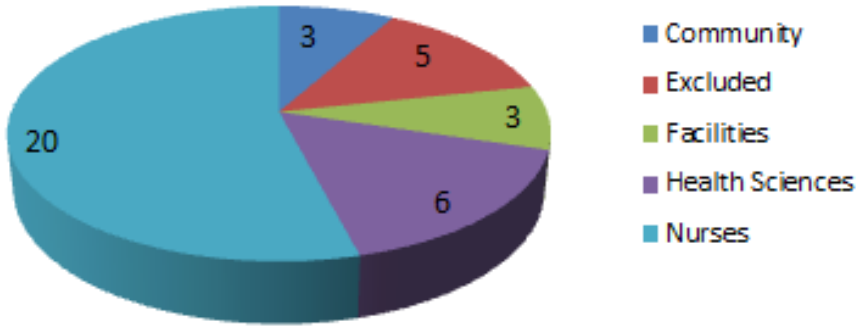
Sonography Canada in Ottawa	May 12 – 14
Physiotherapy Congress in Victoria	May 26 – 28
BC Nurse Practitioner Association in Kelowna	June 3 – 6
UBC Rehab Fair in Vancouver	June 15
Perioperative Nursing Association of BC Kelowna	June 24 – 26

Data and Trending

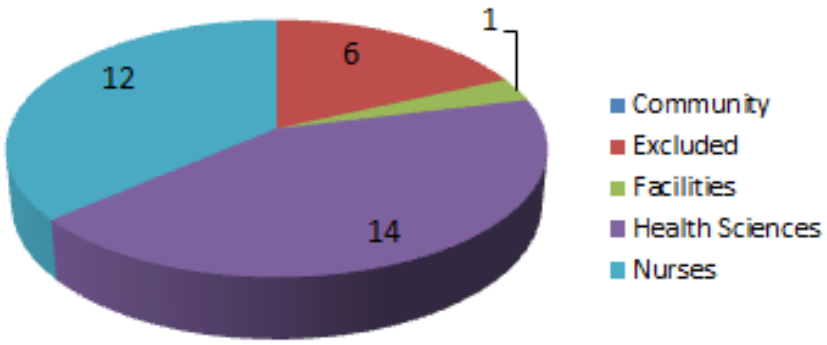
(59) External Postings - NORTHEAST
May 31, 2016 [*does not include casuals*]

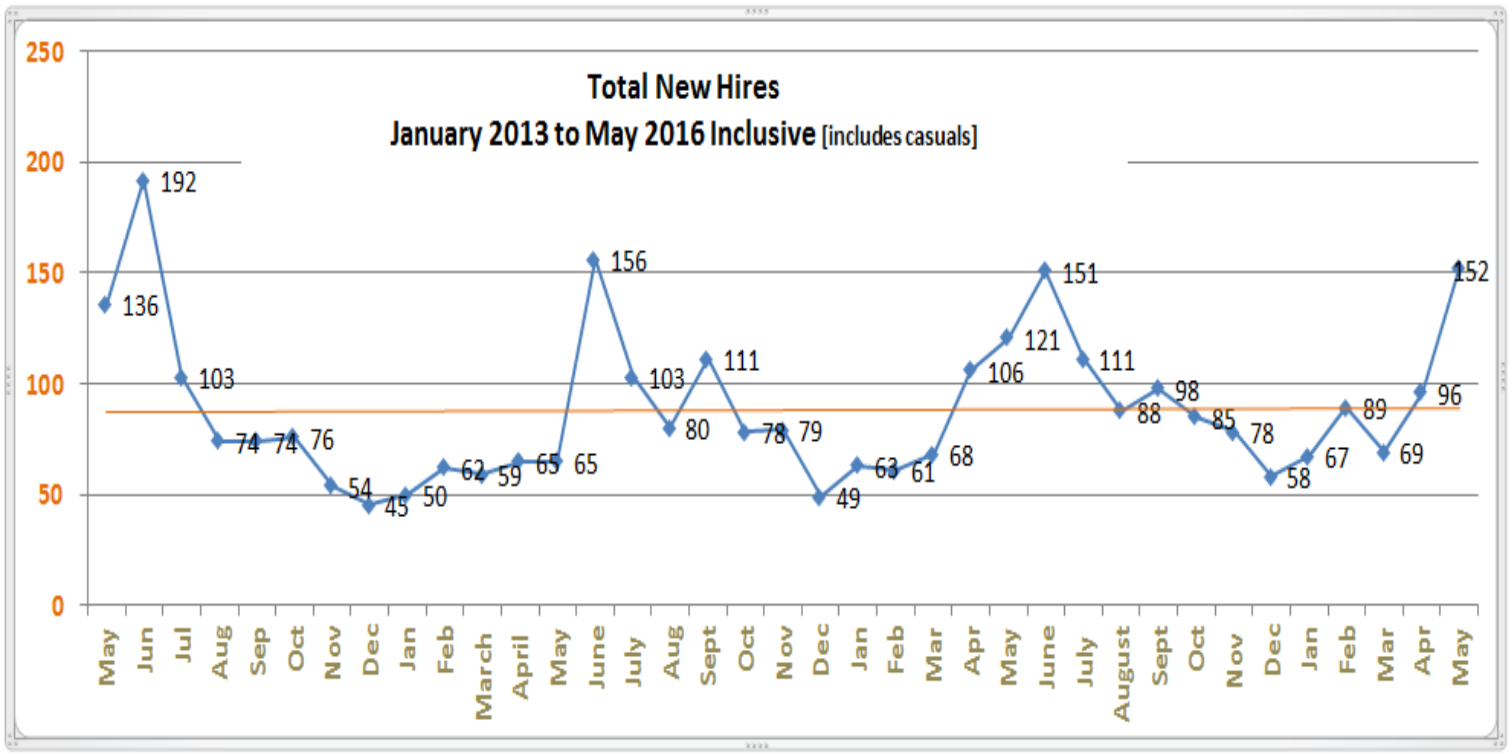


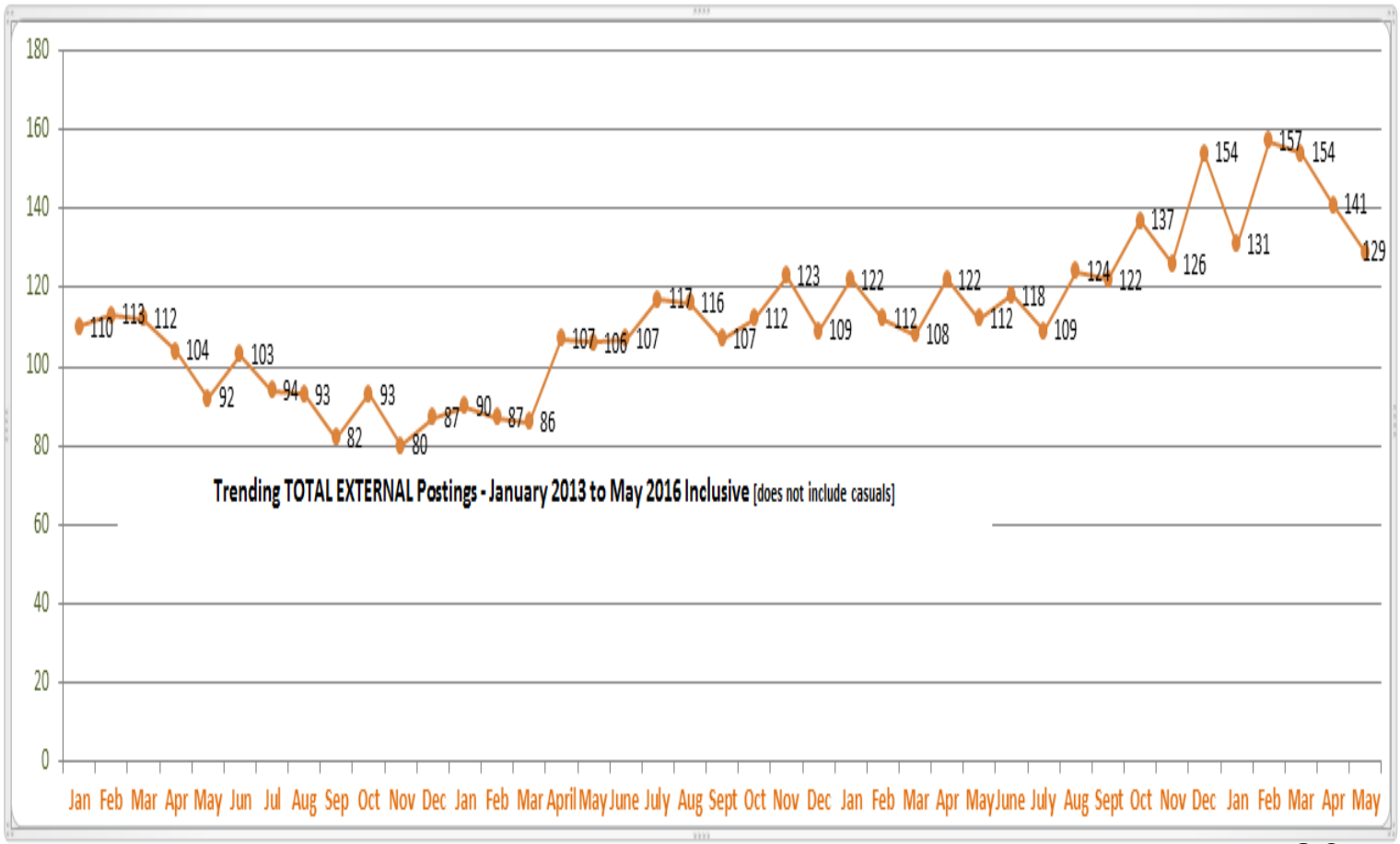
(37) - External Postings - NORTHWEST
May 31, 2016 (does *not include casuals*]

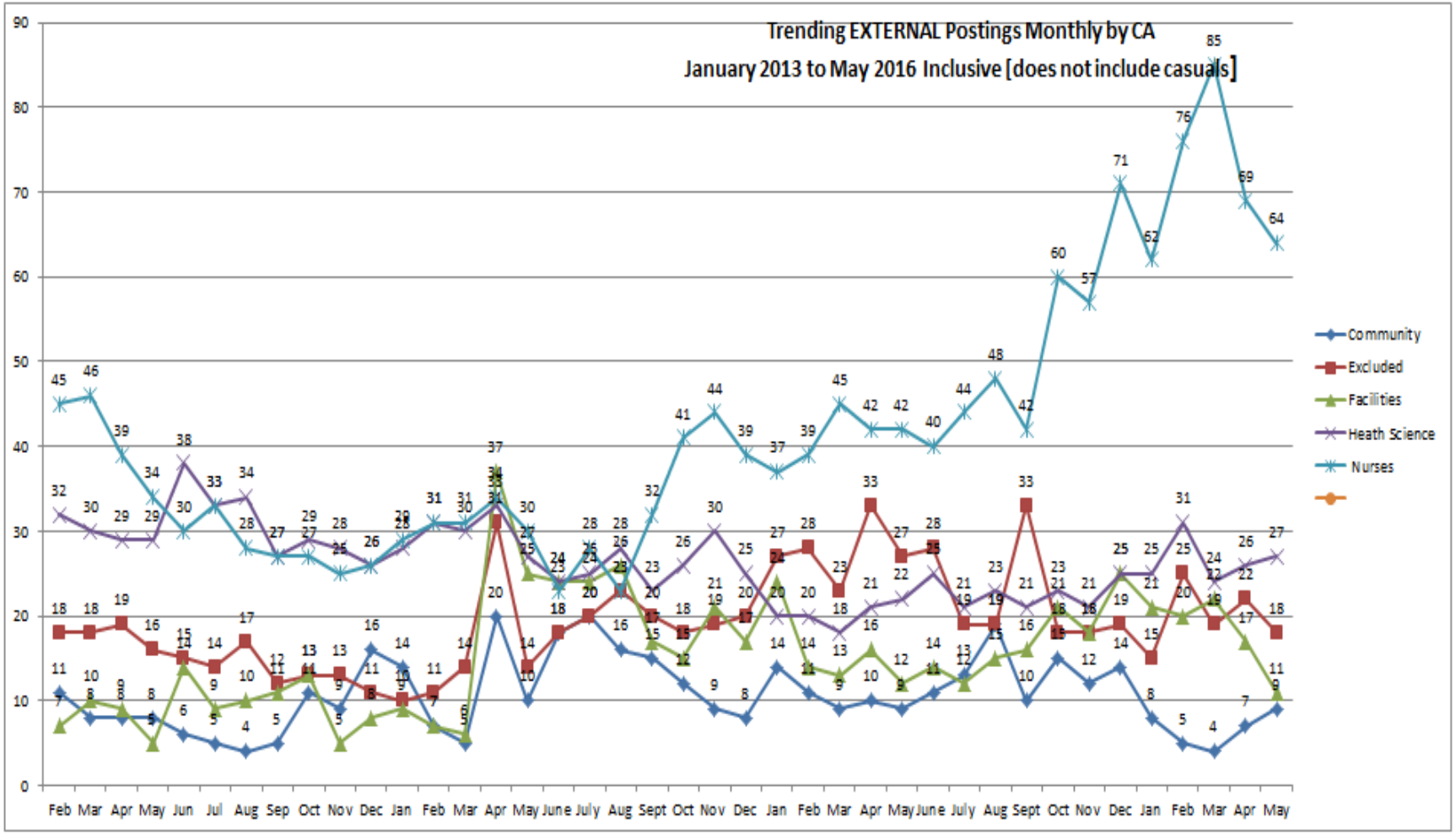


(33) External Postings- NORTHERN INTERIOR
May 31, 2016 [*does not include casuals*]




Total New Hires
January 2013 to May 2016 Inclusive [includes casuals]
250
200
150
100
50
0
May Jun Jul Aug Sep Oct Nov Dec Jan Feb March April May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June July August Sept Oct Nov Dec Jan Feb Mar Apr May
136 192 103 74 74 76 54 45 50 62 59 65 65 156 103 80 111 78 79 49 63 61 68 106 121 151 111 88 98 85 78 58 67 89 69 96 152


180
160
140
120
100
80
60
40
20
0
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 May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May
110 113 112 104 92 103 94 93 82 93 80 87 90 87 86 107 106 107 117 116 107 112 123 109 122 112 108 122 112 118 109 124 122 137 126 154 131 157 154 141 129
Trending TOTAL EXTERNAL Postings - January 2013 to May 2016 Inclusive [does not include casuals]


Trending EXTERNAL Postings Monthly by CA
January 2013 to May 2016 Inclusive [does not include casuals]
Community
Excluded
Facilities
Heath Science
Nurses
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 May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May

The Face of Northern Health

As of June 1, 2016

Total FTE for Active Employees — 4,684

	Headcount	FTE
o Short Term Leaves	480	316
o Long Term Leaves (LTD)	378	332

Status

o Full-time	3,446	(48%)
o Part-time	1,872	(26%)
o Casual	1,908	(26%)

Employees by Headcount per HSDA

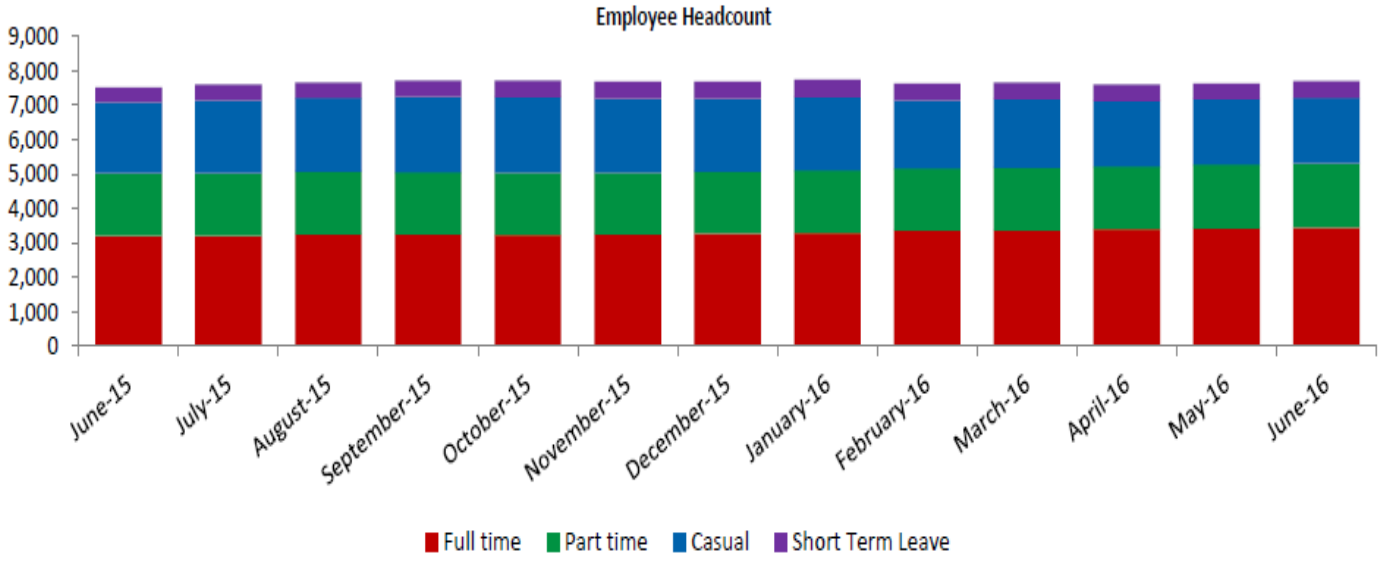
o NE	1,275	(18%)
o NI	3,768	(52%)
o NW	1,835	(25%)
o CORP	348	(5%)

Employees By Headcount — 7,226

o Average Tenure (Yrs) — 8.1

Employees by Collective Agreement

o Health Sciences		887	(12%)
o Excluded		550	(8%)
o Nurses		2,278	(32%)
Registered Nurses	1,647		
Registered Psychiatric Nurses	41		
Licensed Practical Nurses	589		
o Facilities		2,877	(39.8%)
**Clinical	1,211		
**Support	1,666		
o Community		634	(8.8%)
**Clinical	413		
**Support	221		



*Graph depicts total employee headcount over a one year period. Employees with multiple ID's have been included in the group ing where they hold the highest FTE.
**COMM/FAC Clinical #'s include: Care Aides, Home Support, Activity Workers, Nursing Assistants, Lab Assistance, Pharmacy Technicians, etc.

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BOARD BRIEFING NOTE

Date:	**May 19, 2016**	
Agenda item	**2015-16 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 2015-16 financial statements and Government's requirements regarding disclosure of the audited financial statements to the general public.

Background:

Northern Health ended fiscal year 2015-16 on March 31, 2016. The annual financial statements are currently being audited by KMPG.

Upon conclusion of the audit, the audited financial statements will be presented to Northern Health's Board of Directors for approval in June. 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 2015-16 audited financial statements will be posted on its website – www.northernhealth.ca.

Recommendation(s):

Receive the above information.

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BOARD BRIEFING NOTE

Date:	May 16, 2016	
Agenda item:	2015-16 Capital Expenditure Plan/Project Update (Period 13)	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	NH Audit & Finance Committee and Board of Directors	
Prepared by:	Deb Taylor, Regional Manager, Capital Accounting	
Reviewed by:	Mark De Croos, VP Financial & Corporate Services/CFO	

The Northern Health Board approved the 2015-16 capital expenditure plan in February 2015, with minor amendments throughout the year.

The final capital expenditures for 2015/16 totaled $52.2M, with funding support from the Ministry of Health ($25M,49%), Six Regional Hospital Districts ($18.0M, 36%), Foundations and Auxiliaries ($3M, 6%) and Northern Health ($6M, 12%).

$ million	**YTD**	**Plan**
Major Capital Projects (> $5.0M)	25.9	32.4
Major Capital Projects (< $5.0M)	11.1	8.1
Major Capital Equipment (> $100,000)	2.1	3.1
Equipment & Projects (< $100,000)	8.0	10.9
Information Technology	5.1	5.0
	52.2	59.5

Summary of significant capital projects currently underway or completed in 2015-16 are as follows:

Northwest Health Service Delivery Area (NW-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Terrace	Mills Memorial – DR Room 1	$0.46	Complete	MOH, NWRHD, NH
Terrace	Mills Memorial - Nurse Call System	$0.30	Complete	MOH, NWRHD
Smithers	Bulkley Valley - Boiler and	$0.27	In Progress	MOH, NWRHD,

	Controls			Energy Grants
Prince Rupert	Electrical power system upgrade	$1.65	Complete	MOH, NWRHD, NH
Hazelton	Wrinch Sprinkler System	$1.36	Complete	NWRHD, NH
Stewart	Ventilation Isolation	$0.28	In Progress	MOH, NWRHD, Energy Grants
Stikine	Energy Conservation Measures	$0.29	Complete	MOH, NWRHD, Energy Grants
Queen Charlotte	Hospital replacement	$50.00	In progress	MOH, NWRHD

Northeast Health Service Delivery Area (NE-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Dawson Creek	Medication dispensing cabinet	$0.11	Ordered	MOH, PRRHD
Dawson Creek	CT Console Upgrade	$0.20	Complete	Dawson Creek Foundation
Fort Nelson	Morgue room renovation	$0.74	Complete	MOH, NRRHD, NH, FN Hospital Foundation
Fort Nelson	Tub room renovation	$0.30	Complete	MOH, NRRHD, NH
Fort St. John	CT Console Upgrade	$0.20	Complete	FSJ Hospital Foundation
Fort St John	Medical office building	$4.78	Complete	NH

Note 1: Abbreviations used:

MOH	Ministry of Health
FFGRHD	Fraser Fort George Regional Hospital District
SNRHD	Stuart Nechako Regional Hospital District
NWRHD	Northwest Regional Hospital District
CCRHD	Cariboo Chilcotin Regional Hospital District
PRRHD	Peace River Regional Hospital District
NRRHD	Northern Rockies Regional Hospital District
NH	Northern Health

Northern Interior Service Delivery Area (NI-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Burns Lake	Hospital replacement	$55.00	Complete	MOH, SNRHD
Burns Lake	Hospital landscaping	$0.17	Complete	SNRHD, Village of Burns Lake, Burns Lake Auxiliary
Burns Lake	The Pines generator relocation and electrical	$0.62	In Progress	NH

	upgrade			
Prince George	Learning & Development Centre	$10.50	Complete	MOH, NH
Prince George	Gateway 3rd floor renovations	$0.83	Complete	FFGRHD, NH
Prince George	UHNBC – CT Scan Upgrade	$0.19	Complete	Spirit of the North
Prince George	UHNBC – Drug Packaging Machinery	$0.27	Ordered	MOH, FFGRHD
Prince George	UHNBC - ER Telemetry	$0.68	complete	MOH, FFGRHD, NH
Prince George	UHNBC MRI	$2.43	Planning	MOH, FFGRHD
Prince George	UHNBC – Sterile Processing – Cart Washer	$0.30	Ordered	MOH, FFGRHD
Prince George	UHNBC – Waste handling system	$0.99	Ordered	MOH, FFGRHD
Prince George	UHNBC – patient monitoring systems	$0.83	Ordered	FFGRHD, NH
Fort St James	Sprinkler system upgrade	$0.85	In Progress	MOH, SNRHD, NH
Quesnel	Dunrovin – Energy Conservation Measures	$0.32	In Progress	MOH, CCRHD
Quesnel	GRB - Switchgear	$0.18	In Progress	MOH, CCRHD
Quesnel	GRB – QUESST renovation	$0.5	Planning	MOH, CCRHD
Quesnel	GRB – patient monitoring systems	$0.41	Ordered	MOH, CCRHD
Quesnel	GRB – Specialist Offices Renovation	$0.16	In Progress	NH, CCRHD
Quesnel	Avery Clinic Renovations	$0.90	In Progress	NH, CCRHD

Regional Projects

Community	Project	Project $M	Status	Funding partner (note 1)
All	Community Health Record (Phase 1)	$2.63	In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Voice Recognition Electronic Documentation	$0.82	In Progress	MOH, NH
All	Clinical Interoperability	$1.00	In Progress	NH
All	Mobile Shift Booking	$0.48	In Progress	NH

In addition to above major capital projects, NH receives funding from the Ministry of Health, Regional Hospital Districts, Foundations, and Auxiliaries for minor equipment and projects (less than $100,000). For 2015-16, NH spent $8M on such items.

Recommendation:

The Northern Health Board approves Northern Health's Period 13 capital project update, as presented.

Northern Health Regional Office
600-299 Victoria Street, Prince George, BC V2L 5B8
Telephone (250) 565-2649, Fax: (250) 565-2640
www.northernhealth.ca

BRIEFING NOTE

Date:	**May 26, 2016**	
Agenda item	**Partnering for Healthier Communities - Processes in Place**	
Purpose:	☒ **Information**	☒ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Northern Health Board of Directors**	
Prepared by:	**Dr. Sandra Allison, CMHO** **Kelsey Yarmish, Regional Director Population Health Programs** **Sabrina Dosanjh-Gantner, Regional Manager (interim) Healthy Communities and Schools, Population Health Programs** **Theresa Healy, Lead Healthy Community Development – Community Engagement** **Holly Christian, Lead Healthy Community Development- Local Governments**	
Reviewed by:	**Cathy Ulrich, Chief Executive Officer**	

Issue:

With the renewal of the Northern Health *Strategic Plan… Looking to 2021*, Northern Health has prioritized fostering healthy people in healthy communities. Northern Health is committed to partnering with communities to support people to live well and to prevent disease and injury.

These partnerships will require a deeper understanding of community including the diversity across health assets and contributors to positive measures of health and wellness, as well as the health disparities and contributors to poor health as experienced by Northern communities. With this deeper understanding, we will work together to improve population health outcomes, supporting community partners to realize their health promotion and wellness goals and address health disparity through a health equity lens.

One partnership mechanism utilized to realize our priority of healthy people in healthy communities includes the Partnering for Healthier Communities approach and the Partnering for Healthier Communities committees, which has been a priority focus since 2012. This mechanism is in place across many northern communities. How will we know we are successfully engaging and partnering through the Partnering for Healthier Communities mechanism, and what other opportunities exist to support partnerships across all of our Northern communities? This briefing note aims to explore these questions and provide information on the current status of Northern Health's Partnering for Healthier Communities work across Northern BC and to make recommendations for future direction.

Background:

The Regional Population Health programs strive to support community partners in locally-driven healthy living efforts. Our work is demonstrated through programming, in particular through Healthy Community Development where we have invested in supporting integrated community granting and the Partnering for Healthier Communities Committees, as co-chaired by local government and Northern Health. These committees focus on locally identified issues with locally identified solutions. The strategies and impacts of these committees is captured and reflected in the Healthy Living Strategic Plans, that outline the details of each Northern Health and local government partnership and the actions these partnerships have embarked on to support northerners to stay healthy. This work primarily enables Northern Health, in partnership with communities, to address the determinants of health that would often otherwise be beyond the reach of Northern Health to improve.

These efforts are impacted and shaped by the diversity of local governments that exist across the north. Within our region, there are 32 municipalities, consisting of one regional municipality, 13 district municipalities, six cities, one town, and 11 villages, as well as six regional districts (please see Appendix 1). Additionally, there are approximately 126 unincorporated communities in the North, which are considered regions of land not governed by municipal council, but rather by regional-level governments, such as regional districts. As unincorporated communities do not currently fall within the framework, Healthy Community Development and Population Health have committed to developing unique strategies to engage and partner with unincorporated communities to support healthy people in healthy communities as residents in such communities may face unique challenges and vulnerabilities to their health status.

Northern Health's Partnering for Healthier Communities approach supports communities "where they are at", that in turn supports a collaborative stance and encourages the health authority and the community to set priorities, address gaps, and improve the health of their citizens through collective action. The four key components of Healthy Community Development's support of the approach are:

1. Formalized Partnerships,
2. Facilitation Support,
3. Learning Opportunities, and
4. Tools and Resources

There are currently **22 formalized Partnering for Healthier Communities Committees through formalized partnership agreements** between Northern Health and municipalities across Northern BC, resulting in 22 Healthy Living Strategic Plans. Due to differing dates of initiation, these communities are at various stages of readiness and action; some are mature in their evolution, others in early-growth stage, and a small number who are experiencing growing pains.

The success of community action, particularly by the localized committees, is highly dependent on a number of factors. Commitment of time and resource from both local government and the health authority, as well as the involvement of other citizens and inter-sectoral stakeholders in discussions and planning are critical. In addition to backbone support, Collective Impact literature identifies four other key conditions for shared success; a common agenda, shared measurements, mutually reinforcing activities, and continuous communication, which in turn informs the work of Healthy Community Development.

Current Opportunities:

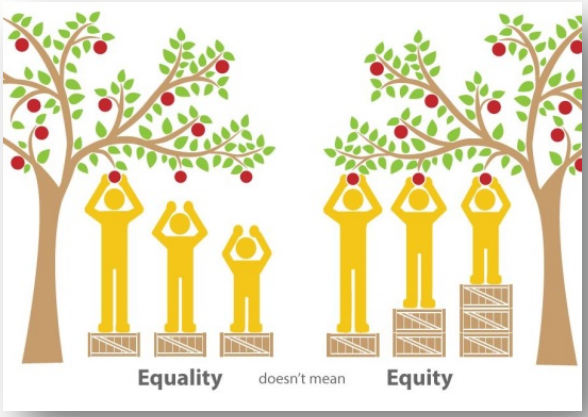
- There are currently 22 formalized Partnering for Healthier Communities Committees, with leadership from Northern Health and local government co-chairs.
    - All Committees have at some time accessed Partnering for Healthier Communities granting opportunities from Northern Health to support locally identified and driven initiatives, and some have sought provincial granting opportunities through the PlanH Healthy Communities Capacity Building Fund. Please see Appendix 2 for an overview of Committees who were successful in obtaining grants in 2016.
- Currently Northern Health is undertaking a research-based investigation into the state of healthy public policy in Northern BC.
    - Policy development at the local government level that supports healthy environments and healthy behaviours (e.g. Tobacco bylaws, Active transportation planning, and local food security) is supportive of healthy communities.
    - This will allow for the identification of successful initiatives and highlight gaps in current policy landscape, thereby supporting Healthy Community Development to target its efforts.
- Recently local government and health authority representatives came together for the Northern Healthy Communities forum in Dawson Creek, co-hosted by Northern Health and PlanH.
    - Representatives of the following communities attended: Northern Rockies Regional Municipality, Peace River Regional District, Taylor, Chetwynd, Hudson's Hope, Dawson Creek, Mackenzie, Granisle, Houston, Fraser Lake, Terrace, Regional District of Kitimat Stikine, and Kelly Lake Cree Nation. The attendees were primarily from Northeastern communities, likely due to the challenge of Northern travel.
    - Communities were able to share how these partnerships have supported their adoption of healthy policies, infrastructure development, and small changes that have benefitted the health of citizens.
    - More effective communication was highlighted as necessary in order to grow our impact, including sharing successful initiatives with other communities and exploring a "healthy communities" community of practice.
- A cohort of leadership from Population Health and Public Health Protection is exploring the intersection of shared work across the Healthy Community Development efforts and Healthy Built Environment efforts by forming a Healthy Community Development/Healthy Built Environment Collaborative to advance strategic efforts through shared work plan and goals, shared planning, decision and resource. This collaborative will be supporting the coordinated efforts of Healthy Built Environment and Healthy Community Development work across the North.
    - Healthy Built Environments include infrastructure, community design and service elements that enhance the ability of residents to maintain active and healthy lifestyles.

Actions moving forward:

In order to reflect on actions moving forward, several important considerations should be taken into account:

- Many existing committees are in need of support to revitalize their work, and to look beyond funding opportunities to more sustainable, long-term actions.
    - Reliance on funding from year to year can be seen as a barrier to these committees who are working towards developing sustainable initiatives and/or long term actions, such as healthy public policy development.

- Committees need support to develop strategic plans on a regular basis to support changing membership, politics, and priorities.
- Unincorporated communities are not currently supported with provincial or Partnering for Healthier Communities grant funding and have no formalized partnerships with Northern Health. However, it should be noted that unincorporated communities are eligible to apply for IMAGINE grants.
- There are concerns regarding equity in funding dispersal
    - Grants are not adjusted based on size of the community, population, vulnerable populations present, and are based off perceived need.
- Northern Health has a record of listening and responding to local needs and building on local assets. This strengths-based approach often generates innovative and successful approaches that could be adopted elsewhere
    - Why the same isn't equal: Understanding how to distribute NH resources equitably is a challenging concept given the complex and multileveled diversities across the northern region. Health promotion and prevention efforts, supported by community granting with an equity lens, is the best approach to building equitable as well as healthy communities.



When taking into account the aforementioned considerations, the following actions are crucial to support ongoing Partnering for Healthier Communities processes and are being considered as part of Healthy Community Development work planning efforts:

Committee Refresh: Evaluating and data informed planning
High turnover, changes within communities, or other significant changes in the community or province at large, can impact even the most functional of committees. An opportunity to reflect on successes and challenges, and strategically "recalibrate" the committee work through a refresher process combines both evaluation and data informed planning.

Community Visioning: Designing and planning
Present for every successful committee was the hosting of a community forum/visioning session at the onset of the work. These sessions were part informative, part educational, and highly experiential, and paved the way for a community-embraced plan for work that was grounded in a rich understanding of a population health approach. We would like to continue to offer this opportunity to newly emerging partnerships/committees, as well as offer this opportunity for interested existing partnerships.

Community Regrouping: Assessing and adjusting
For those communities that are struggling to find their way, readiness to regroup will be a key factor in providing the right supports. Essentially supporting a productive way to re-assess and plan for revitalizing their committee in a positive direction is the overarching umbrella of supports needed.

Strategic Outreach: Gaining new ground
Communities with no established committees will require outreach and recruitment including offering incentives for participation and providing encouraging support and tools. While some of these unattached communities are ready and eager to participate others are not as ready. It is essential to

use community readiness as a tool to manage commitments for the Healthy Community Development program if effective work with newly emerging committees is to continue.

Understanding the landscape of unincorporated communities:
The issues faced by unincorporated communities are fundamental to developing a strategic approach to supporting the health of those residents. In doing this exploratory work, the ideas and possible solutions will be generated from the insights of those living in those communities.

Recommendation(s):

That the Northern Health Board receive this report for discussion, information and advice.

Appendix 1:
Community Landscape in Northern BC (First Nations Communities not included)

Northwest HSDA

Regional Districts			
Regional District of Skeena-Queen Charlotte Regional District of Kitimat-Stikine Stikine Region (unincorporated)			
Cities	**District Municipalities**	**Towns**	**Villages**
Prince Rupert Terrace	Port Edward Kitimat New Hazelton Stewart		Masset Port Clements Queen Charlotte Hazelton
Unincorporated Communities			
(Dodge Cove, Humpback Bay, Hunts Inlet, Lawnhill, Miller Creek, Nadu, Rural Port Clements, Sandspit, Tlell, Tow Hill)[RDSQC] (Bob Quinn, Cedarvale, Dease Lake, Meziadin, Telegraph Creek, Thornhill)[RDKS] (Atlin)[Stikine]			

Northern Interior HSDA

Regional Districts			
Regional District of Bulkley-Nechako*** Cariboo Regional District Regional District of Fraser-Fort George			
Cities	**District Municipalities**	**Towns**	**Villages**
Quesnel Prince George	Fort St. James Houston Vanderhoof Mackenzie Wells	Smithers	Burns Lake Fraser Lake Granisle Telkwa McBride Valemount
Unincorporated Communities			
(Evelyn, Quick, Decker Lake, Donalds Landing, Palling, Rose Lake, Sherton, Tintagel, Germansen Landing, Leo Creek, Takla Landing, Trembleur, Endako, Fort Fraser, Francois Lake, Noralee, Grassy Plains, Ootsa Lake, Southbank, Danskin, Wisteria, Takysie Lake, Engen, Cluculz Lake, Fort Babine, Kuldo, Smithers Landing, Topley, Topley Landing)[RDBN] (Quesnel South, Quesnel West, Bouchie Lake, Barlow, Barkerville)[CRD] (Salmon River, Ness Lake, Nukko Lake, Reid Lake, North Kelly, Chief Lake, Pilot Mountain, Mud River, Beaverly, Miworth, West Lake, Tabor Lake, Pineview, Buckhorn, Red Rock, Stoner, Woodpecker, Hixon, Shelley, Giscome, Willow River, Upper Fraser, Sinclair Mills, Longworth, Penny, Summit Lake, Bear Lake, Dome Creek, Crescent Spur)[RDFFG]			

Northeast HSDA

Regional Districts		Regional Municipalities	
Peace River Regional District		Northern Rockies Regional Municipality	
Cities	**District Municipalities**	**Towns**	**Villages**
Dawson Creek Fort St. John	Chetwynd Hudson's Hope Taylor Tumbler Ridge		Pouce Coupe
Unincorporated Communities			
(Altona, Buick, Cecil Lake, Clayhurst, Clearview, Flatrock, Goodlow, Montney, North Pine, Osborn, Pink Mountain, Prespatou, Rose Prairie, Sikanni Chief, Trutch, Upper Cache, Upper Halfway, Wonowon, Baldonnel, Charlie Lake, Clairmont, Grandhaven, Old Fort, Two Rivers, Arras, Bessborough, Cutbank, Doe River, Farmington, Kelly Lake, Kikerran, One Island Lake, Rolla, Tomslake, Tower Lake, Tupper, East Pine, Groundbirch, Hasler Creek, Jackfish, Lone Prairie, McLeod, Moberly Lake, Pine Valley, Progress, Sunset Prairie)[PRRD]			

***A** **district municipality** can be incorporated "if the area to be incorporated is greater than 800 hectares and has an average population density of less than 5 persons per hectare" http://www.bclaws.ca/civix/document/LOC/complete/statreg/--%20L%20--/Local%20Government%20Act%20[RSBC%202015]%20c.%201/00_Act/r15001_02.xml

**Unincorporated communities may not be entirely accurate due to missing regional district information

***Please note that the Bulkley Valley-Nechako Regional District is within the NW and NI HSDAs.

Appendix 2:
Funding in Action: Partnering for Healthier Community Grants 2016

Committee	Community	Project Title	Deliverables	Amount $
Southern Haida Gwaii Healthy Communities (SHGHC) Team	Queen Charlotte	Localizing Our Food System	Increase knowledge and skill around local food procurement, processing and preparation through field trips, workshops and youth engagement projects	20,000
Masset in Motion	Masset	Local Food to Plate	Develop a reliable tracking system for the local food pantry, a food safety plan, recipes to support a standardized menu, and offer workshops to improve food preservation	7,500
Town of Smithers/Northern Health/Bulkley Valley Social Planning Society	Smithers	Linking Indicators Seed Grants	Disperse small seed grants to fund local initiatives that support health indicators and help to evaluate progress as a healthy community	7,500
Burns Lake Building a Better You Committee	Burns Lake	Secure and Sustain	Deliver educational gardening workshops, provide gardening support and offer food preservation training	7,500
Vanderhoof Healthier Community Alliance	Vanderhoof	Community Seed Grants	Provide community seed grants, focused on food security, to foster the development of local opportunities to promote healthier choices and lifestyles	7,500
North Cariboo Partnering for Healthier Communities Committee	North Cariboo	Empowered Family Health	Develop and enhance gardens at 2 elementary schools and to support educational workshops on the production and preservation of food for students	20,000
Quesnel Healthier Communities Committee	Quesnel	Creating a Tobacco Free Community	Develop and implement a strategy for communication and education around the new bylaw on smoking regulation in the City of Quesnel	7,500
McBride Healthier Communities Committee	McBride	Stay Strong, Live Strong!	Purchase and install outdoor fitness equipment for teens, adults and seniors in Steve Kolida Village Park	6,343
Mackenzie Gets Healthy Committee	Mackenzie	Prescription for Health/Outdoor Exercise Park	Purchase outdoor fitness equipment for adults and seniors and support the delivery of the prescription for health program in an increased capacity	7,500
Hope 4 Health (H4H) Society	Hudson's Hope	H4H Activities for Physical Activity and Healthy Eating	To promote health and wellness in Hudson's Hope and the surrounding area through the support of *That Dam Run*, offering educational workshops, cooking classes, a lunch program, and community seed grants	7,500

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.

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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)
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.
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.

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

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Assessing Board Performance

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

Outside Advisors for Committees and Directors

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~~Deputy-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 and priorities
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 Service~~s~~ 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.

As ~~F~~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~~ 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

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~~ are outlined in Appendix 1
4. The Board may authorize the CEO to approve financial commitments or obligations that are not normally within the authority of the CEO
5. The intentional unbundling of items to reduce the spending threshold is not permitted
6. Financial transactions spread over more than one year shall be valued based on the total contractual commitment for the duration of the contract or commitment
7. Prior to approval, the CEO shall bring to the attention of the Board any financial transactions within the CEO's authority, regardless of value, that have a high risk factor, involve any controversial matter, or that may bring the activities of NH under public scrutiny

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

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8. The 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 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.
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.
10. The Chief Financial Officer (the "CFO"), or the CFO's delegate, is authorized to approve financial transactions related to regulatory payments, utilities and payroll deductions without limit
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-~~0~~2-030~~-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-~~0~~2-030-~~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")~~CFO;
4.4.2 Approved by the CEO.
a) The CEO must consult with the Board Chair and if not available the ~~Vice~~Deputy~~-~~ 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-~~Deputy 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 the Health Employees Association of BC ("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 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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Regional Office
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BOARD BRIEFING NOTE

Date:	2016 May 18	
Agenda item	**Facility and Fund Naming Policy (BRD 240)**	
Purpose:	☐ **Information**	☒ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**NH Board**	
Prepared by:	**K Thomson**	
Reviewed by:	**GMR Committee**	

Issue:
The Facility and Fund Naming Policy has been revised substantially. The new version, including a copy of the electronic Asset Naming Nomination Form, are included, as well as an old version for comparison.

Background:
Following the last review of this policy, and a subsequent naming opportunity using the policy, feedback was received indicating that revision was required to provide more clarity in the process for naming an asset.

The following sections of the policy were added or revised:

1. Procedure – provides a step by step summary of the high level procedure for managing a naming request.
2. Naming Committee Decision Matrix – differentiates between classes of assets and provides specific directions on procedural requirements for each.
3. Evaluation Criteria – addition of a community consultation process
4. Internal Naming Requests – introduction of a new section for health authority naming requests and decisions
5. Electronic Asset Naming Nomination Form

Recommendation(s):
That the Committee review and provide feedback on the proposed revisions of BRD 240 – Facility and Fund Naming Policy.

FACILITY AND FUND NAMING POLICY 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.

This policy establishes 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.

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PROCEDURE

1. **Initial Request**
   a) The Asset Naming Nomination Form (Appendix 1) is completed, and submitted to the appropriate Health Service Delivery Area (HSDA) Chief Operating Officer (COO).
   b) The COO reviews and forwards the request to the Chief Financial Officer (CFO), who is the Office of Record, as soon as possible.
2. **Response to Request**
   a) The CFO consults with the President and Chief Executive Officer (CEO) to consider the appropriateness of the nomination.
      i. If not appropriate, the CFO, in consultation with the COO, will notify the applicant.
      ii. If appropriate, the CFO and CEO will designate a Naming Committee Chair and convene a Naming Committee.
3. **Naming Committee**
   a) The formation, membership, and duties of the Naming Committee will vary depending on the class of the asset in question. Refer to the Naming Committee Decision Matrix for direction.
   b) The Naming Committee will abide by the Terms of Reference and evaluation criteria set out in this policy.
   c) The Naming Committee forwards their recommendation to the appropriate Approving Agent, as defined in the Naming Committee Decision Matrix.
      i. Depending on the class of asset, additional approvals may be required. Refer to the Naming Committee Decision Matrix for direction.
4. **Communication**
   a) Publicity surrounding the naming of an asset, or the change or revocation of the naming of an asset will be handled by Northern Health's Communications Department in conjunction with provincial government, as necessary.

NAMING COMMITTEE – TERMS OF REFERENCE

1. **Standing members of the Naming Committee are:**
   - Vice President, Financial & Corporate Services/CFO
   - COO of applicable HSDA in which asset resides
   - Regional Director, Capital Planning and Support Services
   - Regional Director, Business Development
   - Chief Communications Officer/Regional Director, External Relations
   - 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: Selected by committee members or appointed by CEO

2. **Duties and Obligations:**
   - Assess naming opportunities submitted to the Naming Committee abiding by the established evaluation criteria;

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- 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.

3. 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.
   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.
   e. Is likely to be associated with an unhealthy lifestyle (e.g. alcohol or tobacco usage, obesity etc.)
   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.
   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.

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4. Naming opportunities supported by financial or in-kind gifts may be named after the donor or a third party at the request of the donor.
5. Except where the naming opportunity pertains to the recognition of distinguished service, donations must represent a significant portion of the cost of the facility or activity to be named and/or be critical for the completion of such facility or activity.
6. Where a naming request proposes to honour distinguished service of Board members, staff or physicians, it is recommended that at least three years has passed after the nominee has ended their service with Northern Health or an affiliated Foundation or Auxiliary.
7. Any revenue generated from a naming opportunity that is obtained through a capital campaign organized by a Foundation or Auxiliary affiliated with Northern Health or submitted to the Naming Committee by a Foundation or Auxiliary affiliated with Northern Health will be retained by such Foundation or Auxiliary and used in accordance with the donor's wishes. Final determination of any naming, however, remains with Northern Health. In all other cases, the Naming Committee will make a recommendation as to how revenue should be distributed (including, in the case of Northern Health, which department will receive all or any portion of the proceeds) provided that the donor's wishes will be honoured to the greatest extent possible.
8. 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.
9. 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.
10. 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.
11. For Class I naming requests, community consultation should be considered, including but not limited to: First Nations communities, local government and provincial political leaders, local support societies and advocacy groups

4. 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:

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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.

5. Internal Naming Requests

1. Northern Health may wish to name its own assets, by way of an executive choice, or a request from a staff member or physician.
2. All applicable evaluation criteria in sections 3 and 4 should be considered in the naming process.
3. Where the naming request is a tribute to a geographical feature of the region (e.g. a river or lake), the Office of Record will be consulted and will maintain a listing of named assets to minimize duplication in naming across multiple facilities.

6. Process to Revoke or Change a Naming Right

A naming right may be revoked or changed 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.

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NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
Classification	External Facility (e.g. building, road, park)	Internal Facility (e.g. floor, wing, laboratory)	Program (e.g. clinical unit, health/wellness program, room, lounge)	Equipment	Research/Academic Position	Tribute Marker (e.g. plaque, medallion, other marker usually associated with feature such as tree, bench or small monument)
Ad Hoc Members (additional to standing members)	• Health Services Administrator (HSA) for the community where the applicable external facility resides • Senior representative from the Foundation representing the community where the applicable external facility resides		• If applicable, the manager responsible for the program itself or for the clinical area managing the program • If the program is site-specific, the HSA for the site and a senior representative of the Foundation connected to the site	• HSA for the site where the equipment will be used • If applicable, the manager responsible for the clinical area utilizing the equipment, and • A senior representative of the Foundation for the site where the equipment will be used	N/A	N/A
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.					

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NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
Term	A defined period of time (normally not to exceed 35 years) or the life of the structure, whichever occurs first	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	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	The length of the equipment's useful life	A period of time commensurate with funding support	Negotiable
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.		CEO, upon recommendation of the Naming Committee	COO responsible for the site(s) or clinical area(s) where the equipment will be used, upon recommendation of the Naming Committee	The Naming Committee will delegate the naming of a tribute marker to the appropriate Chief Operating Officer	
Additional Provincial Government	Where the proposed naming of an entire facility, or significant portion thereof, is to receive Board approval, additional					

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NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
Approval	consultation with the 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. Prior to submitting recommendation for GMR and Board approval: For naming opportunities for all classes of asset that are accompanied by a financial or in-kind contribution, complete the "Naming Request Form" appended to the Government of British Columbia Naming Privileges Policy and submit to the applicable government Ministry. 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: 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 re-designate the facility with the new name. Residential Care Facility: This type of facility falls under the *Community Care & Assisted*					

NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
	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.					

APPENDIX 1
ASSET NAMING NOMINATION FORM

[Insert link to Asset Naming Nomination Form – Docusource # 10-300-7052]

APPENDIX 2
Government of British Columbia "Naming Privileges Policy"

APPENDIX 3
Government of British Columbia "Naming Request Form"

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Asset Naming Nomination Form

Name of donor or sponsoring entity	**Contact information**

Proposed asset to be named	**Proposed name**	**Proposed term of naming right**

For proposed name honouring an individual (if applicable)

Full name	Date of birth	Date of death (if applicable)	Occupation (or former occupation)	Length of service to Northern Health

Consideration for naming opportunity (if applicable)

☐ Financial	☐ In-kind (describe)	☐ Distinguished service (no financial or in-kind gift)	☐ Other (describe)

For nomination honouring distinguished service:
Have at least 3 years elapsed since the individual last worked with Northern Health? ☐ Yes ☐ No

Association of proposed name to the asset being named

Association with and main contribution(s) to Northern Health and/or local community

Background and/or biographical information demonstrating significance of proposed name to the community

Optional: **Other reason(s) for proposed name** (to reasonably assist the committee's deliberations)

Source(s) of above information

Completed nomination form is to be submitted to Northern Health's COO responsible for community in which the application asset resides.

FACILITY AND FUND NAMING POLICY 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.

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PROCEDURE

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Quick Overview

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

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

Initial Request - Executive Sponsor

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

Process to Initiate/Respond to Request

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

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

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

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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.

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.

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.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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.
   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.
   e. Is likely to be associated with an unhealthy lifestyle (e.g. alcohol or tobacco usage, obesity etc.)
   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.
   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 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.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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 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.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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:

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

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
Tel: 250 216-5903
Fax: 250 356-6036

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 15 2015 (R)

Board and Administration Services
#600-299 Victoria Street,
Prince George, BC V2L 5B8
T: (250) 565-2922

BOARD BRIEFING NOTE

Date:	**June 3, 2016**	
Agenda item	**Northern Health Board Meeting Calendars**	
Purpose:	☐ **Information**	☒ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	**Board of Directors**	
Prepared by:	**Desa Chipman, Executive Assistant CEO & Northern Health Board**	
Reviewed by:	**Cathy Ulrich, Chief Executive Officer**	

Issue:

Due to the busy schedules for all Northern Health Board members', management is proposing Board calendars are developed two years in advance. The development of the calendars will include the dates for Board meetings and to select the locations of out of town Board meetings.

Background:

Prior to 2016 it was normal practice for the Board to meet the 3rd Monday (full day) and Tuesday (half-day). Recently the Board has trialled a change in the practice which involved the meetings occurring on Sunday and Monday as follows;

- Sundays: Travel to the community followed by the Board Only and In Camera meetings
- Monday: Education Session, Public Meeting, Community Roundtable, a Facility tour followed by travel home.

Meeting location structure will remain 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 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. The following table shows when and where the Board has met since 2005, with a proposal for the meeting locations in 2017 and 2018.

[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

Management is asking the GMR Committee to provide guidance regarding meeting dates and locations for Board Meetings in 2017 and 2018. The calendars have been developed with the structure remaining with meetings occurring on the Sunday and Monday.

Year	NI	NW	NE
PROPOSED			
2017	Mackenzie (Feb)	Terrace (June)	Dawson Creek (Apr)
2018	Vanderhoof (Feb)	Prince Rupert (June)	Fort Nelson (Apr)
HISTORY			
2016	Quesnel (Feb)	Smithers/Hazelton (June)	Fort St John (Apr)
2015	Burns Lake (June)	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 Board Calendar for the years 2017 and 2018 as submitted.

DRAFT Board Calendar - 2017

BRD PREP STAT

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: Mackenzie			

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
Location: Dawson Creek						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						

MAY

S	M	T	W	T	F	S
	1	2	3	4	5	6
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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
Location Terrace				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	

JULY

S	M	T	W	T	F	S
						1
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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31		BOARD: Teleconference			

AUGUST

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6	7	8	9	10	11	12
13	14	15	16	17	18	19
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SEPTEMBER

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17	18	19	20	21	22	23
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OCTOBER

S	M	T	W	T	F	S
Location: Planning Sessions: Prince George						
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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOVEMBER

S	M	T	W	T	F	S
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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
Location: Prince George					1	2
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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1					

SD 57 & 52 Spring Break: March 13-24

DRAFT Board Calendar - 2018

BRD PREP STAT

JANUARY						
S	M	T	W	T	F	S
	1	2	3	4	5	6
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28	29	30	31			

FEBRUARY						
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Location: Vanderhoof				1	2	3
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MARCH						
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APRIL						
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29	30	Location: Prince Rupert				

MAY						
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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
BOARD: Fort Nelson					1	2
3	4	5	6	7	8	9
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17	18	19	20	21	22	23
24	25	26	27	28	29	30

JULY						
S	M	T	W	T	F	S
BOARD: Teleconference						
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22	23	24	25	26	27	28
29	30	31				

AUGUST						
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SEPTEMBER						
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16	17	18	19	20	21	22
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30						

OCTOBER						
S	M	T	W	T	F	S
BOARD: Planning Sessions: Prince George						
	1	2	3	4	5	6
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14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

NOVEMBER						
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DECEMBER						
S	M	T	W	T	F	S
BOARD: Prince George					1	1
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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1				

SD 57 Spring Break March 19-30

northern health
the northern way of caring

Capital Planning and Support Services
300-299 Victoria Street Prince George, BC V2L 5B8
(P) 250-565-2374 (F) 250-565-2753

BOARD BRIEFING NOTE

Date:	*June 2, 2016*	
Agenda item	**2015 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 2015 Carbon Action Neutral Program Results.

There is continuing success with the energy conservation projects, as the Health Authority has further reduced natural gas consumption year over year (2.4% versus 2014, 8.4% since the baseline year 2009).

Electricity consumption has been held to 2009 levels despite additional electrical load related to new diagnostic/clinical equipment and increases in building space.

These accomplishments have resulted in overall cost avoidance of $6.9M over six years. This is despite continued growth of the total operational floor area within the organization – more than 15% during the same time.

Total carbon emissions were reduced by 2.8% in 2015 as compared to 2014. This trend is expected to continue for the foreseeable future as we continue investing in energy conservation projects at key facilities.

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 four facilities during fiscal 2015-2016 (Stikine Health Centre (Dease Lake), Stewart Health Centre (Stewart), Dunrovin Park Lodge (Quesnel) and Bulkley Valley District Hospital (Smithers)).

At the Stikine Health Centre in Dease Lake, propane use from October 2015 to March 2016 was reduced by more than 50% from the previous winter. This is significant not just because of the greenhouse gas emissions reductions, but also because propane costs approximately four times more than natural gas at a typical Prince George facility.

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.

For 2016-2017, projects at the GR Baker Hospital in Quesnel and the University Hospital of Northern BC in Prince George are already in progress. It is anticipated that natural gas use for the entire organization will decline by more than 3% once these projects are completed. In addition, substantial incentive contributions are expected from FortisBC, which can be applied against future energy saving projects.

Several other activities are also underway:

Energy Studies: FortisBC operates a Commercial Custom Design Program aimed at reducing natural gas consumption in their service area (about 45% of our natural gas use). Energy studies are done at qualifying facilities, with FortisBC funding 50% of the initial costs. Upon successful implementation of the recommended energy conservation measures, FortisBC reimburses the remaining 50% of the cost. This program also provides significant capital incentives towards projects. Opportunities have already been identified for 2017-2018 at the University Hospital of Northern BC, which will enable Northern Health to continue reducing its greenhouse gas emissions year over year.

New Construction Incentives: BC Hydro will provide incentive payments of approximately for the new replacement hospital in Haida Gwaii.

Staff initiative: Additionally, NH staff at all NH facilities actively contribute to reducing greenhouse emissions by recycling at work, reducing paper consumption, and turning off lights and equipment when not needed.

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

Recommendation(s):

For information

Northern Health Regional Office
#600-299 Victoria Street, Prince George, BC V2L 5B8
T: (250) 565-2649, F: (250) 565-2640, www.northernhealth.ca

BOARD BRIEFING NOTE

Date:	**2016 May 16**	
Agenda item	**Regulatory Framework – Legislative Compliance** • ***Controlled Drugs and Substances Act***	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Board of Directors &** **Governance & Management Relations Committee (GMR)**	
Prepared by:	**K Thomson, Regional Director, Risk and Compliance**	
Reviewed by:	**C Ulrich, CEO**	

Issue:

To provide the Board of Directors with an update on the legislative compliance review process.

Background:

1. Current Review

The *Controlled Drugs and Substances Act* is a federal Act that regulates the procurement, distribution, and use of scheduled controlled drugs and substances. The Act primarily focuses on criminal offences related to controlled drugs and substances, and the role of police. Requirements for the legal use of controlled drugs and substances within health care are provided within several regulations to the Act.

This review focused on the Narcotic Control Regulations, the Benzodiazepine and Other Targeted Drugs Regulations, and the Medical Marihuana Regulations. Additionally, information on the disposal of controlled drugs and substances is found in the Food and Drugs Regulations (under the *Food and Drugs Act*), which is further clarified in Circular Letter 654 issued in 1985, with specific directions for the destruction request and disposal processes.

Northern Health has developed, or is in the process of developing or revising, policy and procedure to address all of the requirements of these regulations. Recent audits have been completed

respecting the secure storage of controlled drugs, as well as the disposal practices for controlled drugs on nursing units.

The policy in place in Northern Health is adequate to meet the legislative requirements; however, there remain areas where policy is not consistently followed, particularly around loss reporting and appropriate disposal. Risk Management is working with Pharmacy to provide education and support for improved reporting using the Patient Safety and Learning System (PSLS), and with the Medication Safety Officer to revise and update policy to provide more clarity on the disposal requirements and procedures.

This *Act* does not impose outstanding obligations or compliance issues on Northern Health.

2. Upcoming Review(s)

Bill 16 – 2016 *Community Care and Assisted Living Amendment Act*

3. Completed Reviews

The running list of completed reviews has been deleted from this briefing note and is being maintained in a separate spreadsheet stored in the GMR Committee folder on the network drive.

Recommendation:

That the Board receives this briefing note for information.