Meeting of the Northern Health Board
Public Meeting
1:15pm – 3:00pm

Wednesday, October 19, 2016

Brunswick Boardroom

325 Brunswick Street, Prince George BC

northern health

the northern way of caring

northern health

Public Session

AGENDA

October 19, 2016
Brunswick Boardroom
Prince George, BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Open Board Session	Chairman Jago		**1:15pm**	
2. Opening Remarks	Chairman Jago			
3. Conflict of Interest Declaration	Chairman Jago	Discussion		
4. Approval of Agenda	Chairman Jago	Motion		**1**
5. Approval of Previous Minutes: June 20, 2016	Chairman Jago	Motion		**3**
6. Business Arising from Previous Minutes	Chairman Jago			
7. CEO Report	C Ulrich	Information		**8**
7.1 Human Resources Report Workplace Health & Safety	D Williams	Information		**12**
8. Audit & Finance Committee				
8.1 Period 5 Financial Statements	M De Croos	Motion		**24**
8.2 Reappointment of External Auditor	M De Croos	Motion		**26**
8.3 Public Capital Update (Period 5)	M De Croos	Motion		**27**
9. Performance, Planning & Priorities Committee				
9.1 Innovation & Development Commons	F Bell	Information		**31**
10. Governance & Management Relations Committee				
10.1 Policy Manual BRD 300 Series	K Thomson	Motion		**40**
10.2 Community Consultation Child Health Update	S Raper	Information		**68**
10.3 Medical School Officers Appointment	K Thomson	Motion		**71**
10.4 Regulatory Framework – Legislative Compliance	K Thomson	Information		**75**
10.4.1. Bill 16-2016 Community Care & Assisted Living Amendment Act				
Adjourned			**3:00pm**	

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Public Motions

Meeting Date: October 19, 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 June 20, 2016 public minutes as presented	☐	☐
8.1	Period 5 Financial Statements	The Northern Health Board accepts the 2016-17 period 5 year to date financial update as presented.	☐	☐
8.2	Reappointment of External Auditor	The Northern Health Board approves the reappointment of KPMG LLP as external auditor to Northern Health for the fiscal year ending March 31, 2017, representing Year Five of a five-year term of engagement.	☐	☐
8.3	Public Capital Update (Period 5)	The Northern Health Board approves Northern Health's Period 5 Capital Projects Report, as presented.	☐	☐
10.1	Policy Manual BRD 300 Series	The Northern Health Board approves the revised BRD 300 series.	☐	☐
10.3	Medical School Officers Appointment	The Northern Health Board request that the Provincial Health Officer proceed to recommend to the Lieutenant Governor in Council that Dr. Andrew Gray be designated as a medical health officer for the Northern Health Authority, with powers under the Public Health Act.	☐	☐

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Date: June 20, 2016

Board Meeting

Location: Hazelton, BC

Chair: Dr. Charles Jago

Recorder: Desa Chipman

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

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

Public Minutes

1. Call to Order Public Session

The Open Board session was called to order at 9:15am.

2. Opening Remarks

Chairman Jago noted that the Board was delighted to be in Hazelton to hold the Open board meeting, to participate in the events to honor the 115 years of health service provided by the United Church of Canada and the United Church Health Services Societyand to underline the commitment from Northern Health to carry on with the legacy that has been left by the United Church. Chairman Jago recognized Michael Hare and Margaret Watts-Hammond from the United Church Health Services Society Board who were in attendance to observe the meeting.

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 was no conflict of interest declarations made related to the June 20, 2016 Public agenda.

4. Approval of Agenda

Moved by R Landry seconded by S Hartwell
The Northern Health Board approves the June 20, 2016 public agenda as presented

5. Approval of Board Minutes

Moved by G Townsend seconded by M Squires
The Northern Health Board approves the April 18, 2016 public minutes as presented

6. Business Arising from Previous Minutes

There was not business arising from previous minutes.

7. CEO Report

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

- Dr. Appleton who 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 will be retiring at the end of June. Northern Health has appreciated his dedication and commitment to providing quality health care to those in the north.
- Aboriginal Health Improvement Committee Gathering
  - Northern Health 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.
- The transfer of Wrinch Memorial Hospital services from the United Church Health Services Society to Northern Health would not have been possible without the hard work of those who participated on the steering committee and working group. Northern Health Executive and Board are appreciated of the work the committee members did to ensure a smooth transition.
- North Central Local Government Association Convention – Dawson Creek, May 3-6, 2016
  - Chairman Jago and Cathy Ulrich attended the convention and 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. The forum provided an opportunity to learn about building healthy communities and to share initiatives underway in northern communities.
- Quesnel Primary 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 the MLA Coralee Oakes.
- The Haida Gwaii Hospital and Health Centre Replacement Project is progressing well. The hospital is scheduled to be complete in the fall of 2016. The majority of community, primary care, and acute care programs will be located on this site.

7.1. Human Resources Report

David Williams provided an overview of the Human Resources Report as follows:

- Disability management continues to focus on Long-Term Disability (LTD) claims activity, both provincially and at health authority level. In May, a provincial meeting occurred with seniors leaders from Great West Life (GWL0, Health Employer Association of BC, the Healthcare Benefit Trust (HBT), and representatives from the BC Health Authorities).
  - Over the next year and a half, a provincial committee with the Health Authorities represented will continue to meet with a focus on the expectations and outcomes outlined in the report.
- Health Human Resources Planning is occurring at a Provincial and Health Authority level. The Northern Health HR Planning and Design team is working with other departments, including Planning,

Quality, and Information Management, Finance, HR Operations, Recruitment and other operational leaders across Northern Health to project health human resource needs.

- Grow your own sessions were held on May 12 and May 19 at College Heights Secondary School in Prince George and at Caledonia Senior Secondary in Terrace. The 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 session to assist parents in starting a conversation with their children about moving towards a health care career.

8. Audit and Finance Committee

8.1. Public Comments Fiscal Y/E 2015-16

- Northern Health ended fiscal year 2015-16 on March 31, 2016. The annual financial statements are currently being audited by KPMG.
- Upon conclusion of the audit, the audited financial statements will be presented to Northern Health's Board of Directors for approval. Following approval the audited financial statements will be submitted to the Ministry of Health. Once Ministry approval is received, Northern Health's 2015-16 audited financial statements will be posted on its website.

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 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%).
- A summary of significant capital projects currently underway or completed in 2015-16 was outlined in the report.
- In addition to the major capital projects noted in the report, 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, Northern Health spent $8M on such items.

9. Performance Planning and Priorities Committee

9.1. Strategic Priority: Healthy People in Healthy Communities

9.1.1. Partnering for Healthy Communities

- With the renewal of the Northern Health Strategic Plan…Looking to 2021, Northern Health has prioritized fostering health people in healthy communities. Northern Health is committed to partnering with communities to support people to live well and to prevent disease and injury.
- 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 following actions are crucial to support ongoing Partnering for Healthier Communities processes:
    - Committee Refresh: Evaluating and data informed planning
    - Community Visioning: Designing and planning
    - Community Regrouping: Assessing and adjusting

- Strategic Outreach: Gaining new ground
- Understanding the landscape of unincorporated communities

10. Presentation – Healthy Communities Partnerships in Prince Rupert and Haida Gwaii

Michael Melia, Health Service Administrator, Prince Rupert and Haida Gwaii provided a presentation on the successful work that has occurred as a result of the Healthy Communities Partnerships in Prince Rupert and Haida Gwaii.

11. Governance and Management Relations Committee

11.1. Policy Manual BRD 200 Series

- The revised policy manual BRD 200 Series were presented to the Board for their approval. The minor revisions and edits were highlighted to ensure the Board of Directors were aware of where changes occurred. In particular, the revisions made to Policy 240 - Facility and Fund Naming Policy were highlighted.

Moved by R Landry seconded by S Hartwell
The Northern Health Board approves the revised BRD 200 policy series as presented.

11.2. 2017 & 2018 Board Meeting Calendar

- The proposed 2017 & 2018 Board meeting calendars were shared with the Board for review and discussion.
- Management will canvass the Board members on potential June dates before finalizing the calendars.

Moved by G Parmar seconded by M Squires
The Northern Health Board approves the Board Calendars for the years 2017 and 2018 as revised.

11.3. 2015 Carbon Neutral Report

- The 2015 Carbon Action Neutral Program results were shared. There is continuing success with the energy conservation projects, as the Health Authority has further reduced natural gas consumption year over year.
- Electricity consumption has been held to 2009 levels despite additional electrical load related to new diagnostic/clinical equipment and increase in building space.
- These accomplishments have resulted in overall cost avoidance of $6.9M over six years.
- The report highlights key actions taken to reduce greenhouse gas emissions over this past year and describes future plans.
- Northern Health is committed to sustainable actions and supporting a healthy environment for future populations of northern British Columbia.

11.4. Regulatory Framework – Legislative Compliance

11.4.1. Controlled Drug & Substance Act

- An update was provided to the Board of Directors on the legislative compliance review process.
- The Controlled Drug & Substance 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.

- 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.

The Open session was adjourned at 10:45am
Moved by S Hartwell

Dr Charles Jago, Board 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:	October 7 , 2016
Agenda Item:	CEO Report		
Purpose:	Information		
Prepared by:	Cathy Ulrich		

10th Annual BC Health Care Awards

The Health Employers Association of BC held the 10th Annual BC Health Care Awards event on June 27, 2016 in Vancouver BC. The Health Care Hero Gold Apples are awarded to individuals who go the extra mile to make a difference in health care. Their passion and dedication is evident in everything they do. A Health Care Hero is someone who all staff members can look to for inspiration.

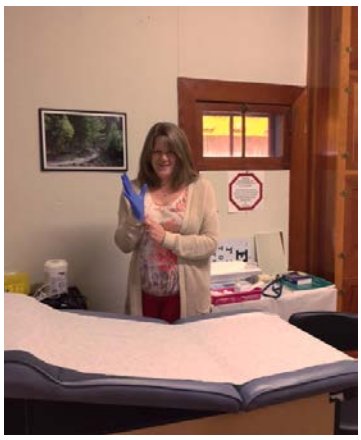
Barb Crook, Health Services Administrator, Mackenzie & District Hospital & Health Centre was this year's recipient. Before becoming Health Services Administrator for Mackenzie, Barb was a frontline nurse for 26 years, gaining critical leadership experience in every department.

Additional Awards
Dr. Nadine Caron, an Associate Professor in the Department of Surgery and Co-Director of the UBC Centre for Excellence in Indigenous Health, has received the Dr. Thomas Dignan Indigenous Health Award from the Royal College of Physicians and Surgeons. Dr. Caron is a general and endocrine surgeon in Prince George and is a faculty member in the Northern Medical Program. The Dr. Thomas Dignan Indigenous Health Award was established in 2014 to recognize physicians who epitomize a zeal and devotion to the pursuit of rights and justice for Canada's Indigenous peoples.

Dr. Becky Temple, Clinical Instructor, Department of Family Practice has been awarded the 2016 Clinical Faculty Award for Excellence in Community Practice Teaching by the Faculty of Medicine. This award recognizes clinical faculty members throughout BC who have demonstrated excellence in teaching and made an educational impact in a local community.

Union of BC Municipalities Convention – September 2016
Dr. Charles Jago, Northern Health Board Chair attended the UBCM Convention in Victoria. We met with 21 municipalities and Regional Hospital Districts over the course of two days. The main topics discussed included capital development in Northern Health, primary and community care, physician and health professional recruitment, services for seniors and seniors housing.

The Wells Primary Care Clinic
Northern Health is very pleased to share that the Wells Primary Care Clinic official opening occurred on September 20, 2016. An open house took place to welcome members of the community to visit the new clinic and enjoy some refreshments. Northern Health appreciates the partnership and contributions made by the Cariboo Chilcotin Regional Hospital District, Cariboo Regional District Director John Massier and the Barkerville Gold Mines.



Magnetic Resonance Imaging (MRI) services in Terrace and Fort St John

The expansion of access to magnetic resonance imaging (MRI) in northern B.C. will grow significantly over the next year as the Request for Proposals (RFP) process has been completed and the tender has been awarded for three new MRIs as part of the Northern Health 10-year medical imaging strategy.

The expansion of services began with a concept that was built on mobile MRI. However, Northern Health has been able to procure three fixed MRIs through the tender processes and with the financial commitment from the Regional Hospital Districts and the Ministry of Health. Mills Memorial Hospital in Terrace, B.C. and the Fort St. John Hospital and Health Centre in Fort St. John, B.C. will receive new MRIs, and University Hospital of Northern BC will replace their current MRI.

The total capital cost for all three MRIs including installation is $8.3 million. Funding support for the MRIs is being provided by the Province of B.C, three Regional Hospital Districts (Fraser Fort George RHD, Peace River RHD, Northwest RHD), Northern Health and local foundations who choose to join the partnership.

The purchase of three MRI's is the first part of an overall medical imaging strategy to help improve access to medical imaging technology in northern B.C., and some of the equipment continues to be supported through health care and hospital foundations in the region. The 10-year plan will address access to MRI, ultrasound imaging and other modalities, and includes the implementation of the Provincial Breast Health Strategy.

Haida Gwaii Hospital and Health Centre

Their Royal Highnesses The Duke and Duchess of Cambridge visited Haida Gwaii on Friday, September 30th to meet with Northern Health physicians, health care workers, and patients to acknowledge the dedication and services of Canadians who are doing important work in Northern and West Coast communities. During their visit, The Duke and Duchess toured the new hospital and health centre and met with patients, residents and their families.

A plaque unveiling took place to mark the opening of the new facility alongside federal and provincial government representatives, First Nations representatives and other special guests.


THEIR ROYAL HIGHNESSES
THE DUKE AND DUCHESS OF CAMBRIDGE

Human Resources Board Report

Focus on Workplace Health & Safety

October 2016

northern health

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Workplace Health & Safety (WH&S)

Northern Health's Workplace Health & Safety (WH&S) department consists of two distinct groups: Disability Management (DM), and Health, Safety, and Prevention (HSP). DM provides support and guidance to help injured or ill employees recover and return to work activities, as soon as medically possible; HSP supports the organization to prevent workplace incidents and illnesses, and to investigate and correct workplace hazards. WH&S comprises of a diverse team of Advisors, specializing in: Disability Management, Occupational Health Nursing, Violence Prevention, Occupational Hygiene, and regulatory compliance.

WH&S has made good progress in several areas, and continues to focus efforts on supporting a safe and healthy workplace. These include:

- Reducing WorkSafeBC (WSBC) short-term duration;
- Instituting a provincial strategy for reducing long-term disability (LTD) claims;
- Creating strategies for assisting employees struggling at work and early intervention in return to work (RTW);
- Identifying workplace psychological health and safety as a significant factor influencing LTD rates;
- Increasing the focus on workplace violence reduction through a comprehensive strategy that incorporates a systems approach; and,
- Fostering a culture of health & safety within Northern Health.

Long-Term Disability

Long Term Disability insurance is part of the benefit plan for permanent employees that are unable to work for a prolonged period of time due to an illness or injury. The chart below highlights the quarterly LTD claims activity since April 2015 and indicates that NH is experiencing slight growth in LTD claims each year. The reporting period highlights an 18 claim decrease from January 2016 to April 2016. In addition, when compared to other quarters depicted, we see a peak number of 35 claim terminations this last quarter (April-June 2016). As part of our work plan, WH&S Disability Management (DM), in collaboration with Great West Life (GWL) the insurance provider that administers our LTD benefits, plans to continue proactive case management and early identification of rehabilitation intervention and RTW opportunities.

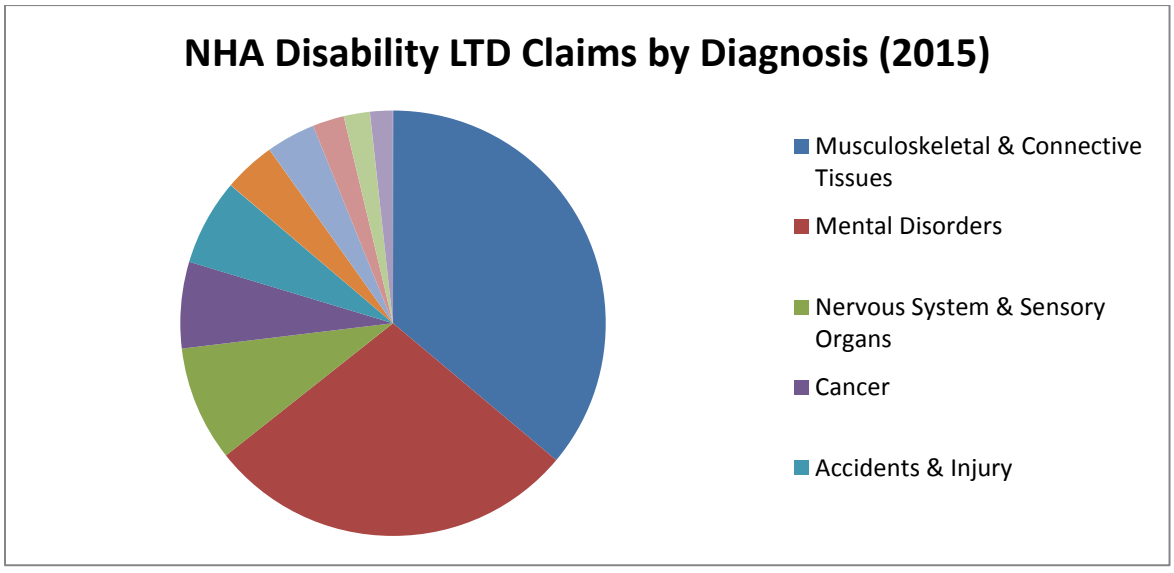
Quarterly Reporting April 2015-present	Apr - Jun 2015	Jul - Sep 2015	Oct - Dec 2015	Jan - Mar 2016	Apr - Jun 2016
Open Claims at Beginning of Period	343	356	354	365	377
New claims	22	17	28	25	15
Reopened claims	7	6	9	8	2
Terminated claims	16	25	26	21	35
Open at End of Period	356	354	365	377	359

Definitions:

- Open Claims at Beginning of Period: LTD claims open the month before the start of the current reporting period
- New Claims: LTD claims opened for the first time within the reporting period
- Reopened Claims: LTD claims reinstated within the reporting period
- Terminated Claims: LTD claims terminated within the reporting period
- Open at reporting period end: LTD claims open at the end of the reporting period

Primary Diagnosis of new claims:

In 2015, Musculoskeletal/Connective Tissue disorders (35%) and Mental Health disorders (27.3%) were the top two primary diagnoses for all new claims. This is fairly consistent with the previous year (2014), in which Musculoskeletal/Connective Tissue claims accounted for 38% of all claims and Mental Health disorders accounted for 25.2%. Mental health disorders have remained prevalent the past few years, which could be due to increased public awareness and acceptance of mental health diseases in general. With the removal of the stigma of mental health illness, it may be that individuals feel more supported and are seeking assistance for their issues inside and outside of the workplace.



Strategy for reducing long-term disability claims:

In partnership with other health authorities, WH&S, Great West Life (GWL), and HBT has participated in the development of an action plan to improve LTD performance and reduce claims. The goal is to continue to promote early, safe RTW and reduce overall LTD claim count.

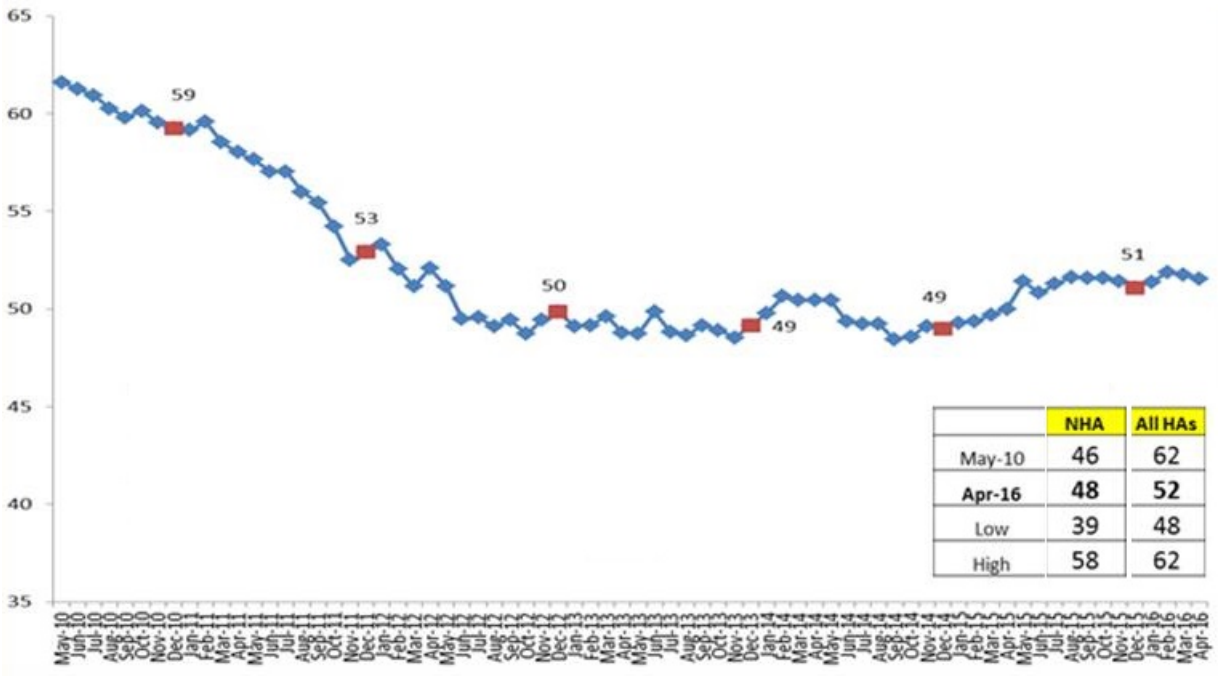
This partnership has implemented three main strategies to improve LTD outcomes by either mitigating LTD claims or reducing claim duration. The strategies focus on improved early referral criteria to GWL's Early Referral Services, greater opportunities to improve RTW outcomes, and enhanced reporting of LTD claims activity. The actions currently being taken to improve LTD processes and outcomes include commitments such as:

- Maximum acceptance by GWL of all Early Referral Services to ensure that all opportunities for early return to work and a reduction in LTD duration timelines are being assessed.
- Timely communication by GWL of claims acceptance, changes and denials to the employer to ensure a timely and more stream lined process.
- GWL review and communication to the employer of all active claims, including those in the prequalification period for functional restrictions and limitations that may support an early return to work.
- GWL's assessment of all claims based on personal, vocational, and workplace barriers in addition to medical barriers to ensure a holistic approach to case management planning and early RTW.
- GWL's ongoing commitment to joint reviews with the employer of all active LTD claims at pre-established intervals to ensure all RTW options have been reviewed consistently and periodically throughout the first two years of a claim.
- WH&S's continued focus on early RTW opportunities with management and Human Resources through temporary transitional/modified work and permanent accommodation opportunities.

Short-Term Disability

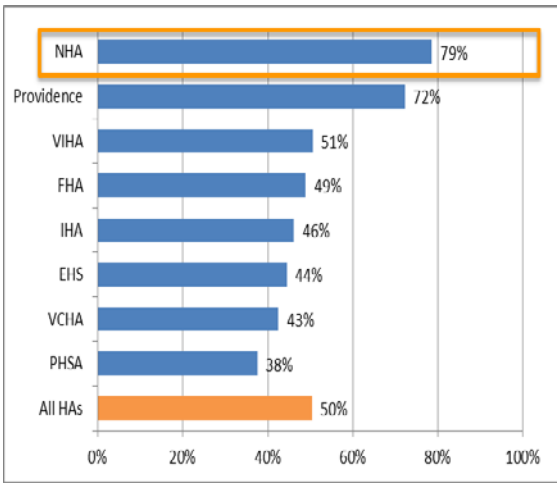
Short-Term Disability (STD) duration is the average number of days an employee is off for a work-related injury/illness. When injured employees are able to return to modified duties as soon as medically approved, WSBC STD duration outcomes and claims costs decrease for the organization.

The average STD duration for all BC health authorities has decreased by 10 days from 62 days in May 2010 to 52 days in April 2016. Between March and May 2016, NH's STD duration remained relatively stable at 48 days.

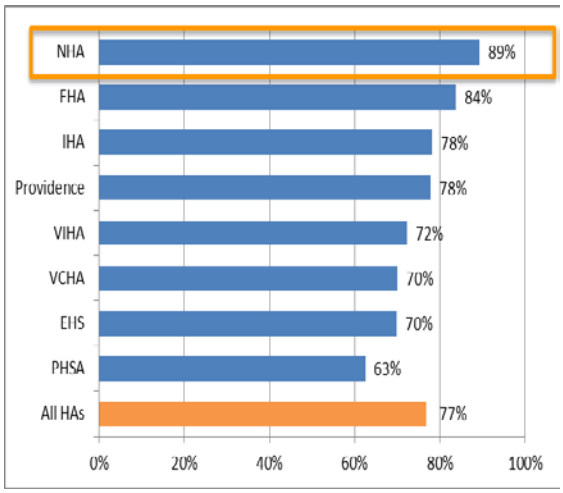


As of May 2016, 79% of NH employees with an accepted WSBC claim were returning to work within four weeks (highest percentage among all health authorities). Of note, when reviewing monthly trends, recent NHA STD durations have decreased by 2% (one day) from 48 days in April to 47 days in June 2016.

RTW at 4 weeks

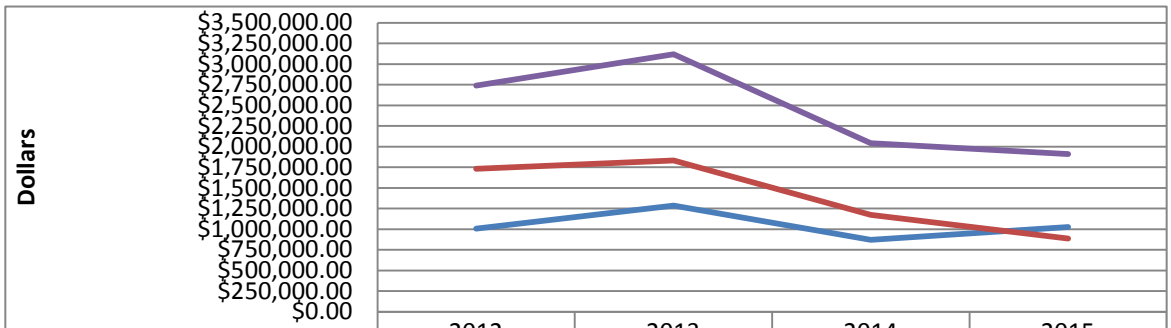


RTW at 12 weeks



The charts above highlight RTW rates by health authority, calculated as a percentage at the four-week and twelve-week claim point. In these measurements, NH is performing higher than other health authorities. These are excellent results for RTW outcomes; however, it is important to note this measurement can change monthly.

WSBC Total Claim Costs Paid – 2012-2015



	2012	2013	2014	2015
Claim Costs Paid (Year of Injury)	$1,005,994.86	$1,287,255	$870,213	$1,025,497
Claim Costs Paid (other Years)	$1,732,606	$1,831,243	$1,172,560	$885,682
Total Claim Costs Paid	$2,738,601	$3,118,498	$2,042,773	$1,911,179

The total yearly cost for all work related WSBC NH Claim costs has been trending downward since 2013.

Focused Early RTW Initiative:

The NH DM team and WSBC completed a review of joint processes, guiding principles, and shared goals for RTW planning immediately following a workplace injury. The outcome:

- The new pilot program, titled "Focused Early RTW", refocused efforts to facilitate and support return/stay at work of injured workers.
- Now, the RTW planning process is initiated jointly between WSBC and the NH Disability Claims Centre (DCC) immediately, regardless of adjudicative status of the WSBC claim (i.e., pending or accepted) through twice weekly conferences and collaborative RTW planning between NH's DM team and WSBC's RTW specialists.
- This pilot commenced in June 2016 and will be reviewed shortly for evaluation.

Focus on Workplace Violence Prevention

Workforce violence prevention is a complex and multifaceted issue – and is a priority for health authorities, WorkSafeBC and Ministry of Health. Over the past few years we have strengthened training curricula, established a provincial call Centre and improved workplace safety data reporting. Prevention of workplace violence will remain a focus as we build on the work already accomplished in order to further protect the safety of workers in BCs health system.

Health Safety in Action

The Health Safety in Action (HSIA) project is aimed at reducing the number and duration of short and long-term disability claims through better prevention and management of occupational and non-occupational injury. The project is led by BC's six health authorities and Providence Health Care in partnership with HEABC, WorkSafeBC (WSBC) and Healthcare Benefit Trust (HBT). The Health Safety in Action (HSIA) Phase 2 initiative involved the Provincial Violence Prevention Program rollout and aims to enhance existing health authority violence prevention programs. The main focus of HSIA Phase 2 is to deliver education

beyond the health authorities' current capabilities, and to develop infrastructure that enables sustainability of violence prevention initiatives at sites. The overarching goal is to develop on-site facilitators and train 100% of the employees working in high-risk units/programs (emergency, mental health/psychiatry, and residential care) between April 2015 and June 30, 2017.

Baseline Provincial Violence Prevention Curriculum (PVPC) :

During the first year of HSIA Phase 2, the goal was to develop infrastructure and site-based facilitators to provide training to staff. The second year of HSIA has continued to develop site-based facilitators and support these facilitators in targeting high-risk locations to develop site-specific plans to increase participation in the PVPC classroom training.

The table below shows the number of site facilitators and WH&S staff who are certified to facilitate independently, and those who are becoming facilitators. The last column shows the waitlist for requests from sites to have one (or more) of their employees trained as a site facilitator, and demonstrates that a healthy demand exists

Area	Certified Trainers	Developing Trainers	Trainer Requests
Northeast HSDA	**0**	**5**	**5**
Northern Interior HSDA	**3**	**8**	**5**
Northwest HSDA	**1**	**9**	**11**
Workplace Health & Safety	**3**	**1**	**1**

PVPC Training in High Risk Areas: The primary focus of training is on the high-risk areas of emergency, mental health/psychiatry, and residential care. The table below shows the progress of training attendance for high risk workers in the three high-risk areas as outlined by WSBC's High-Risk Strategy and the Health Safety In Action Project. This data is current to June 30, 2016.

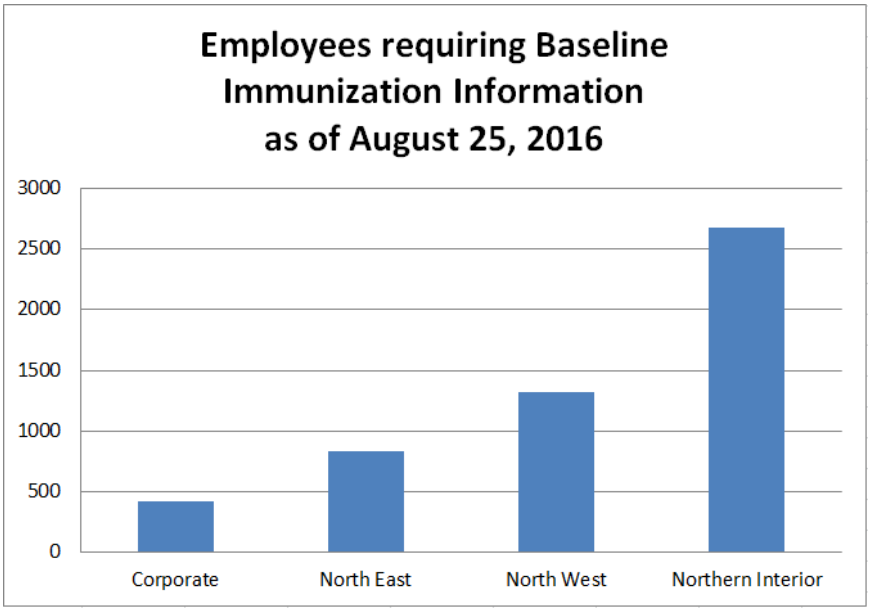
	Total Staff in Area	Received PVPC Classroom Training	% of Staff Received PVPC Classroom Training
Residential	1371	428	31%
Psychiatry/MHAs	390	349	89%
Emergency	223	41	18%
Total	**1984**	**818**	**41%**

Since June 2016, NH has been onboarding to the updated PVPC, including training site-based and WH&S facilitators to provide this education with the updated curriculum. WH&S communications and Violence Prevention Risk Assessment provide ongoing encouragement to sites to ensure high-risk area employees receive the PVPC classroom training, and develop site facilitators to improve violence prevention education sustainability at the site. In October, WH&S will be meeting with the NH Senior Leadership Team to discuss a strategy to ensure 100% of high-risk area employees have received PVPC classroom training by June 30, 2017.

Immunization:

WH&S implemented Immunization Status Reporting on April 1, 2015 with the objective to increase the immunization reporting rates for new employees. Prior to then, the reporting rate for new employees was approximately 43%. The potential consequence of low reporting is significant as – in the event of a communicable disease outbreak such as measles – a large number of staff may be infected and/or excluded from work, putting a strain on staffing resources and negatively impacting patient care. There are also increased costs from WSBC claims and sick leave for unprotected employees who are exposed to vaccine-preventable communicable diseases.

The new program was a success as reporting rates for all new employees hired since January 1, 2016 was 75%, a significant increase over historical reporting rates.



WorkSafeBC

High Risk Strategy:

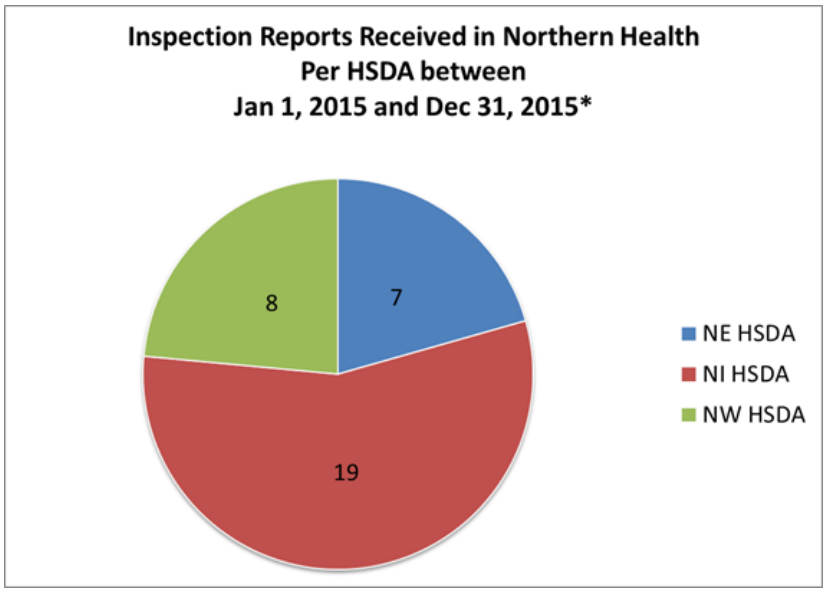
The 2015 WSBC High Risk Strategy identified nine target locations, including four acute care locations, three residential care facilities, and one Mental Health and Addiction Services program. The 2015 High Risk Strategy was primarily focused on violence prevention at the point of care, with an emphasis on supervisor roles and responsibilities. This focus was carried over to the 2016 High Risk Strategy.

WH&S activity continues to align with the WSBC High Risk Strategy (HRS) through the following work:

- Violence prevention risk assessments, and ongoing violence prevention training (including the development of a train the trainer program).
- Resources for specific Occupational Health and Safety training required by supervisors and new employees.
- A new investigation tool developed and launched in May 2016 to support the investigation process.

Inspections:

During the 2015 calendar[1] year, there were 34 WSBC Inspection Reports received at 15 sites, which included all nine of the WSBC High Risk Strategy target locations. Of the 27 Inspection Reports received at the High Risk Strategy locations, 15 contained no orders and 12 contained orders which were all complied with.



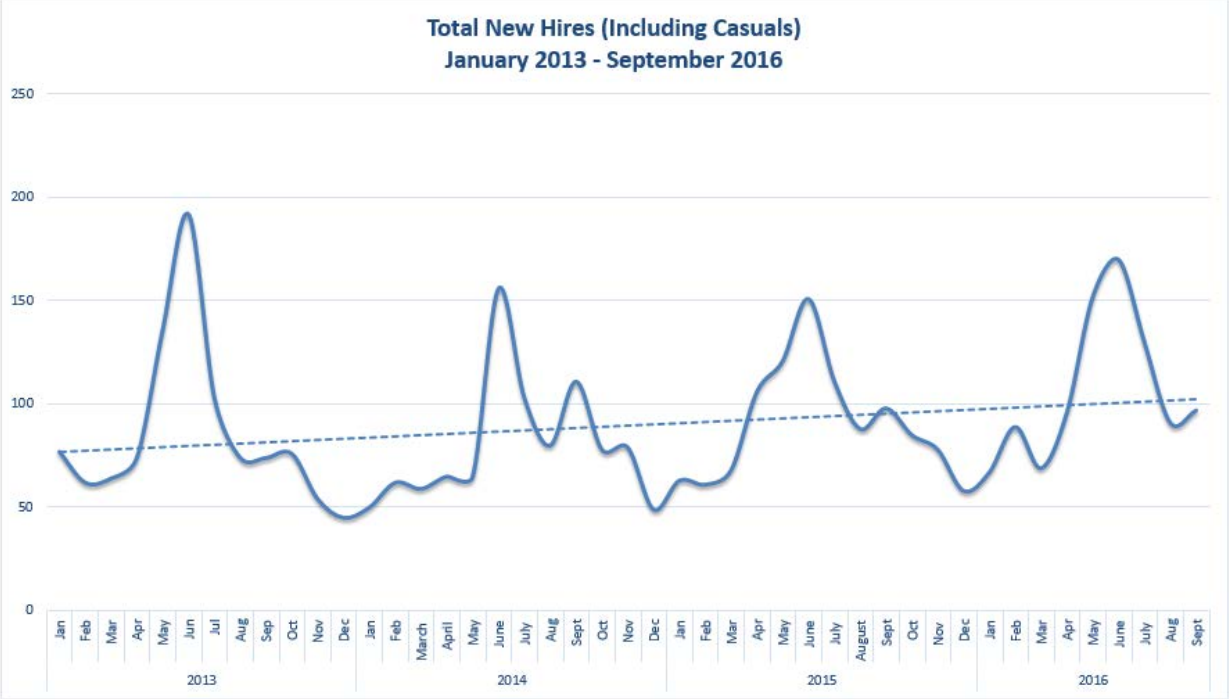
[1] WorkSafeBC IR statistics were pulled for the calendar year, Jan. 1 – Dec. 31, 2015 to correspond with WSBC's High Risk Strategy period.

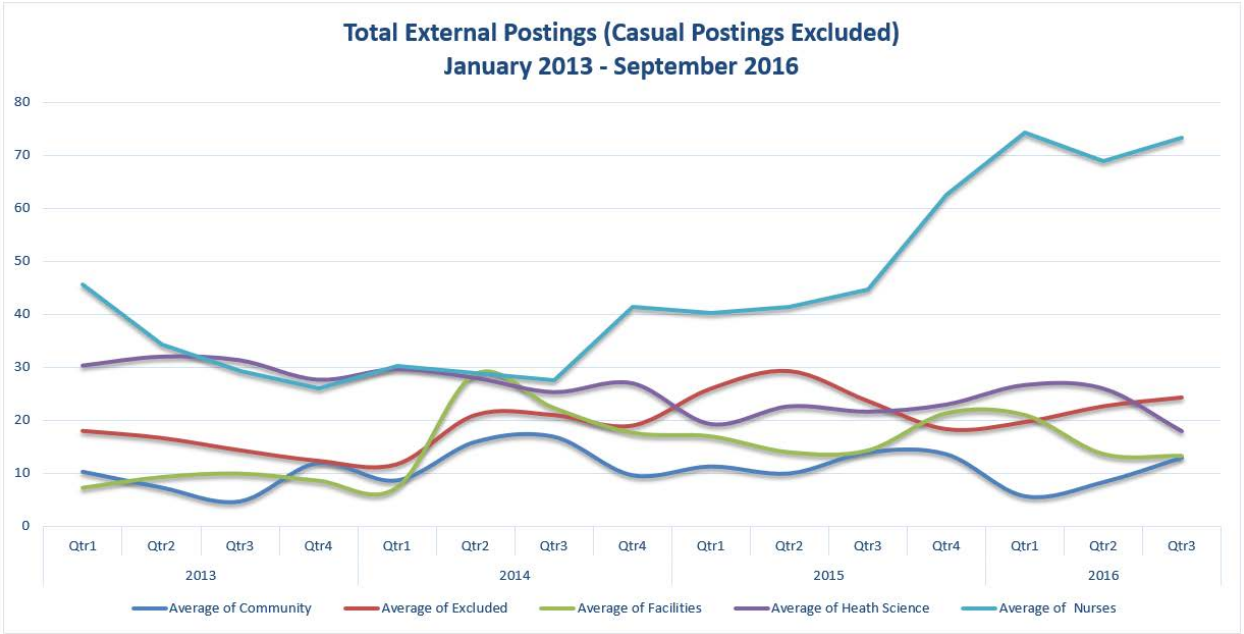
[2] The number of Inspection Reports (left) reflects only the initial inspection reports and does not include follow-up inspections.

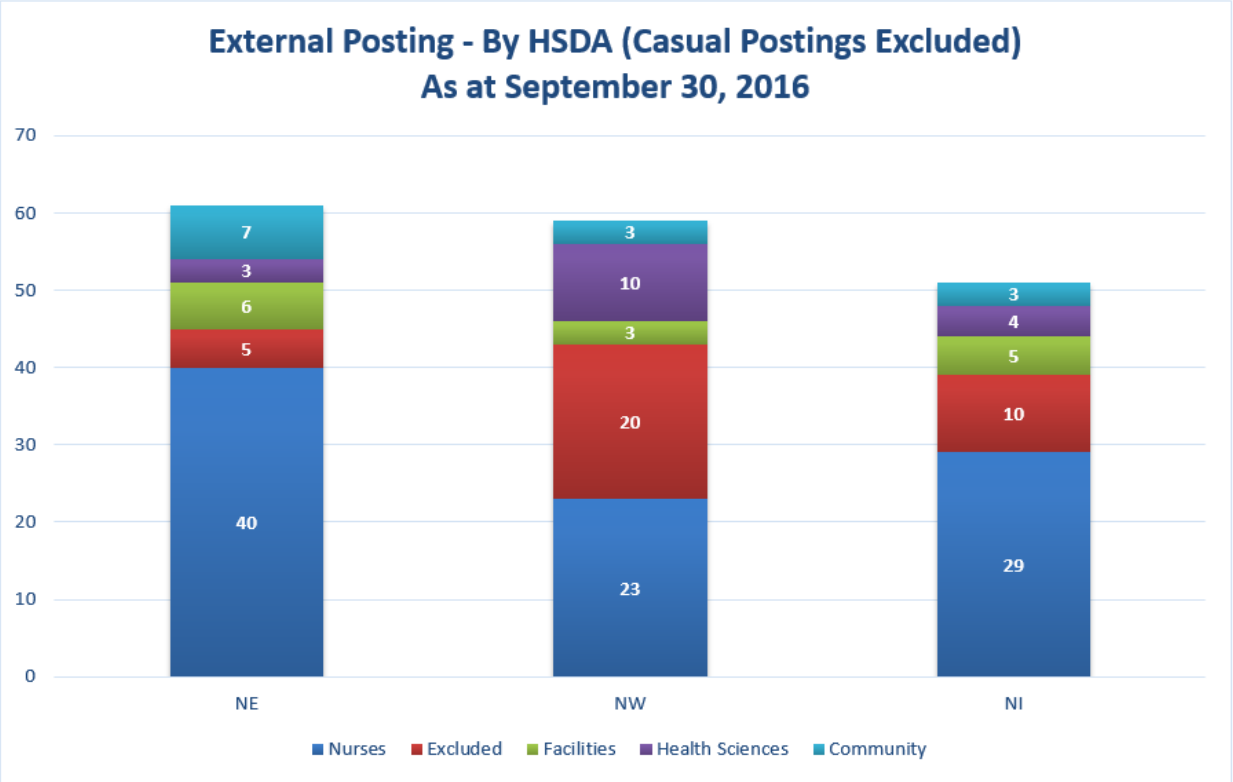
Workplace preconditions of respect and safety, in which the well-being of every person is a priority, creates conditions for workforce excellence. Meaningfully engaged employees deliver high-quality and safe care, are more satisfied, are less likely to experience burnout, and are less likely to leave the organization or the profession. Engaged employees are more likely to go beyond the call of duty and consistently provide *"exceptional health services for Northerners".* A safe and healthy workplace will remain one of the Human Resources' top priorities for the foreseeable future.

Recruitment

Data and Trending







Upcoming Career Events

- UBC Pharmacy Career Fair Avenues (Vancouver) - October 5, 2016
- Northern Lights College – Health Care Aide Cohort Presentation (Fort St. John) - October 20, 2016
- Canadian Association of Perinatal and Women's Health Nurses Conference (Calgary) - October 21 – 23, 2016
- National Association of Dually Diagnosed Conference (Niagara Falls) - November 2 - 4, 2016
- Canadian Nurses Student Association Conference (Edmonton) - November 4 – 6, 2016
- St. Paul's Primary Care Conference (Vancouver) - November 17 - 18, 2016
- Northern Lights College – Health Care Aide Cohort and Licensed Practical Nurses Cohort Presentation (Fort St. John) - November 2016

The Face of Northern Health

As of October 3, 2016

Total FTE for Active Employees — 4,685

	Headcount	FTE
o Short Term Leaves	499	327
o Long Term Leaves (LTD)	366	323

Status

o Full-time	3,449	(46%)
o Part-time	1,855	(25%)
o Casual	2,146	(29%)

Employees by Headcount per HSDA

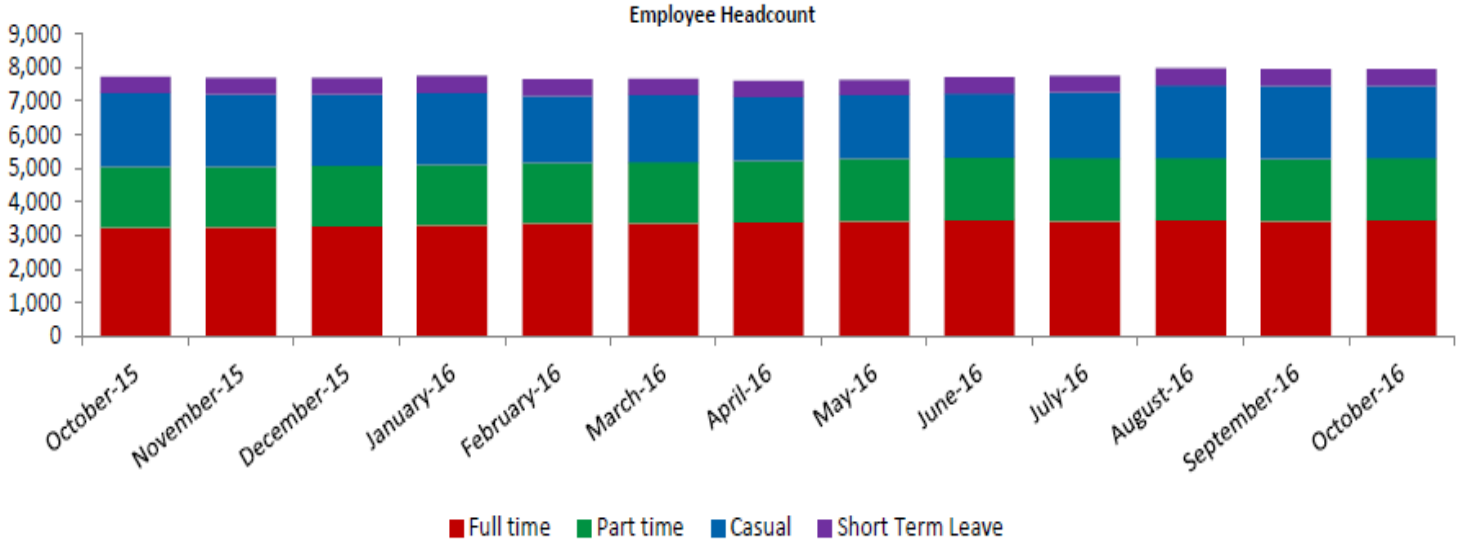
o NE	1,286	(17%)
o NI	3,904	(52%)
o NW	1,905	(26%)
o CORP	355	(5%)

Employees By Headcount — 7,450

o Average Tenure (Yrs) 7.9

Employees by Collective Agreement

o Health Sciences	903	(12%)
o Excluded	547	(7%)
o Nurses	2,492	(34%)
Registered Nurses	1,842	
Registered Psychiatric Nurses	36	
Licensed Practical Nurses	614	
o Facilities	2,891	(39%)
**Clinical	1,251	
**Support	1,640	
o Community	617	(8%)
**Clinical	398	
**Support	219	



*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:	September 14, 2016	
Agenda item:	2016-17 Period 5 – Operating Budget Update	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	Audit & Finance Committee / Board of Directors	
Prepared by:	Mark De Croos, VP Financial & Corporate Services/CFO	

As at August 11, 2016

Year to date Period 5, expenses exceeded revenues by $3,380,000.

Revenues are unfavourable to budget by $2.1 million or 0.7%. Expenses are unfavourable to budget by $5.5 million or 1.9%.

Higher than expected patient volumes, primarily at the University Hospital of Northern BC and related third-party billings, are contributing to the favourable variance in revenues.

The same higher than expected patient volumes is contributing to the unfavourable variance in expenses as additional unbudgeted staffing and supply resources are being used to care for the higher volumes.

Forecast Yearend 2016-17

At this time, Northern Health is forecasting to be in a balanced position on base operations at yearend.

Recommendation:

The following motion is recommended:

> The Northern Health Board accepts the 2016-17 period 5 year to date financial update as presented.

NORTHERN HEALTH
Statement of Operations
Year to date ending August 11 (Period 5)
$ thousand

	Annual Budget	YTD August 11, 2016 (Period 5) Budget	Actual	Variance	%
REVENUE					
Ministry of Health Contributions	590,374	212,041	211,603	(438)	-0.2%
Other revenues	219,669	78,411	80,994	2,583	3.3%
TOTAL REVENUES	**810,043**	**290,452**	**292,597**	**2,145**	**0.7%**
EXPENSES (BY PROGRAM)					
Acute Care	446,886	161,197	168,041	(6,844)	-4.2%
Residential Care	103,299	37,795	38,644	(849)	-2.2%
Community Care	121,086	42,514	35,265	7,249	17.1%
Mental Health & Substance Use	44,344	15,136	17,839	(2,703)	-17.9%
Population Health & Wellness	28,605	10,362	12,363	(2,001)	-19.3%
Corporate	65,823	23,448	23,825	(377)	-1.6%
TOTAL EXPENSES	**810,043**	**290,452**	**295,977**	**(5,525)**	**-1.9%**
DEFICIENCY OF REVENUES OVER EXPENSES	**-**	**-**	**(3,380)**		

BOARD BRIEFING NOTE

Date:	September 22, 2016	
Agenda item	Reappointment of External Auditor: 2016-17 Fiscal Year	
Purpose:	☐ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	Board of Directors	
Prepared by:	Beverly Little, Director, Finance & Controller	
Approved by:	Mark De Croos, Vice President Financial & Corporate Services/Chief Financial Officer	

Issue:

Board approval is required for the reappointment of KPMG LLP as Northern Health's external auditor for the fiscal year ending March 31, 2017.

Background:

In October 2012 the Board approved a five-year service contract with KPMG LLP for the provision of external audit services (representing fiscal years 2012/13 - 2016/17 inclusive). Board approval is required each year to reappoint the external auditor for the next fiscal year-end audit.

Recommendation:

The Northern Health Board approves the reappointment of KPMG LLP as external auditor to Northern Health for the fiscal year ending March 31, 2017, representing Year Five of a five-year term of engagement.

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BOARD BRIEFING NOTE

Date:	August 30, 2016	
Agenda item:	Capital Update (Period 5)	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	Audit & Finance Committee / Board of Directors	
Prepared by:	Deb Taylor, Regional Manager Capital Accounting	
Reviewed by:	Mark De Croos, VP Finance & Chief Financial Officer	

The Northern Health Board approved the 2016-17 capital expenditure plan in February 2016, and amended in July 2016. The updated plan approves total expenditures of $54.8M, with funding support from the Ministry of Health ($20.0M, 37%), Six Regional Hospital Districts ($15.6M, 29%), Foundations and Auxiliaries ($4.4M, 8%), Northern Health ($7.6M, 14%), and funding received in prior years ($7.2M, 13%).

Year to date Period 5 (August 11, 2016), $7.6M has been spent towards the execution of the plan as summarized below.

$ million	**YTD**	**Plan**
Major Capital Projects (> $5.0M)	1.1	11.5
Major Capital Projects (< $5.0M)	0.5	6.8
Major Capital Equipment (> $100,000)	1.8	17.8
Equipment & Projects (< $100,000)	3.1	12.9
Information Technology	1.0	5.7
	7.6	54.8

Significant capital projects currently underway or completed in 2016-17 are as follows:

Northern Interior Service Delivery Area (NI-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Mackenzie	Integrated Care Space Development	$0.70	Planning	FFGRHD, NH
Prince George	UHNBC – Boiler Plant Upgrades	$0.63	In Progress	MOH, FFGRHD, Energy Grants
Prince George	UHNBC – Optical Tomography	$0.25	Ordered	Spirit of the North
Prince George	UHNBC – Drug Packaging Machinery	$0.27	Ordered	MOH, FFGRHD
Prince George	UHNBC Magnetic Resonance Imaging	$2.86	Ordered	MOH, FFGRHD
Prince George	UHNBC – Analyzer, Immunohistochemistry	$0.13	Approved	Spirit of the North
Prince George	UHNBC – Analyzer, Chemistry	$0.21	Approved	MOH, FFGRHD
Prince George	UHNBC – Laser System, Holium	$0.24	Approved	Spirit of the North
Prince George	UHNBC – Mass Spectrometer	$0.30	Ordered	Spirit of the North
Prince George	UHNBC – Waste Handling System	$0.99	Ordered	MOH, FFGRHD, NH
Prince George	UHNBC – Patient Monitoring Systems	$0.83	Ordered	FFGRHD, NH
Prince George	UHNBC – Patient Monitoring Systems	$1.44	Approved	FFGRHD, NH
Prince George	UHNBC – Ultrasound, General and Echo	$0.11	Ordered	MOH, FFGRHD
Quesnel	Dunrovin – Elevator Replacement	$0.33	In Progress	MOH, CCRHD
Quesnel	GRB – Digital Mammography	$0.98	Ordered	MOH
Quesnel	GRB – Emergency Generator Replacement	$1.21	In Progress	CCRHD, NH
Quesnel	GRB – QUESST renovation	$0.75	In Progress	CCRHD, NH
Quesnel	GRB – Patient Monitoring Systems	$0.41	Ordered	NH, CCRHD
Quesnel	GRB – Ventilation System & Boiler Plant Upgrade	$0.37	In Progress	MOH, RHD, Energy Grants
Vanderhoof	SJH – C-Arm	$0.13	Approved	MOH, SNRHD
Vanderhoof	SJH – Patient Monitoring Systems	$0.33	Approved	SNRHD, NH

Northeast Health Service Delivery Area (NE-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Dawson Creek	Digital Mammography	$0.90	Ordered	MOH
Dawson Creek	Fluorography Room Renovation	$0.24	Approved	MOH, PRRHD
Fort Nelson	Automated Medication Dispensing Cabinet	$0.14	Approved	MOH, NRRHD
Fort St. John	Magnetic Resonance Imaging Machine	$2.60	Ordered	MOH, PRRHD

Northwest Health Service Delivery Area (NW-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Terrace	MMH – Magnetic Resonance Imaging Machine	$2.84	Ordered	MOH, NWRHD
Terrace	MMH Digital Mammography	$1.16	Ordered	MOH
Terrace	MMH Patient Monitoring Systems	$0.37	Approved	NWRHD, NH
Terrace	MMH Phone System	$0.35	Approved	MOH, NWRHD
Terrace	MMH SPECT Scanner	$1.20	Approved	MOH, NWRHD
Smithers	BVDH Maternity Modernization Project	$0.21	In Progress	MOH, Bulkley Valley Healthcare & Hospital Foundation
Hazelton	Wrinch Automated Medication Dispensing Cabinet	$0.11	Ordered	NWRHD, NH
Houston	Air Handling Unit	$0.31	In Progress	MOH, NWRHD
Stewart	X-Ray Room	$0.25	Approved	MOH, NWRHD
Queen Charlotte	Hospital replacement	$50.00	In Progress	MOH, NWRHD
Northern Haida Gwaii	Automated Medication Dispensing Cabinet	$0.14	Ordered	MOH, NWRHD

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	$0.52	In Progress	NH

In addition to the 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 2016-17, it is forecasted that NH will spend $10.4M on such items.

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

Recommendation:

The Northern Health Board approves Northern Health's Period 5 capital update, as presented.

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BOARD BRIEFING NOTE

Date:	October 17, 2016	
Agenda item	Innovation and Development Commons	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	Northern Health Board of Directors	
Prepared by:	Tammy Hoefer, Regional Manager IDC Tanis Hampe, Regional Director Quality and Innovation	
Reviewed by:	Fraser Bell, VP Planning, Quality and Information Management	

Issue:

This briefing note is intended to update the Board on key activities within the Innovation and Development Commons (IDC) in three sections: quality education, quality improvement resources, and innovation.

Quality Education

Background

Northern Health's in-house quality training program began in late 2011 with the development of an Introductory-level quality improvement (QI) workshop. These interactive workshops bring together staff from across departments and communities to talk about quality and to develop a foundational understanding of quality improvement, systems thinking, teamwork, and measurement.

From 2012 through 2014 Introductory workshops were offered frequently in communities across the region with the goal to increase the number of staff with exposure to QI, a common language and understanding of QI, and to inspire and

increase their confidence in undertaking QI. Alongside these Introductory workshops, staff were encouraged to complete the provincial Introduction to Lean (White Belt) online workshop and the Lean-in-Practice (Yellow Belt) simulation workshop.

Demand for a 'next level' of QI training grew and in 2013-14 the first cohort of Intermediate QI students was accepted. The Intermediate Program involves learning sessions, webinars and completion of a QI project in NH with mentorship over eight months. Students produce a 'storyboard' (a poster presentation of their project) that is housed on the IDC site. Students are encouraged to present at the annual NH Quality Conference.

In 2015, with the addition of leadership for physician engagement in QI under the VP Medicine portfolio, the Introduction to QI workshop was adapted for a physician and clinical team audience (called "Principles of QI"). This workshop will be the basis for the Interprofessional Team Development Training QI Module starting this year.

Overall, QI education in NH has evolved in the past four years from introductory training for a large number of staff to:

- more intensive intermediate level training (with mentorship) for staff and teams,
- training tailored to the needs of teams/departments/etc. by request, (i.e., "customized"), and
- training for physicians and interprofessional teams.

Other Quality Education for NH staff and physicians

Since 2007, QI training at the office practice level (Quality by Design: A Clinical Microsystems Approach) has been provided to Practice Support Coaches in BC through the General Practice Services Committee. In 2013 Northern Health's Primary Care Department assumed responsibility for training all new Practice Support Coaches in this program.

External QI training is also encouraged, such as participation in the BC Patient Safety & Quality Council's Quality Academy and Clinician Quality Academy, advanced Lean training through the Leading Edge Group, and courses through the Institute for Healthcare Improvement's Open School.

The table below summarizes quality education opportunities in NH and the number of staff and physicians trained.

Quality Education in Northern Health		
Quality Improvement Training	**Description**	**# Trained to September 7, 2016**
Introduction to QI	1 day workshop on foundations of QI with a 'commitment statement' and individual follow up by the facilitator after 3 months	1596 (since 2012)
Principles of QI (Physician audience, CME accredited)	3.5 hour workshop Introduction to QI workshop tailored for Physician audience	71 (since 2015)
Introduction to Lean (White Belt)	Online course (3 modules ~90 min) Standard provincial course	889 (since 2012)
Lean in Practice (Yellow Belt)	1 day workshop Simulation of an Emergency Room environment with improvement cycles	364 (since 2013)
Intermediate QI	8+ months, combination of learning sessions, webinars and completion of QI project with mentorship. Pre-requisites: Introduction to QI and Introduction to Lean (White Belt) Option to write exam and report for Lean Green Belt certification with Leading Edge	77 complete (cohorts 1, 2 & 3) 22 in progress (cohort 3) 14 withdrawn (cohorts 1, 2 & 3) 56 accepted for cohort 4 (September 2016 – April 2017)
Green Belt certification (Leading Edge)	Online course (completed within 12 months) with exam and project report	136 complete (since 2009) 15 in progress 25 withdrawn
Black Belt certification (Leading Edge)	Online course (multi-year) with advanced project	10 complete (5 of these trained staff are still working with NH) 11 in progress
Quality Academy (BC Patient Safety & Quality Council)	6 month provincial course with residencies and a QI project	26 complete (since 2011) (20 of these trained staff are still working with NH)

QI Training at the Office Practice Level (Dartmouth Institute-Quality by Design: A Clinical Microsystems Approach)	For Practice Support Coaches (QI support for Primary Care) 6 months, combination of learning sessions, assignments, and the culmination in a QI project	All 24 Practice Support Coaches are trained (Practice Support Coaches take the training in the first six months of their role)
Interprofessional Team Development Training – QI module	Anticipated to be Principles of QI workshop with facilitation of a small QI project with the team	Under development
Customized QI training	Tailored to the audience, by request. May be offered as/through: - Department/team meetings - Conferences/events (e.g., front line leaders day, administrative professionals conference) - Modified workshops (e.g., Intro to QI/Yellow Belt combination) - Specific QI tools (e.g., driver diagram, 5S sessions)	Not yet tracked
Canadian Patient Safety Officer Course (Canadian Patient Safety Institute)	Online course, 100 hours of study, up to 12 months to complete Annual application process in NH for one staff member in each HSDA to be trained. Funded through NH's Patient Safety Plan for Accreditation Canada. Accompanied by a NH Community of Practice.	First cohort will start in fall 2016

Northern Health Quality Conference (April 27 & 28, 2016)

- Theme: Person and Family Centred Care
- 145 attendees
- 51 storyboards presented
- 25 quality initiatives showcased in concurrent sessions
- 6 workshops offered

Learning Pathways

Northern Health is undertaking the development of learning pathways. An important component of pathway development in the 2016/17 Detailed Operational Plan is to "ensure quality improvement competencies are embedded in development throughout employee lifecycle." This is being achieved through the incorporation of Accreditation Canada Required Organizational Practices into competencies in the pathways and a commitment that the Managers leading the pathway development will all achieve quality improvement certification, to bring this lens and focus to pathway development. In addition, a "Management 101" educational program is under development that incorporates quality improvement competencies.

Quality Improvement Resources

Background

Northern Health has intentionally invested in the development of quality infrastructure over the past decade with the incorporation of the Planning, Quality and Information Management (PQIM) portfolio, Clinical Quality Programs, Quality Improvement in Medical Services and Quality Improvement supports in Primary Care and Integrated Health Care.

PQIM employs expertise in data analytics, process modelling, quality improvement, evaluation, research, education, and project management that actively support quality improvements across the region. To standardize the process for quality improvement priorities within NH and understand how to optimize the deployment of these supports to achieve the quality improvement priorities, PQIM led the development of a Process Model for Quality Improvement Priorities.

Quality Priority Process Improvement Model: How are regional quality initiatives identified, prioritized, developed, implemented, evaluated, and sustained in Northern Health?

Process Model Development

Since the Clinical Quality Programs were established in NH, we have learned about the facilitators and challenges to moving a clinical practice standard into day-to-day practice across the region. Clinical Quality Program Leads and Operational Leads shared their experiences in developing and executing on Board Goals. The result was a future state process model for regional quality initiatives.

Between April and August 2016, the process model was utilized in focused Executive team discussions on quality and in sessions with Clinical Quality Program leadership, operational leadership and other stakeholders. The model has been continuously refined to incorporate stakeholder feedback.

This model provides a vision for NH's quality improvement process. It will inform decision-making around resource deployment to successfully achieve and sustain quality improvement at point-of-care.

Next steps

- Continue to engage with staff and physicians around the process model
- Incorporate local quality improvement processes and the adverse event management (i.e., quality review/Section 51 review) process into the model
- Develop and implement a work plan that moves NH to achievement of this process model: to ensure alignment of improvement priority planning with the NH planning cycle and to successfully develop and align organizational quality structures and supports.

Culture and Physician Engagement in Quality Improvement

Two additional critical success factors to achieve the strategic initiative of *establish a culture of quality & safety* are:

- Enhance physician leadership and engagement in quality improvement, and
- Identify critical elements of quality/safety culture and align measures and improvement mechanisms.

Physician engagement:

Physician engagement and leadership are essential elements of high performing health care systems[1]. In 2015, an Executive Lead, Physician Quality was hired to build and strengthen physician leadership and engagement in quality improvement. A broad consultation process was undertaken to help identify how to best support our physicians and teams in quality improvement. This consultation process has directed activities to date and this will continue to be an area of intentional investment and collaboration for NH in 2016-17.

[1] Denis, J.L., Baker, G.R., Black, C., Langley, A., Lawless, B., Leblanc, D., Lusiani, M., Moore Hepburn, C., Pomey, M.P., & Tré, G. (2013). *Exploring the dynamics of physician engagement and leadership for health system improvement: Prospects for Canadian healthcare systems.* http://www.cfhi-fcass.ca/sf-docs/default-source/reports/Exploring-Dynamics-Physician-Engagement-Denis-E.pdf?sfvrsn=0

Culture:
An analysis of the over 4000 staff comments collected through the NH strategic plan consultation process is underway to extract staff perspectives of, and ideas for, NH's culture. The results will be integrated with the findings from a literature review on organizational culture and the measurement of culture.

Innovation

NH/UNBC Memorandum of Understanding

Core members of the NH/UNBC Steering Committee have been meeting to discuss the renewal of the partnership MOU. Since the signing of the original MOU in June 2010, the partnership has grown and evolved and there is a need to reflect this formally in an updated MOU. The committee is in the process of identifying its partnered strategic business objectives and critical success factors. As well, it has identified six areas of focus for developing and integrating knowledge into practice:

1. Seniors health and wellbeing inclusive of frailty, home care, housing, dementia care
2. Mental health/mental wellness
3. Chronic disease prevention and management
4. Rural health services
5. Healthy child development
6. Industry and the resource economy and the impact on health of northern peoples

As Martha MacLeod has stepped down from her role as Chair, UNBC School of Nursing and will be on sabbatical for the next year, Geoff Payne, UNBC Interim Vice President Research, will be co-chairing the NH/UNBC Steering Committee with Fraser Bell.

BC Academic Health Sciences Network (AHSN) and Strategy for Patient Oriented Research (SPOR)

NH and UNBC have entered into an agreement with the BC Academic Health Science Network (AHSN) to establish a Strategy for Patient-Oriented Research (SPOR) Northern Regional Centre. The NH/UNBC partnership is well positioned to create a Northern Regional Centre of excellence that facilitates partnerships and knowledge mobilization while complementing and leveraging its existing infrastructure and resources. These initiatives provide us with the opportunity to increase capacity to:

- Conduct patient oriented research in ways that enhance and support the NH person & family centred care strategy
- Leverage resources to extend research and knowledge mobilization capacity
- Improve data access & infrastructure
- Build capacity for participation in clinical trials

- Create opportunities for researchers and knowledge users to collaborate in the creation of knowledge and its mobilization
- Answer questions of relevance to rural and remote policy and practice
- Enable the synthesis of knowledge relevant to rural and remote policy and practice
- Strengthen the implementation of evidence into policy and practice
- Develop rural and remote implementation science

For the purpose of the agreement, the IDC Regional Manager has been identified as the Lead with operational accountability for the Northern Regional Centre. However, the centre will be a partnership with UNBC and resources will be spread where they will have the biggest impact.

PHSA/UNBC/NH Health Research Grant

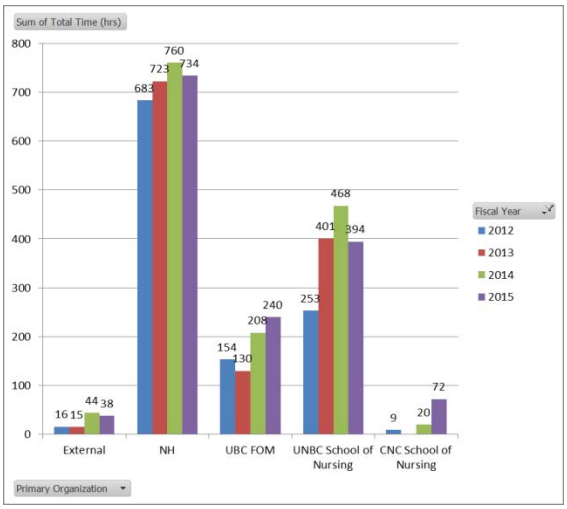
In April 2015, the Provincial Health Services Authority (PHSA), Northern Health (NH) and University of Northern BC (UNBC) released its first call for a new Seed Grant Program. The goal of this program is to enable researchers and knowledge users at PHSA, NH and UNBC to work in partnership and initiate new research projects that focus on improving the quality of health services and improving population health in northern BC. The total amount for this funding opportunity was $100,000, enough to fund a maximum of ten grants. The maximum amount per grant, which will cover a six month period, is $10,000. Since May 2015 there have been three seed grant proposal intakes with a total of nine teams funded out of 17 applications. Areas of research include:

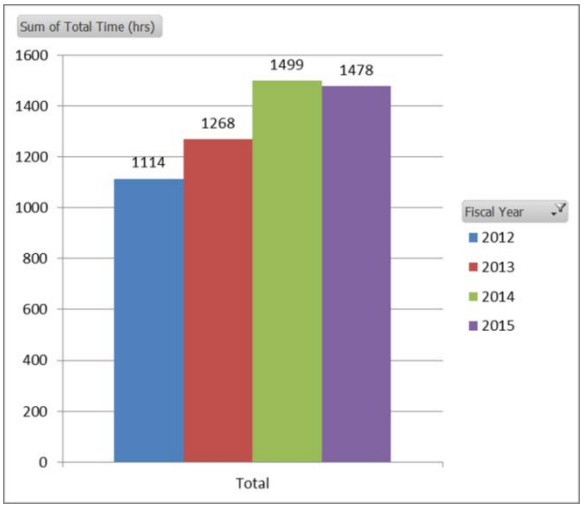
- Health services and policy research
    - Oncology and primary care
    - Chronic disease management
    - Mental health and addictions
    - Preventative population and public health
- Social and environmental determinants of health
    - Indicators of population health outcomes
    - Health literacy
    - Health impacts related to resource development
- Aboriginal Health
    - Culturally sensitive chronic disease management and screening
- Clinical/Biomedical
    - Long term pain drug interventions
    - Cognitive assessment

A fourth intake is underway with a submission deadline of October 10th, 2016. Northern Health, UNBC, and PHSA have agreed to continue the seed grant program for 2016/17.

Clinical Simulation

In 2015/16 there was a combined total of 1478 hrs. of simulation performed across the four Northern Health sites, a slight decrease (1.4%) from 2014/15. Contributing factors for the decrease was the turnover of clinical educators in Terrace and Prince George and the purchase of two high fidelity simulators by the UNBC School of Nursing. While NH and UNBC School of Nursing usage were down in 2015/16, there was an increase for in simulation hours for the UBC Faculty of Medicine and CNC School of Nursing.





<u>Recommendation(s):</u>

The Northern Health Board accepts this briefing note for information.

BOARD COMMITTEES V.1 BRD 300

PURPOSE

1. Board committees are a mechanism that permits deeper examination of major areas for which the Board of Directors of Northern Health (the "Board") has governance responsibilities, both continuing and emergent, and supports the Board in handling its responsibilities.
2. Only Directors may serve as voting members on Board committees.
3. Board committees and their respective mandates are established by the Board, and the Board may vary the committee structure from time to time to meet its governance needs. The current Board committees are:
    - Audit and Finance Committee
    - Governance and Management Relations Committee
    - Performance, Planning and Priorities Committee
4. From time to time the Board may assign exceptional tasks to a committee not captured by the committee's terms of reference.
5. The Board may delegate, by Board motion, specific areas of business to a committee to act on behalf of the Board between Board meetings and the committee must report thereon at the Board meeting immediately following.
6. Board committees are not established to assume functions or responsibilities that properly rest with management.

GENERAL GUIDELINES FOR COMMITTEES

1. Each committee reviews its mandate and terms of reference annually. These are submitted to the Governance and Management Relations Committee (GMR) for review in terms of alignment to policy standards, and then submitted by GMR to the Board for approval.

2. Each year the Board Chair is responsible for proposing to the Board the leadership and membership of each committee to be appointed. This will occur in accordance with the Board and Committee work plans or as needed to fill vacancies during the year.

3. In preparing recommendations for committee membership and leadership, the Board Chair will consult with the President and Chief Executive Officer (the "CEO") and take into account the preferences, skills and experience of each Director. Periodic rotation in committee membership and leadership is to be considered in a

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way that recognizes and balances the need for new ideas, continuity, and maintenance of functional expertise.

4. The Board Chair will be an ex-officio and voting member of all committees on which the Board Chair is not a formal member.

5. The CEO shall be an ex-officio and non-voting member of all committees.

6. A committee member may be removed or replaced at any time by the Board and will cease to be a member upon ceasing to be a Director of the Board.

7. The number of members and composition of each committee is indicated in each committee's terms of reference.

8. Each committee will normally meet before each Board meeting or more frequently as deemed necessary by the committee. Generally, meetings will be scheduled each year in advance.

9. Business conducted by committees of the Board will not be open to the public (BRD220).

10. Each committee shall have a committee timetable and work plan that outlines when the committee will address each of its duties and responsibilities during the course of the year. The timetable and work plan shall be referenced in the committee's terms of reference, but does not form part of the terms of reference. Changes to the terms of reference require Board approval; changes to the timetable and work plan are the domain of the committee, can be made at any time, and must be recorded in the minutes of the committee. If, in the view of the committee, a work plan change is substantive, the terms of reference and work plan should be referred back to the Board for approval.

11. Notice of the time and place of every committee meeting shall be given in writing or by facsimile or email communication to each regular and ex officio member of the committee at least 48 hours prior to the time fixed for such meeting provided, however, that a member may in any manner waive notice of a meeting; and attendance at a meeting is a waiver of notice of the meeting, except where a member attends a meeting for the express purpose of objecting to the transaction of any business on the grounds that the meeting was not lawfully called.

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12. The Chair of a committee or any two members of a committee may call a meeting of the committee.

13. If a committee Chair is unable to attend or is not present at any meeting of a committee within thirty minutes after the time that the meeting is scheduled to commence, one of the other members of the committee present at the meeting shall be chosen by the committee to preside at the meeting.

14. A committee member may participate in a committee meeting by means of such telephonic, electronic or other communication facilities that permit all persons participating in the meeting to communicate adequately with each other. A member participating in such a meeting by any such means is deemed to be present at the meeting.

15. A quorum for the transaction of business at a committee meeting will be a majority of the voting members, which includes the Board Chair if in attendance as an ex officio member as per #4 above. Questions arising at a meeting will be determined by a majority of votes of the members present. Note: 50% is the majority for a quorum; more than 50% is a majority for the purpose of voting.

16. The committee shall designate a Recording Secretary who will ensure that the minutes of each committee meeting are prepared and given in a timely fashion to each committee member and to the Corporate Secretary. A complete meeting record will be maintained electronically by the Recording Secretary and the Corporate Secretary and shall be made available to Directors and the CEO.

17. A committee may invite such Director or, in consultation with the CEO, such Northern Health employees or consultants as may be considered desirable to attend meetings and assist in the discussion and consideration of the business of the committee.

18. A committee may, from time to time, require the expertise of outside resources. No outside resource will be retained without the approval of the Board or Board Chair, generally in consultation with the CEO.

19. Committees will provide written reports to the Board through minutes as outlined in #16 above, and will report to the Board at each Board meeting with respect to specific recommendations or advice consistent with its mandate or other responsibilities as assigned by the Board. The Board will take whatever action it deems appropriate.

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TERMS OF REFERENCE FOR THE AUDIT AND FINANCE COMMITTEE (PROPOSED REVISIONS PRESENTED MAY 26, 2016) BRD 310

Purpose

The primary function of the Audit and Finance Committee (the "Committee") is to advise the Board of Directors of Northern Health (the "Board) in fulfilling its oversight responsibilities by reviewing financial planning and performance related to the operating and capital budgets, including:

a. The provision of financial information to the Government and other stakeholders
b. The systems of internal controls
c. Compliance with legal and regulatory requirements related to financial planning and performance
d. All audit processes conducted through the office of the Internal Auditor
e. All other external financial audits
f. Financial risk management
g. Oversight of investment management activities

This Committee is not intended to act on behalf of the Board unless specific delegated authorities have been given to it.

Composition and Operations

The Committee shall be composed of not fewer than three directors and not more than five directors. (see Membership section for complete Committee membership details).

The Committee shall operate in a manner that is consistent with the General Guidelines for Committees (BRD 300).

All Committee members shall be both independent and "financially literate" and at least one member shall have "accounting or related financial expertise"[1].

[1] The Board has defined "financial literacy" as the ability to read and understand standard financial reporting. Where there is a requirement for a Director to have "accounting or financial expertise", this

Northern Health's external auditors and the BC Office of the Auditor General (OAG) shall be advised of the names of the Committee members. The Committee shall meet with the external auditor and the OAG as it deems appropriate to consider any matter that the Committee, auditors or the OAG determine should be brought to the attention of the Board.

Duties and Responsibilities

Subject to the powers and duties of the Board, the Committee will perform the following duties:

A. Financial Performance

The Committee shall:

1. Review and recommend for approval to the Board, financial information that will be forwarded to the Government or made publicly available, including:
   a. The financial content of Northern Health's annual report and other significant reports required by government or regulatory authorities (to the extent such reports discuss the financial position or operating results) for consistency of disclosure with the financial statements themselves
2. Review and approve Northern Health's annual "Statement of Financial Information (SOFI)" (also referred to as "Public Bodies Report)[2]
3. Review normal periodic financial information provided to the Board, including:
   a. Periodic financial statements
   b. Capital budget reports that provide information on both a project and expenditure basis
   c. Annual audited financial statements
4. Request and review various other financial and operational information as needed to ~~fulfill~~fulfil the Committee's oversight responsibilities.

means the Director shall have the ability to analyze and understand a full set of financial statements, including the notes attached thereto in accordance with Canadian GAAP.

[2] In accordance with BRD 300 as a delegated authority from the Board (Oct 19, 2010: Motion Public/10-18)

5. Ensure that:
   a. The Board receives timely, meaningful reports that keep it properly informed of Northern Health's financial situation and that provide the information needed for decision-making
   b. All reports to the Board clearly display the financial results of each principal area of activity and include cash flow for the period and year-to-date
   c. The Board receives, at each meeting, an up-to-date forecast of year-end results, which reflects events to date and known factors which may materially influence either revenue or expense components
6. Review and discuss:
   a. The appropriateness of accounting policies and financial reporting practices used by Northern Health
   b. Any significant proposed changes in financial reporting and accounting policies and practices to be adopted by Northern Health
   c. Any new or pending developments in accounting and reporting standards that may affect Northern Health

B. <u>Budget Development</u>

The Committee will, with the assistance of the Chief Financial Officer, make an examination of the budget development process, including:

1. The methodology used to establish the operating budget such as revenue estimates, base assumptions for expense projections, financial risk factors, inflation allowances
2. Planned capital expenditure by category and the projections for expenditures justified by a priority scoring method endorsed by the Committee, including rate of return
3. Alignment/correlation of planned operating and capital budget decisions to the strategic direction of Northern Health

The Committee will review the planned management summary presentation to the Board to ensure that it will provide the Directors with a clear, concise picture of the financial implications of the operating plan and the associated financial risks.

C. Financial Risk Management, Internal Control and Information Systems

The Committee will review and obtain reasonable assurance that financial risk management, internal control and information systems are operating effectively to produce accurate, appropriate and timely financial information.

This includes:

1. Reviewing Northern Health's financial risk management controls and processes relating to financial planning and performance
2. Reviewing management steps to implement and maintain appropriate internal control procedures
3. Obtaining reasonable assurance that the information systems are reliable and the systems of internal controls are properly designed and effectively implemented through discussions with and reports from management, the internal auditor and the external auditor
4. Reviewing the adequacy of security of information, information systems and recovery plans and annually receiving affirmation of security and integrity
5. Monitoring compliance with statutory and regulatory obligations relating to financial planning and performance (such as the Taxpayer Accountability Principles)

Comment [BAS1]: Added per revised Workplan Item 3.(d)

Level of Spending Authority

The Committee shall:

6. Develop with management a comprehensive statement of authorities for operating and capital expenditures, in compliance with Northern Health's executive limitations policy, and present these authorities to the Board for approval
7. Monitor compliance with the approved signing authority policy[3] through the internal audit process and recommend to the Board any changes which may be necessary from time to time

D. Internal Audit

The Committee will oversee Northern Health's internal audit function and the

[3] DST 4-4-02-030-P: Finance>Accounts Payable>Signing Authority

internal audit relationship with the external auditor and with management.

This includes:

1. Reviewing the objectivity and independence of the internal auditor
2. Reviewing goals, resources and work plans
3. Reviewing any restrictions or issues
4. Reviewing significant recommendations and management responses
5. Meeting periodically, and at least twice per year, with the Regional Director of Internal Audit without management present
6. Reviewing proposed changes in the internal audit function

E. External Audit

The Committee will review the planning and results of audit activities and the ongoing relationship with the auditor.

This includes:

1. Assessing the performance of, and recommending to the Board for approval, engagement of the auditor
2. Reviewing the annual audit plan, including but not limited to the following:
   a. engagement letter
   b. objectives and scope of the external audit work
   c. materiality limit
   d. areas of audit risk
   e. staffing
   f. timetable
   g. proposed fees
3. Meeting with the external auditor to discuss Northern Health's annual financial statements and the auditor's report including the appropriateness of accounting policies and underlying estimates
4. Reviewing and advising the Board with respect to the planning, conduct and reporting of the annual audit, including but not limited to:
   a. Any difficulties encountered, or restrictions imposed by management, during the annual audit
   b. Any significant accounting or financial reporting issue

c. The auditor's review of Northern Health's system of internal controls, procedures and documentation
d. The post audit or management letter containing any findings or recommendations of the external auditor, including management's response thereto and the subsequent follow-up to any identified internal control weaknesses
e. Any other matters the auditor brings to the Committee's attention

5. Reviewing any disagreements between management and the auditor regarding financial reporting
6. Reviewing and receiving assurances on the independence of the auditor
7. Reviewing the internal audit services and non-audit services to be provided by the auditor's firm or its affiliates (including estimated fees), and consider the impact on the independence of the audit
8. Meeting periodically, and at least annually, with the auditor without management present

F. Banking and Investment Management Activity

The Committee shall:

1. Annually review the banking policy and recommend any needed revisions to the Board.
2. Receive, at minimum, an annual report of all bank accounts, including their purposes and signing officers.
3. Annually review the investment policy for those handling Northern Health's funds and recommend any needed revisions to the Board
4. Receive, at minimum, semi-annual reports from the Chief Financial Officer on Northern Health's investment portfolio in accordance with NH Investment Policy 4-4-6-050.
5. Where appropriate, recommend the appointment, renewal or replacement of fund managers
6. Regularly review the performance of fund managers, if any, against the investment policy

G. Other

The Committee shall:

1. ~~Oversee the organizational and Board processes that foster a productive relationship with the Regional Hospital Districts (RHDs) for the purpose of accomplishing the Capital Plan, including renewal of any Memorandum of Understanding (MoU)s with RHDs~~
2. ~~Oversee the organizational and Board processes that foster a productive relationship with the Foundations, Auxiliaries and Societies involved in fundraising for the benefit of Northern Health, including the renewal of MoU(s) with Foundation(s)~~
3. Review annually a Business Development report detailing progress on goals and objectives set out for the prior and current fiscal years
4. Review annually insurance coverage of significant risks and uncertainties
5. Review annually material litigation and its impact on financial reporting
6. Institute and oversee special examinations or investigations, as needed
7. Receive reports regarding Ministry of Health funding models, as needed
8. Review annually the Committee work plan ~~annually~~ and the Committee terms of reference as part of the regular Board Policy Review cycle
9. Confirm annually that all responsibilities outlined in the work plan attached to these terms of reference have been carried out

Comment [BAS2]: Moved to GMR Workplan

Comment [BAS3]: Moved to GMR Workplan

Accountability

The Committee is accountable to the Board and will maintain minutes of its meetings and will bring forward advice and recommendations for Board deliberation and decision-making at the next Board meeting.

Membership

- Committee Chair (Board member)
- Minimum two additional Board members (to a maximum of four)

Ex Officio:

- Northern Health Board Chair (voting)
- President and Chief Executive Officer (non-voting)

Executive and Management Support:

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- Vice President, Financial & Corporate Services/Chief Financial Officer
- Regional Director, Internal Audit
- Regional Director, Capital Planning and Support Services

Recording Secretary:

- Executive Assistant to Vice President, Financial & Corporate Services/Chief Financial Officer

Ad Hoc:

Presenters to the Committee will be called upon from time to time, at the request of the Committee Chair, including:

- Chief Information Officer
- Regional Director, Business Development
- Regional Director, Finance & Controller
- Regional Director, Financial Planning & Budgeting

COMMITTEE WORK PLAN

The Recording Secretary shall maintain ~~(and shall be advised of any changes to)~~ the Committee's annual work plan and will:

1. ~~-~~Ensure that changes to the Committee's terms of reference are reflected in the work plan, and
2. In accordance with G.(9), annually provide to the Committee a report that:
   a. Reconciles the Committee's Terms of Reference to the Committee's work plan for the upcoming year
   ~~a.~~ Reconciles the Committee's work plan to actual ~~Indicates all elements of the work plan were undertaken~~performance in the previous year, noting .
   b. ~~Notes~~ any exceptions and providing an explanation for these.
3. Committee reviews and approves the work plan for the upcoming year ~~and provides an explanation.~~

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EXTERNAL AUDITOR INDEPENDENCE BRD 315

PURPOSE

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

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

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

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

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

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

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

ENGAGEMENT OF THE EXTERNAL AUDITOR

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

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

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

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

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

INTERNAL AUDIT SERVICES

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

   "... during either the period covered by the financial statements subject to audit or the engagement period, …the ~~licensed~~ firm or a member of the firm … provides an internal audit service to the ~~client~~ entity or a related entity unless, with respect to the entity for which the internal audit service is provided; ~~that relates to the client's, or the related entity's, internal accounting controls, financial systems or financial statements unless it is reasonable to conclude that the results of that service will not be subject to audit procedures during the audit of the financial statements. In determining whether such a conclusion is reasonable, there is a rebuttable presumption that the results of the internal audit service will be subject to audit procedures."~~

   (i) the entity designates an appropriate and competent resource within senior management to be responsible for internal audit activities and to acknowledge responsibility for designing, implementing and maintaining internal controls;

   (ii) the entity or its audit committee reviews, assesses and approves the scope, risk and frequency of the internal audit services;

   (iii) the entity's management evaluates the adequacy of the internal audit services and the findings resulting from their performance;

   (iv) the entity's management evaluates and determines which recommendations resulting from the internal audit services to implement and manages the implementation process; and

   (v) the entity's management reports to the audit committee the significant findings and recommendations resulting from the internal audit services."
3. The external auditor should not provide internal audit services where the services comprise a significant portion of the internal audit activities.

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

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4. Certain internal audit activities may impair the independence of the external auditor and should not be undertaken by the external auditor:
   a. Performing ongoing monitoring or quality control activities that relate to the execution, accounting for, or approval of transactions
   b. Determining which, if any, recommendations for improving the internal control system should be implemented
   c. Reporting to the Board or the Committee on behalf of management or Internal Audit
   d. Approving or being responsible for the overall internal audit work plan, including the determination of the internal audit risk and scope, project priorities, and frequency of performance of audit procedures
5. The licensed firm is required to identify threats to its independence and either apply safeguards to reduce the threats to an acceptable level or refuse to accept the external audit engagement.[3]

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

NON-AUDIT SERVICES

1. External audit services are those related to the formulation of an opinion on financial statements prepared by management and include advice on accounting

[3] Ibid, 204.2.

policies. Non-audit services are those services other than external or internal audit services.

2. Non-audit services undertaken by the external auditor create actual and/or perceived self-review, self-interest or advocacy threats to the independence of the external auditor. The degree of the threat depends on the nature, scale and scope of the non-audit services.
3. In relation to the provision of non-audit services, the term external auditor shall be interpreted as meaning the external auditor and any of its affiliates. The term affiliates will be interpreted by reference to the substance of a relationship with the audit firm but will generally include any entity controlled by the audit firm or under common control, ownership or management.
4. The external auditor may be engaged to provide non-audit services where there are good reasons and the services to be provided do not create a material threat to the independence of the external auditor. Good reasons for the external auditor to be appointed to perform non-audit services include:
    a. It is economical in terms of skill and effort for the external auditor to provide such services as a result of his or her intimate and specialised knowledge of the business
    b. The information required is a by-product of the audit process
    c. The services are required by legislation or regulation
5. Certain categories of non-audit services are considered to be potentially incompatible with the independence of the external auditor and should normally be avoided. These categories include:
    a. Performance of management functions or making management decisions
    b. Financial statement preparation services and bookkeeping services
    c. Valuation services
    d. Actuarial services
    e. Designing or implementing a hardware or software system
    f. Designing or implementing internal controls over financial reporting
    g. Legal services
    h. Recruiting services
    i. Certain corporate finance activities that create an unacceptable advocacy or self-review threat including making investment decisions or having custody of assets such as securities
6. A proposal by Northern Health management to engage the external auditor for any services in the categories set-out in #5 above must be approved in advance by the

Committee. In the review of such proposals the Committee will, where further detailed guidance is considered necessary, refer to standards and guidelines issued by the Canadian Institute of Chartered Accountants and the Institute of Chartered Accountants of British Columbia.

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

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

HIRING OF EXTERNAL AUDIT STAFF

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

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TERMS OF REFERENCE FOR THE GOVERNANCE & MANAGEMENT RELATIONS COMMITTEE V.1 BRD 320

PURPOSE

The primary function of the Governance and Management Relations Committee ("GMR" or the "Committee") is to assist the Board of Directors of Northern Health (the "Board") in fulfilling its oversight responsibilities by providing advice to the Board in the following areas of responsibility:

- Overseeing the development of Board meeting agendas to address the critical issues emerging from the deliberations of Board Committees and elsewhere in the organization
- Assessing and making recommendations regarding Board effectiveness, providing direction in relation to ongoing Director development and leading the process for recommending Director criteria to the government for consideration when appointing Directors, and setting and reviewing Board policies and procedures
- Providing guidance to the Board Chair and to the President & Chief Executive Officer (the "CEO") regarding the development and management of government relations
- Developing the agreement between Northern Health and the Government of British Columbia as set out in the mandate letter
- Assisting the Board in fulfilling its obligations related to management compensation policy and overseeing plans for the continuity and development of senior management

This committee is not intended to act on behalf of the Board unless specific delegated authorities have been given.

COMPOSITION AND OPERATIONS

The Committee shall be composed of the Chair of the Audit and Finance Committee, the Chair of the Performance, Planning and Priorities Committee, the Board Chair, and one or two Directors, one of whom will serve as Committee Chair. (See Membership section for complete committee membership details).

The Committee shall operate in a manner that is consistent with committee guidelines outlined in policy BRD 300 of the Board policy manual.

DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Committee will include:

A. Governance

The Committee shall:

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1. Develop Board meeting agendas with a focus on the strategic and critical issues emerging from Board Committee deliberations.
2. Establish the key internal and external communication messages arising from the Board meeting agenda and initiate the development of Board communication releases based on these messages.
3. Oversee the creation and distribution of the annual report.
4. Recommend to the Board the plan for Northern Health's community consultation strategy and oversee the implementation of this strategy.
5. Oversee the development and monitoring of Northern Health's enterprise-wide Integrated Risk Management Framework.
6. Review and advise the Board with respect to risk management issues including major incident/negligence summaries, and issues involving litigation.
7. Review and advise the Board with respect to Privacy and the Patient Care Quality Office (PCQO).
8. Develop, and annually update, a long-term plan for Board composition that takes into consideration the current strengths, skills and experience on the Board, retirement dates and the strategic direction of Northern Health.
9. Develop recommendations regarding the essential and desired experiences and skills for potential Directors, taking into consideration the Board's short-term needs and long-term succession plans.
10. In consultation with the Board Chair and the CEO, recommend to the Board for subsequent recommendation to government, criteria and potential candidates for consideration when they are appointing Directors.
11. Review, monitor and make recommendations regarding Director orientation and ongoing development.
12. Recommend to the Board, and annually implement, the appropriate evaluation process for the Board.
13. Review annually, for Board approval, a board manual outlining the policies and procedures by which the Board will operate including, but not limited to, the terms of reference for the Board, the Board Chair, the CEO, individual Directors and Board committees.
14. Ensure there is a system that enables a committee or Director to engage separate independent counsel in appropriate circumstances, at Northern Health's expense, and be responsible for the ongoing administration of such a system.
15. Review annually, for Board approval, all Board Enduring Motions to ensure that they are still current and relevant.
16. Monitor compliance with laws and regulations and ensure that procedures have been established to receive and address reports and complaints regarding non-compliance.
17. Recommend to the Board any reports on governance that may be required or considered advisable.

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18. Oversee the development, revision and renewal of the Memorandum of Understanding between Northern Health and the University of Northern British Columbia including the Innovation and Development Commons (IDC)
19. Oversee the development, revision and renewal of the Northern Partnership Accord between the First Nations Health Council: Northern Regional Caucus, Northern Health, and the First Nations Health Authority
~~19.~~20. Oversee the development, revision and renewal of the Memorandum of Understanding with the Foundation(s), and the development and maintenance of a productive relationship with the Auxiliaries and Societies that support Northern Health.
~~20.~~21. At the request of the Board Chair or the Board, undertake such other governance initiatives as may be necessary or desirable to contribute to the success of Northern Health.
~~21.~~22. Provide direction for content of the annual Board planning session and build items arising from this planning into the Board's work plan.
~~22.~~23. Review the existence and application of the corporate conduct policy on an annual basis (BRD 260).

B. Management Relations

The Committee shall:

1. Recommend a performance planning and review process for the CEO and, when approved, lead the implementation of the process.
2. Review and recommend the CEO's compensation to the Board for approval, subject to the legislative guidelines.
3. Review policy and procedures related to the review and approval of the CEO's expenses.
4. Review the CEO's analysis of the senior management team structure, processes, and performance.
5. Review with the CEO the succession planning strategy across all management levels and ensure that comprehensive succession plans are in place for all senior executive positions.
6. Review and recommend Northern Health's compensation philosophy and guidelines and ensure compliance with any applicable guidelines established by Health Employers' Association of BC (HEABC) and the Public Sector Employers Council (PSEC).
7. Review and recommend to the Board the ratification of collective agreements. Only the Board has the authority to ratify collective agreements.
8. Review with the CEO any significant outside commitments the CEO is considering before the commitment is made. This includes commitments to act as a Director or Trustee of for-profit and not-for-profit organizations.

C. Government Relations

The Committee shall:

1. Provide advice to the Board Chair and CEO in relation to regular interactions with government through such forums as the Board Chairs/CEO meeting, Northern Caucus, meetings with the Minister of Health Services, and other ministries and government bodies.
2. Create an environment that fosters productive relationships with the North Central Local Government Association (NCLGA), Regional Hospital Districts (RHD), and MLAs through regular communication, management of issues, and opportunities for interaction with the Board during regular Board meetings.
3. Receive reports and provide advice regarding Board Chair and CEO meetings with local government at the NCLGA and Union of British Columbia Municipalities (UBCM) meetings.
4. Organize opportunities for the Board to interact with the Minister and Ministry of Health leadership, as relevant to Northern Health priorities and issues.
5. Oversee the communications processes between Northern Health, Government Communications & Public Engagement (GCPE), the Ministry of Health and other government organizations and bodies.
6. Oversee the performance of the Health Shared Services BC (HSSBC) and determine if it is meeting the needs of Northern Health.
7. Oversee the relationship between Northern Health and the Provincial Health Services Authority (PHSA), HEABC and Healthcare Benefit Trust (HBT).
8. Annually review Northern Health's (a) Energy and Sustainability Policy, and (b) Carbon Neutral Action Report.

ACCOUNTABILITY

The Committee is accountable to the Board and will maintain minutes of its meetings and will bring forward advice and recommendations for Board deliberation and decision making at the next Board meeting.

MEMBERSHIP

- Northern Heath Board Chair
- Chairs of the Standing Committees (Audit & Finance; Performance, Planning and Priorities)
- 1 or 2 other Board Members one of whom will serve as the Committee Chair

Ex Officio:

- President and Chief Executive Officer (non-voting)

Executive and Management Support:

- Regional Director, Risk Management & Compliance
- Executive Assistant, Northern Health Board & President/CEO

Recording Secretary:

- Executive Assistant, Vice President Human Resources

Ad Hoc:

- Presenters to the Committee will be called upon from time to time, at the request of the Committee Chair

COMMITTEE WORK PLAN

The Recording Secretary shall maintain the Committee's annual work plan and will:

1. Ensure that changes to the Committee's terms of reference are reflected in the work plan, and
2. Annually provide to the Committee a report that:
    a. Indicates all elements of the work plan were undertaken in the previous year.
    b. Notes any exceptions and provides an explanation,
    c. Affirms that the work contemplated in the Terms of Reference is reflected in the Committee work plan.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): October 21 2015 (R)

TERMS OF REFERENCE FOR THE PERFORMANCE, PLANNING AND PRIORITIES COMMITTEE BRD 330

PURPOSE

The purpose of the Performance, Planning and Priorities Committee ("3P" or the "Committee") is to assist the Board of Directors of Northern Health (the "Board") in fulfilling its oversight responsibilities by providing advice to the Board in the following areas of responsibility:

- Oversight of quality and patient safety review processes for the purpose of improving the quality of health care or practice within Northern Health (NH)
- Development and review of the Strategic Plan
- Setting of strategic priorities designed to enable the organization to meet the goals set out in the Strategic Plan
- Monitoring performance of the organization in achieving the goals set out in the Strategic Plan and the performance expectations set forth by the Ministry of Health
- Ensuring a Communications Strategy is developed, implemented and monitored

This Committee is not intended to act on behalf of the Board unless specific delegated authorities have been given.

COMPOSITION AND OPERATIONS

The Committee shall be composed of not fewer than three Directors and not more than five Directors. (See Membership section for complete Committee membership details).

- The Committee shall operate in a manner that is consistent with the Committee Guidelines outlined in Policy BRD300 of the Board Manual
- Each committee meeting will focus on one (or two) strategic priorities with the understanding that there may be the need to include additional agenda items that are time sensitive
- Each Committee meeting will include a review of the scorecard indicators for the strategic priority being reviewed

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): May 26, 2016 (R)

DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the Committee will include:

1. **Strategic Plan**
   The Committee will oversee the development and review of the Strategic Plan and will provide guidance in setting the strategic priorities and directions required to achieve the expected outcomes by:
   a. reviewing organizational priorities
   b. reviewing the operational plan

2. **Service Plan**
   The Committee will oversee and approve Northern Health's public Service Plan each year by:
   a. reviewing the Ministry of Health mandate letter
   b. overseeing the development of the annual Service Plan
   c. monitoring and evaluating NH's performance as per the annual Service Plan
   d. reviewing and overseeing clinical quality priorities

3. **3P Terms of Reference**
   The Committee will annually review and update the 3P Terms of Reference to ensure it accurately reflects the performance, planning and priorities identified for the Board and Northern Health.

4. **Strategic Priority: Healthy People in Healthy Communities**
   The Committee will oversee the work done to partner with communities to support people to live well and to prevent disease and injury by:
   a. reviewing scorecards[1] for Healthy People in Healthy Communities
   b. reviewing the report provided by the Chief Medical Health Officer on the health status overview for the population served by Northern Health
   c. overseeing the partnering with communities, industry, and other organizations to ensure healthier communities for all residents of northern BC
   d. overseeing various population health initiatives such as age-friendly communities and child health and wellbeing
   e. overseeing and reviewing work being done to promote and protect environmental health

[1] The Committee will regularly analyze scorecards in an effort to measure performance and management's success in achieving the goals and targets as set out in the Strategic Plan, annual Service Plan and Ministry of Health performance expectations.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): May 26, 2016 (R)

5. **Strategic Priority: Coordinated and Accessible Services**
   The Committee will oversee the provision of health services based in a Primary Care Home and linked to a range of specialized services, which support each person and their family over the course of their lives from staying healthy, to addressing disease and injury, to end-of-life care by:
   a. reviewing scorecards[1] for Coordinated and Accessible Services
   b. reviewing person and family centered care within Northern Health
   c. reviewing primary care and community services to ensure that NH is collaborating with the Division of Family Practice to plan, implement, evaluate and improve quality and that interprofessional teams are established
   d. reviewing the implementation of specialized services teams connected to specialist physicians, with service pathways for the person and their family
   e. overseeing the distribution of services by community size
   f. reviewing the work done by Aboriginal Health to understand and implement the Northern First Nations Health & Wellness Plan

6. **Strategic Priority: Quality**
   The Committee will oversee the development and implementation of the quality improvement framework including the policies, standards, structures and processes necessary to support quality improvement and patient safety. The Committee will ensure a culture of continuous quality improvement in all areas by:
   a. reviewing scorecards[1] for quality
   b. reviewing high level work of clinical programs to ensure establishment of quality improvement goals at the program level and to oversee quality monitoring:
      i. Chronic Disease
      ii. Critical Care
      iii. Elder Services
      iv. Mental Health & Addictions
      v. Perinatal
      vi. Surgical Services
      vii. Child & Youth
   c. Reviewing information from local teams and departments that design and test innovative solutions within the Innovation and Development Commons through:
      i. quality education
      ii. quality improvement resources
      iii. innovation
   d. overseeing the engagement in research, education and quality improvement partnerships with academic organiations to create a learning environment throughout NH
   e. reviewing patient satisfaction surveys from facilities throughout NH

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): May 26, 2016 (R)

f. reviewing and advising the Board with respect to an Annual Quality Review and receiving reports arising from quality review committees properly constituted within the provisions of Section 51 of the *Evidence Act [RSBC 1996] Chapter 124*[2]
g. overseeing the development and review of the Integrated Ethics Framework

7. Enabling Priorities: Our People

The Committee will oversee the provision of services through its people and will work to have those people in place and to help them flourish in their work by:

a. reviewing scorecards[1] for Our People
b. overseeing the development, monitoring and evaluation of the Health Human Resource Plan
c. overseeing the development, monitoring and evaluation of the Recruitment and Retention Strategy
d. overseeing the development, monitoring and evaluation of the employee education framework and plan
e. overseeing the development, monitoring and evaluation of Workplace Health and Safety
f. reviewing Northern Health's policies, structures and processes for the development of the Physician Human Resource Plan
g. review and advise the Board with respect to annual school medical officer appointments

8. Enabling Priorities: Communications, Technology and Infrastructure

The Committee will oversee the implementation of effective communications systems and sustain a network of facilities and infrastructure that enables service delivery by:

a. reviewing scorecards[1] for Communication, Technology and Infrastruture
b. reviewing an annual overview of the Information Management and Information Technology Plan and progress to the plan
c. overseeing the development, implementation, and evaluation of the Communication strategy and policies including:
    i. internal communications
    ii. external communications
    iii. media relations
d. Providing advice to the Board Chair and President and Chief Executive Officer (the "CEO") regarding emerging communication issues involving the Board

[2] The 3P Committee does not itself conduct quality reviews under Section 51 of the Evidence Act.

ACCOUNTABILITY

The Committee is accountable to the Northern Health Board and will maintain minutes of its meetings and will bring forward advice and recommendations for Board deliberation and decision making at the next Board meeting.

Membership

- Committee Chair (Director – not the Board Chair)
- Two to four additional Directors

Ex Officio:

- Board Chair (voting)
- CEO (non-voting)

Executive & Management Support:

- Vice President, Planning, Quality and Information Management
- Regional Director, Internal Audit

Recording Secretary:

- Executive Assistant, VP Planning, Quality and Information Management

Ad Hoc:

- Presenters to the Committee will be called upon from time to time, at the request of the Committee Chair.

COMMITTEE WORK PLAN

The Recording Secretary shall maintain the Committee's annual work plan and will:

1. Ensure that changes to the Committee's terms of reference are reflected in the work plan, and
2. Annually provide to the Committee a report that:
   a. Indicates all elements of the work plan were undertaken in the previous year.
   b. Notes any exceptions and provides an explanation,
   c. Affirms that the work contemplated in the Terms of Reference is reflected in the Committee work plan.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): May 26, 2016 (R)

TASK FORCES V.1 BRD 340

A task force is a committee of the Board of Directors of Northern Health (the "Board") established for a defined period of time, normally not longer than six months, to undertake a specific task, and is then disbanded.

Guidelines for Task Forces

1. A task force operates according to a Board approved mandate, which outlines its duties and responsibilities.
2. Each task force must have terms of reference with the following headings:
    - Purpose
    - Composition
    - Duties and Responsibilities
    - Completion Date
3. A task force must get an extension approved to go beyond the time limit specified in its terms of reference. The Guidelines for Committees (Policy BRD 300) also apply to task forces established by the Board.

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): October 21 2015 (r)

BRIEFING NOTE

Date:	**September 1, 2016**	
Agenda item	**2016 Community Consultation – Update**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**GMR Board Committee &** **Northern Health Board of Directors**	
Prepared by:	**Gary Ockenden, WithInsight** **Steve Raper, CCO** **Dr Sandra Allison, CMHO**	
Reviewed by:	**Cathy Ulrich, CEO**	

Issue:

To provide an update on the community consultation – learnings to date and next steps.

Background:

The community consultation sessions on 'Growing up Healthy in Northern BC' was completed by the end of July. The consultation results are being analyzed to provide a comprehensive report to the board. There were two main approaches to listening to residents. The first approach was comprised of community meetings were held across the north, including open public sessions, stakeholder focus groups and youth groups. These meetings were facilitated by Gary Ockenden (With*in*sight) and included a presentation of the recent Child Health Report by CMHO Dr. Allison. Communities visited include (alphabetically):

Burns Lake	Kitimat	Queen Charlotte City
Chetwynd	Mackenzie	Quesnel
Dawson Creek	Masset	Smithers
Fort Nelson	McBride	Terrace
Fort St John	Prince George	Valemount

Hazelton Prince Rupert Vanderhoof

The second approach was an electronic process where residents were also asked to contribute ideas and select priorities through an innovative online process, using Thoughtexchange as the platform for that engagement. We asked people these questions (slightly modified, depending on the situation):

1. What does growing up healthy mean to you?
2. What is working in your community to support children and youth to group up healthy?
3. What could be improved in your community to support children and youth to group up healthy?
4. What opportunities or initiatives should be built upon or created in order to support children or youth in your community?

The participation levels where not as high on the face-to-face tour as they have been for previous consultations. We will be looking at why that might be over the coming months, but suspect the topic and timing could both be contributing factors to that. However, the introduction of an electronic consultative element was very successful, providing a different means to engage and consult with the population. That noted, there was great diversity– including deeply involved child and youth stakeholders, local government and First Nations leaders, health care professionals, youth, parents and community members. Those who found time to meet with Northern Health were very engaged, appreciative and contributed generously, as did those who added ideas online.

Face to face meeting participants (all approaches)	275
Thoughtexchange participants	599
Total (note: there may be overlap in individuals)	874

From the 599 Thoughtexchange participants there were 1,994 individual thoughts contributed and the participants assigned 39,574 stars to those thoughts that resonated with them, providing clear priorities and themes. This is a very rich and very powerful sorting and ranking process. The full data from the consultations is still being analyzed, yet there are some strong themes emerging, from both the meetings and the online input. Below is a brief summary (these will be refined and may change in the October report).

Q1: What does growing up healthy mean to you?	Q2: What is working in your community to support children and youth to group up healthy	Q3: What could be improved in your community to support children and youth to group up healthy?	Q4: What opportunities or initiatives should be built upon or created in order to support children or youth in your community?
▪ Feeling loved, safe, valued and worthy - with healthy attachment to one or more adults ▪ Access to nature and to free play ▪ The necessities (good food, adequate shelter, safety, health care, transportation, education) ▪ Participation in recreation and cultural activities ▪ A family not struggling with poverty ▪ Reducing use of technology (or use too young)	▪ Outdoor recreation opportunities and access to nature ▪ A wide range of early childhood support programs, including public health services. ▪ Sports and other recreation and cultural facilities and opportunities, supported by volunteers ▪ Caring, supportive communities – community events and neighbors who care ▪ Focus on traditional First Nations and Aboriginal culture	▪ Increase supports for mental health and substance use issues for children and youth ▪ Address poverty and related issues (food security well noted) ▪ Improve services for early childhood development ▪ Remove barriers to recreation and cultural activities (transportation, cost) ▪ Improve collaboration in services for children and youth (NH, MCFD, FNH, local government, NGOs) ▪ Supports to vulnerable parents	▪ Collaborate with health, social, business and government on poverty reduction ▪ Increase parent support programs ▪ Increase screening of 3.5 year olds ▪ Improve youth mental health services ▪ School food programs and gardens ▪ Increase access to existing recreation and culture activities ▪ Increase access to indigenous culture learning ▪ Build local child and youth 'tables'

A full report will be presented to the Northern Health Board at its October meeting.

Recommendation: The Northern Health Board receive for information only.

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

BOARD BRIEFING NOTE

Date:	2016 September 6	
Agenda item	**NI Medical Health Officer – Dr. Andrew Gray**	
Purpose:	☐ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	**NH Governance and Management Relations Committee & Northern Health Board of Directors**	
Prepared by:	**K Thomson, Regional Director, Risk and Compliance**	
Reviewed by:	**C Ulrich, CEO**	

Issue:

A motion is required for the Board to request the Provincial Health Officer to arrange for an Order in Council for Dr. Andrew Gray as a Medical Health Officer for Northern Health with powers under the *Public Health Act*.

Background:

Dr. Andrew Gray (CV attached) has been recruited as the Medical Health Officer for the Northern Interior health service delivery area and is based in Prince George. He started in his position on August 29th, 2016.

Under Section 71 of the *Public Health Act* medical health officers are designated through an Order in Council on the recommendation of the Provincial Health Officer (PHO), and it is up to the health authority to pass a Board motion and make the formal request to the PHO.

Once passed, a letter will be sent to the PHO with a copy of the Board motion, Dr. Gray's CV, and his certificate to practice medicine in BC.

Recommendation(s):

The NH Board of Directors request that the Provincial Health Officer proceed to recommend to the Lieutenant Governor in Council that Dr. Andrew Gray be designated as a medical health officer for the Northern Health Authority, with powers under the Public Health Act.

Andrew Paul Gray MD MSc FRCPC

#204-2055 Ingledew St. Prince George, BC V2L 5S1
778-349-4398 andrew.gray@northernhealth.ca

Employment

Medical Health Officer, Northern Interior Health Service Delivery Area — Aug 2016–present
Northern Health, Prince George

Education

Public Health & Preventive Medicine Residency Program — Jul 2011–Jun 2016
McGill University, Montréal

- Rotations in surveillance, communicable disease control, environmental health, occupational health, health promotion, chronic disease and injury prevention, management, planning, research.
- Training settings included urban (Montreal), suburban (Laval), rural (Northern BC), and remote Indigenous regions (Nunavik, James Bay Cree region), as well as provincial institutions (INSPQ).

Master of Science in Epidemiology — Sep 2012–Oct 2014
McGill University, Montréal

- Courses covered epidemiology, biostatistics, population health, and participatory research. GPA: 4.0.
- Thesis examined social determinants of Inuit youth mental wellness in Nunavik.

Doctor of Medicine — Aug 2007–Jun 2011
University of British Columbia, Vancouver

BSc Combined Honours, Mathematics & Computer Science — Sep 2001–May 2005
University of British Columbia, Vancouver

Licenses and certification

Licensed by the College of Physicians and Surgeons of British Columbia (CPSBC) — Sep 2, 2016

Certified by the Royal College of Physicians of Canada — Jun 30, 2016

Licentiate of the Medical College of Canada (LMCC) — Dec 14, 2012

Academic publications

Andrew P. Gray, Wesley Cote. "Historical trauma, cultural connectedness, and mental health in a sample of Algonquin youth." (in preparation).

Andrew P. Gray, Faisca Richer, Sam Harper. "Individual- and community-level determinants of Inuit youth mental wellness." *Canadian Journal of Public Health*. 2016:170(3) (in press).

Andrew P. Gray, Robert Allard, Renée Paré, Terry Tannenbaum, Brigitte Lefebvre, Simon Lévesque, Michael Mulvey, Lara Maalouf, Silvana Perna, Yves Longtin. "Management of a hospital outbreak of extensively drug-resistant *Acinetobacter baumannii* using a multimodal intervention including daily chlorhexidine baths." *Journal of Hospital Infection*. 2016;93:29-34. http://dx.doi.org/10.1016/j.jhin.2015.12.013

Teaching experience

Public health and preventive medicine resident teaching — Apr 2013–Jan 2016
Shared academic half-days, Québec public health residency programs

- Taught on Aboriginal health, infectious disease surveillance, public health ethics, qualitative methods, and STI contact tracing and management.
- Contributed substantially to planning and evaluation of academic half-days overall.

Medical student small group teaching and mentorship Sep 2013–Jun 2016
MD Undergraduate Program, McGill University

- Wrote small group case in Aboriginal health.
- Facilitated small groups in Aboriginal health, epidemiology, and public health.
- Mentored two students in research projects on Aboriginal health and environmental health.

Volunteer activities

Jeunes médecins pour la santé publique: Treasurer Nov 2014–Jul 2016
Public Health Physicians of Canada: Chair of Resident Council, Resident representative to General Council, Representative to Resident Council for Québec residency programs, Resident Council liaison with National Collaborating Centres for Public Health Jul 2012–Jul 2015
McGill University Public Health & Preventive Medicine program: Chief resident Jul 2013–Jun 2015
Canadian Public Health Association: Student Ad Hoc Committee member Jul 2012–Dec 2013
McGill University Epidemiology, Biostatistics & Occupational Health Student Society: Communications Representative Oct 2012–Oct 2013
Universities Allied for Essential Medicines: UBC chapter chair, International Coordinating Committee member, and advisor/coordinator of Canadian chapters 2006–2011
UBC MD program: student representative for Doctor, Patient & Society course 2008–2009

Awards

During residency: Resident Leadership Award from Public Health Physicians of Canada 2014
During medical school: Pacific Blue Cross Medical Entrance Scholarship; Medical Microbiology Prize; Hamber Scholarship in Medicine; William, Sadie and Edwin Rowan Scholarship in Medicine 2007–2011

Languages spoken

English – fluent

French – highly functional in professional settings

northern health
the northern way of caring

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 August 30	
Agenda item	Regulatory Framework – Legislative Compliance • *Community Care and Assisted Living Amendment Act (Bill 16)*	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	GMR Committee & Northern Health Board of Directors	
Prepared by:	K Thomson, Regional Director, Risk and Compliance	
Reviewed by:	C Ulrich, CEO	

Issue:

To provide an update on the legislative compliance review process.

Background:

1. Current Review

The *Community Care and Assisted Living Amendment Act* received Royal Assent on May 19, 2016, providing revisions to the *Community Care and Assisted Living Act* to both improve the quality of assisted living residences and to enable those requiring care to stay longer in an assisted living environment before requiring long-term care admission.

The significant changes that the Act will effect include increased powers of the assisted living registrar respecting inspection and oversight, and a new definition of professional health services, of which a resident may receive an unlimited number, providing that unscheduled support or services are not regularly required.

The impact on Northern Health will not be fully known until such time as the enabling regulations are written and approved. The few assisted living residences that are owned and operated by Northern Health will, when regulations are passed, be able to apply the criteria for residence to current and prospective residents, potentially allowing residents to remain longer in the assisted living environment before requiring long term care.

The powers of inspection and oversight in the legislation sit entirely with the appointed provincial assisted living registrar. It is expected that the regulations will delegate some of these duties to parties within each health authority, in order that oversight and monitoring can be meaningfully conducted. While it is anticipated Licensing will have a role, the precise nature will not be known until such time as regulations are available.

2. Upcoming Review(s)

Hospital Act (last reviewed February 2011)

3. Completed Reviews

The running list of completed reviews is maintained in a separate spreadsheet stored in the GMR Committee folder on the network drive.

Recommendation(s):

Northern Health Board of Directors receive for information.