Meeting of the Northern Health Board
Public Session

Monday, June 10, 2019

Northern Grand Hotel
Meeting Room #2
Fort St John BC

northern health
the northern way of caring

northern health

Public Session

AGENDA

June 10, 2019
Northern Grand Hotel - Meeting Room #2
9830 100 Ave, Fort St John BC

AGENDA ITEMS	Responsibility of…	Expected Outcome	Time (Approx.)	Page
1. Call to Order of Open Board Session	Chair Nyce		**9:00am**	
2. Opening Remarks	Chair Nyce			-
3. Conflict of Interest Declaration	Chair Nyce	Discussion		-
4. Approval of Agenda	Chair Nyce	Motion		
5. Approval of Previous Minutes: April 15, 2019	Chair Nyce	Motion		**3**
6. Business Arising from Previous Minutes	Chair Nyce			**-**
7. CEO Report	C Ulrich	Information		**8**
7.1 Human Resources Report	D Williams	Information		**12**
8. Audit & Finance Committee				
8.1 Public Comments 2018-19 Fiscal Year End	M De Croos	Information		**21**
8.2 Public Capital Expenditure Plan Update	M De Croos	Motion		**22**
9. Performance, Planning & Priorities Committee				
9.1 Strategic Priority: Quality				
9.1.1. Overdose Prevention & Response Update	Dr. S Allison	Information		**27**
10. Presentation: Tackling the Opioid Crisis Locally: Fort St John Community Action Team and Healthy FSJ; Presenters: • Amanda Trotter, Executive Director, Fort St John Women's Resource Society • Julianne Kucheran, Community Consultant, Urban Matters	A De Smit	Information		**-**
11. Governance & Management Relations Committee				
11.1 Policy Manual BRD 200 Series	C Ulrich	Motion		**32**
11.2 Policy BRD 510	C Ulrich	Motion		**76**
11.3 2021 Board Meeting Calendar	C Ulrich	Motion		**78**
11.4 Annual Report: 2018-2019	S Raper	Information		**80**
11.5 Emergency Preparedness	S Raper	Information		**83**
Adjourned			**10:30am**	

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Public Motions *Meeting Date:* *June 10, 2019*				
Agenda Item		**Motion**	**Approved**	**Not Approved**
3.	Conflict of Interest Declaration	Does any Director present have a conflict of interest they wish to declare regarding any business before the Northern Health Board at this meeting?	☐	☐
4.	Approval of Agenda	The Northern Health Board approves the public agenda as presented		
5.	Approval of Minutes	The Northern Health Board approves the April 15, 2019 public minutes as presented	☐	☐
8.2	Public Capital Expenditure Plan Update	The Northern Health Board receives the Period 13 update on the 2018-19 Capital Expenditure Plan.	☐	☐
11.1	Board Policy Manual 200 Series	The Northern Health Board approves the revised BRD 200 Series.	☐	☐
11.2	Board Policy BRD 510	The Northern Health Board approves Board Policy BRD 510 as revised.	☐	☐
11.3	2021 Board Meeting Calendar	The Northern Health Board approves the 2021 Board meeting calendar as presented.	☐	☐

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Board Meeting

Date: April 15, 2019

Location: Smithers, BC

Chair: Colleen Nyce

Recorder: Desa Chipman

Board:
- Stephanie Killam
- Frank Everitt
- John Kurjata
- Patricia Sterritt
- Edward Stanford
- Rosemary Landry
- Wilfred Adam
- Brian Fehr

Executive:
- Cathy Ulrich
- Fraser Bell
- Mark De Croos
- Ciro Panessa
- David Williams
- Dr. Margo Greenwood
- Dr. Ronald Chapman
- Dr. Sandra Allison
- Dr. Helene Smith
- Danielle Guglielmucci
- Eryn Collins

Public Minutes

1. Call to Order Public Session

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

2. Opening Remarks

Chair Nyce welcomed members of the public in attendance to observe the meeting and acknowledged the traditional territory of the Wet'suwet'en on which we are holding this meeting.

3. Conflict of Interest Declaration

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

- There were no conflict of interest declarations made related to the April 15, 2019 Public agenda.

4. Approval of Agenda

Moved by S Killam seconded by W Adam
The Northern Health Board approves the April 15, 2019 public agenda as presented

5. Approval of Previous Minutes

Moved by J Kurjata seconded by F Everitt
The Northern Health Board approves the February 11, 2019 minutes as presented

6. Business arising from the previous minutes

There was no business arising from the February 11, 2019 minutes.

7. CEO Report

- An overview of the April 2019 CEO Report was provided for information and discussion with the following topics being highlighted:
  - Mobile Mental Health and Substance Use Service in the North West: On March 21, 2019 Chair Nyce attended an event where the Honourable Judy Darcy, Minister of Mental Health and Addictions announced a new mobile Mental Health and Substance Use unit in the North West. The mobile service will initially be scheduled for outreach in Terrace and surrounding communities. Supports offered through the mobile service will be assessed over time and changes may be made to scheduling and services to reflect the unique needs of people living with mental health and addictions challenges in the Northwest.
  - Third Annual Dr. Charles Jago Awards – 2019 Winners: On April 3, 2019 the winners of the Dr. Charles Jago Awards were recognized at the April Northern Health Leadership Forum. The winners for 2019 are as follows:
    - Empathy: Jennifer Haas, Manager, Specialized Mental Health & Addictions Services (Terrace)
    - Respect: Theresa Healy, Lead Capacity Development & Education, Indigenous Health (retired), (Prince George)
    - Collaboration: Dr. Anthon Meyer, Family Physician and Medical Director, (Stuart Lake & Fort St James)
    - Innovation: Gene Saldana, Nuclear Medicine Technician (Fort St John)
  - Bulkley Valley District Hospital (BVDH) Master Planning Update: Northern Health is undertaking a Master Planning process for the Bulkley Valley District Hospital in Smithers. There have been two rounds of comprehensive user group meetings to gather the information and perspective required for the Master Plan and Master Program. The process is on schedule with a Fall 2019 expected completion date.
  - Cultural Safety & Humility: Northwest Indigenous Health Improvement Committee (IHIC) have hosted a series of well attended Cultural Learning Sessions, Mental Health Workshops and Welcome and Information Sharing Feasts in 2018 and 2019.
  - Terrace Physician Recruitment Update: As a result of collaborative efforts between the City of Terrace, North West Regional Hospital District, the Pacific Northwest Division of Family Practice and Northern Health, there has been a significant improvement in the number of general practice physicians in Terrace over the past year.

7.1. Human Resources Report

- An overview of the April Human Resources Report was provided for information and discussion with the following areas being highlighted:
- Workplace Health & Safety Structure:
  - Workplace Health and Safety is focused on supporting a safe and healthy workplace including:
    - Promoting disability support and services to frontline workers to encourage participation and facilitate program uptake as early as possible.
    - Developing additional tools and resources to support the organization in health promotion and early, proactive intervention, with a specific focus on the psychological health and wellness of workers.
    - Continuing partnerships with unions and insurers to reduce costs and claim duration, and to lower incidences of long-term disability.
- Health, Safety, and Prevention:
  - Northern Health staff are able to access the Provincial Violence Prevention Curriculum which is an education and training program for all BC Health Care workers. It is designed to reduce incidents related to violence in the workplace. Workplace Health & Safety continues to support the organization in sustaining the training.

  - Northern Health continues to demonstrate a positive reporting culture for violent incidents with a favourable ratio of report-only incidents compared to incidents that do result in an injury and a WorkSafeBC claim.
- Influenza Prevention:
  - During the 2018-19 Influenza season, Workplace Health & Safety collaborated with the Infection Prevention and Control, Public Health and operational leadership to minimize the spread of influenza through immunization, prevention activities and surveillance. Northern Health has continued to see an increase in both reporting and immunization rates related to improvements made to the communications and education campaign.
  - Northern Health Recruitment Update:
    - To date in fiscal year 2018/19, Northern Health has posted 3666 positions, 72% have been filled by internal staff and 9% have been filled externally within 90 days. Some unfilled positions are currently in the competition phase. Positions that remain unfilled for more than 90 days become difficult-to-fill vacancies. In addition to the postings that are filled externally, 10% of approximately 3000 external postings go to difficult-to-fill vacancies.

8. Audit and Finance Committee

8.1. Public YTD Period 11 Comments & Financial Statement

- Year to date Period 11, Northern Health has a net operating deficit of $5,258,000. Revenues are favourable to budget by $7.2 million or 1.0% and expenses are unfavourable to budget by $12.5 million or 1.7%.
- Budget coverage in Acute Care is primarily due to higher than expected patient volumes at a number of acute care facilities. The daily inpatient census has averaged 586.2 for the current year versus 548.4 for the same period last year; an increase in daily patient days of 37.8 or 6.9%.
- Budget surplus in Community Care and Corporate is primarily due to vacant positions.
- Northern Health continues to work towards a balanced position by yearend without compromising services to patients, residents and clients.

Moved by S Killam seconded by J Kurjata
The Northern Health Board receives the 2018-19 Period 11 financial update as presented.

8.2. Capital Projects Expenditure Plan update (Period 11)

- The Northern Health Board approved the 2018-19 capital expenditure plan in February 2018, and amendments in June and November 2018. The updated plan approves the total expenditures of $50.3M, with funding support from the Ministry of Health ($18.5M, 37%), six Regional Hospital Districts ($16.4M, 33%), Foundations, Auxiliaries and other entities ($4.6M, 9%), and Northern Health ($10.7M, 21%).
- Year to date Period 11 (February 7, 2019), $32M has been spent towards the execution of the plan as summarized in the material in the package.

Moved by J Kurjata seconded by E Stanford
The Northern Health Board receives the Period 11 update on the 2018-19 Capital Expenditure Plan.

9. Performance, Planning & Priorities Committee

9.1. Indigenous Health: Northern First Nations Wellness Plan and Joint Project Board initiatives

- The Indigenous Health team values innovation, relationships and the opportunity to realize these values and those of NH's strategic plan in its activities and processes. Innovative education initiatives along with ongoing partnerships with the First Nations Health Authority,

northern First Nations and Indigenous groups across the north anchor the work and ensure its relevance.

- The briefing note contained detailed information and highlights of ongoing and new initiatives currently underway on the following:
  - Implementation of the Northern First Nations Health and Wellness Plan
  - Joint Project Board Initiatives
  - Related Primary Care Initiatives
  - More Partnered Activities
  - Education – Cultural Safety
  - Resources and Website Development
  - Research and Evaluation

9.2. Multi-Agency Quality Committee: BC Cervix Screening Program Quality Management Committee

- Under Section 51 of the Evidence Act, health authority boards are permitted to establish standing quality committees that include two or more health authorities, for the purposes of improving medical or hospital practice or care within those health authorities, providing there is a matter of common interest.
- The Provincial Health Services Authority (PHSA) is initiating the British Columbia Cervix Screening Program Quality Management Committee and is seeking Northern Health board endorsement for Northern Health participation in this committee.

Moved by S Killam seconded by R Landry
WHEREAS the Board of Directors of Northern Health (the "Board") has established the Performance, Planning and Priorities Committee (3P) for the purpose of improving the quality of health care within Northern Health, and

THAT the 3P Committee may delegate specific quality review functions to sub-committees, therefore be it resolved:

THAT the Northern Health Board approves, through the 3P Committee, the establishment of the British Columbia Cervix Screening Program Quality Management Committee as a committee established or approved by the boards of management of two or more hospitals, that include health care professionals employed by or practicing in any of those hospitals and is for the purposes of improving medical or hospital practice or care in those hospitals, and is charged with the function of studying, investigating or evaluating the care provided in hospitals as a matter of common interest among those hospitals, and

THAT it is affirmed that Northern Health agrees to participate in these joint quality assurance activities with other health authorities, whereby the Committees or the Northern Health participant will direct reports and anonymized data relevant to quality issues identified therein to the 3P Committee of Northern Health.

10. Presentation: Bulkley Lodge Integrated Adult Day Program

Northern Health employees Cormac Hikisch, Health Service Administrator, Liza Hart, Manager Residential Care NW East Cluster and Shelene MacNeil, Recreation Therapist presented to the Northern Health Board on the Smithers Integrated Adult Day Program.

- The program objective was to make quality respite care accessible every day for high risk seniors. The presentation included details and information on the following areas:
  - Rationale for integrating the Adult Day Program into Bulkley Lodge including key principles and strategies

- Outcomes were shared of clients being able to access a wider range of services and programming
- Work will continue with exploring community-based solutions to transportation barriers, facilitation of expanded community programming for seniors and exploring partnerships with existing community programs to enhance services offered through the Adult Day Program.

- Board members appreciated the information shared and recognized staff for their exceptional work and ongoing efforts in providing accessible services to all clients.

11. Governance and Management Relations Committee

11.1. Policy Manual BRD 100 Series

- The revised policy manual BRD 300 Series was presented to the Board for review and approval.

Moved by R Landry seconded by F Everitt
The Northern Health Board of Directors approves the revised BRD 100 series

11.2. Code of Conduct and Conflict of Interest Guidelines for Directors Signing (Policy BRD 210)

- The revised policy BRD 210 was presented to the Northern Health Board of Directors for review and approval.

Moved by S Killam seconded by F Everitt
The Northern Health Board of Directors approves revised BRD 210 Policy and agrees that each Director review and sign the declaration and forward to the Corporate Secretary for filing.

11.3. Overview of Research Partnerships

- An update was provided to the board on the key research activities. Northern Health supports research activity and the use of research findings for innovation and evidence-informed practice.
- Northern Health uses knowledge generated from research, evaluation and quality improvement to inform the quality and safety of services provided and as a vehicle for innovation in the region to provide exceptional health services for Northerners.
- The material included information on the 2018 Research Review Committee Annual Report and overview of research partnerships.

Meeting was adjourned at 11:00am
Moved by S Killam

Colleen Nyce, Chair

Desa Chipman, Recording Secretary

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

CEO REPORT

Meeting:	Northern Health Board Meeting	Date:	May 30, 2019
Agenda Item:	CEO Report		
Purpose:	Information		
Prepared by:	Cathy Ulrich		

NCLGA: Healthy Communities Forum – May 6, 2019

As part of the North Central Local Government Association convention the 4th annual Northern Healthy Communities Forum *"Resilient & Healthy Communities"* was attended by 75 local government officials, health authority staff, and community partners. This was the first time Northern Health has co-hosted this event with Interior Health.

Mayors from Terrace, the Northern Rockies Regional Municipality, Burns Lake, Wells and Houston were present. Councillors also represented the Cariboo Regional District, the Bulkley Nechako Regional District, the Kitimat Stikine Regional District, Chetwynd, Taylor, Pouce Coupe, Valemount, McBride, Fraser Lake, and Williams Lake.

The partnership with Northern Health and Interior Health was reflected throughout the day in the shared facilitation of the event as well as the speakers presentations from NH/IH teams on Local Level Health Data and Food Security.

This year's theme focused on resilience with the aim to support resilience at the community level by providing information, resources, and targeted recommendations for local government action. The topics included in the day were:

- An overview of what resilience looks like, and the services available through Healthy Settings, the Health authorities, and the Province
- Local-level Health Data to inform Local Action
- Healthy & Resilient Communities: Food Security in BC, and
- Housing for Resiliency and Community Well-being

2019 Indigenous Health Improvement Committee Gathering: Cultural Safety – A Journey of Partnership, Reflection and Understanding – May 28 and 29

Northern Health, leaders and health care providers from First Nations communities and the First Nations Health Authority have worked together to establish Aboriginal or Indigenous Health Improvement Committees in each geographic area across the North. These committees have been working together to improve the cultural safety of health care services for First Nations and Métis people. On May 28 and 29, the committees came together in an annual gathering. The overarching goals for the gathering were:

- To share experiences and knowledge with each other,
- To celebrate accomplishments
- To explore bias and related concepts
- To investigate roles in partnerships, and
- To reflect and express thoughts through art

There were over 125 attendees who participated in interactive sessions over the two days including:

- Indigenous Health: Where have we been, Where are we going? – Dr. Margo Greenwood, Vice President, Indigenous Health, Northern Health
- Presentations from the Northeast, Northwest and Northern Interior Indigenous Health Improvement Committees to highlight and celebrate the work underway.
- A panel presentation from Northern Health senior leaders describing the impact that this work has had on their practice and their perspective as leaders
- Métis Nation overview – Tanya Davoren, Director of Health, Métis Nation
- An educational workshop on the second day of the gathering focused on racism entitled, 'Being in good relationships: Cultural competence and challenging racism' – Rose LeMay, Indigenous Reconciliation Group

Northern Occupational and Physical Therapy Education Program

On May 24, 2019, the Honourable Melanie Mark, Minister of Advanced Education, Skills and Training announced increases to the occupational and physical therapy education program seats including additional seats based in the North. This will enable northern students to receive their education in the north. Our experience demonstrates that when students are educated in the north, they are more likely to choose to start their careers in the north.

The province is providing $2.2 million to UBC for start-up and planning to expand the Master of Physical Therapy program in the north in partnership with UNBC, with the anticipated first intake of 20 first year students in September 2020. An additional $1.1 million will be provided to UBC to work towards expanding the Master of Occupational Therapy program in the north in partnership with UNBC with 16 first-year students in September 2022.

Northern Health Capital Announcements:

Northern Interior – GR Baker Memorial Hospital ED & ICU, Quesnel

On April 16, 2019, the Honourable John Horgan, Premier, Province of BC and the Honourable Adrian Dix, Minister of Health announced approval of the business plan for the redevelopment of the emergency department and intensive care unit (ICU) at G.R. Baker Memorial Hospital in Quesnel. The emergency department and ICU will increase in size and will enable these two departments to work together in order to improve patient and staff workflow.

The emergency department will include a triage area, two examination rooms, a trauma and resuscitation room, an isolation and examination treatment room, and a psychiatric observation room. The new ICU will have five treatment rooms as well as a private family waiting area. Construction is expected to start in late 2019 and be complete in 2021.

Northern Interior – Prince George Primary Care Network and Urgent & Primary Care Centre

In April, the Honourable John Horgan, Premier, Province of BC and the Honourable Adrian Dix, Minister of Health also announced Prince George Primary Care Network as well as the establishment of an Urgent and Primary Care Centre (UPCC) anticipated to open in June 2019.

The Primary Care Network will enable new and existing heatlh care professionals to work collaboratively to provide team based care to the community of Prince George and the surrounding area, including the community of Lheidli T'enneh. The urgent and primary-care centre will be located in the Parkwood Place Mall, 1600 15th Ave. People will be able to access services from family practice physicians and other members of the health care team in the evenings and weekends for urgent needs that do not require the level of expertise found in emergency departments. During the weekdays, team based care and care coordination can be accessed through scheduled appointments.

North West – Mills Memorial Hospital, Terrace

On May 21, 2019, the Honourable Adrian Dix, Minister of Health announced that the business plan for a new Mills Memorial Hospital has been completed and the project is officially approved to proceed to the procurement and construction phases of work. The new Mills Memorial Hospital will increase to 78-beds with an expanded emergency department including trauma bays, four operating rooms, as well as the latest diagnostic imaging equipment. Mental health service delivery will also be expanded through a new Seven Sisters regional mental health facility with 25 beds.

Northern Health led the business planning process in conjunction with the Ministry of Health, the North West Regional Hospital District and various partners, including the First Nations Health Authority, Kitsumkalum Band, Kitselas Band and Nisga'a Lisims Government.

North East – Dawson Creek District Hospital
In July 2018, Northern Health received approval from the Ministry of Health to proceed with the development of a business plan for the replacement of the Dawson Creek District Hospital. Over the last none months extensive work has been undertaken to develop the functional program and buseinss plan with engagement of staff and physicians in the process.

BC College of Family Physicians (BCCFP) - Family Physician of the Year
The BCCFP gives out awards as a way to honour physicians from each of B.C.'s health regions. This year, Dr. Catherine Textor, a Prince George family practice physician has been recognized by the College of Family Physicians as BC's Family Physician of the Year. Dr. Aryn Khan of Vanderhoof was also honoured by the BCCFP with the First Five Years of Practice Award. Dr. Marlowe Haskins, based in Smithers, won the northern region's My Family Doctor Award as nominated by his patients.

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

HR REPORT

Workforce Planning

Northern Health's Human Resources department supports the health authority's enabling priority: Our People. The priority states that "Northern Health (NH) provides services through its people and will work to have those people in place and to help them flourish in their work." With regards to workforce planning, this includes understanding our workforce and plan for future needs within the context of the Northern population.

Northern Health (NH) has 3 levels of workforce planning:

- Provincial Workforce Planning – The Provincial Integrated Health Human Resources Planning (IHHRP) initiative which aims to establish a single, comprehensive and collaborative process to align supply, mix, and distribution of the workforce to meet patient and population health needs.
- Health Authority Human Resources Strategy – Northern Health is developing a Human Resources (HR) Strategy which aims to optimize, support, and retain the existing workforce. This includes profession-specific workforce plans which summarize the unique challenges facing each of the priority professions. It also contains the strategic initiatives that are forthcoming or underway to address these challenges.
- Operational Workforce Planning – The implementation of standardized workforce planning for the organization to support evidence-based decision making, improve engagement, and provide a better understanding of our workforce. This work is specific to departments and units within NH.

Provincial Workforce Planning

The Integrated Health Human Resources Planning (IHHRP) process is a provincial initiative for assessing and planning BC's health workforce, and its ability to meet the health care needs of the population. As a result of IHHRP collaborative, the Ministry of Health published the British Columbia Provincial Health Workforce Strategy, 2018/19 – 2020/21[1]. This strategy identifies five provincial workforce strategies related to ensuring a sustainable workforce in four priority areas. The four priority areas include:

- Primary care
- Those working with adults with complex medical conditions and/or frailty
- Mental health and substance use
- Surgical services

The five strategies are intended to respond to population needs and workforce gaps over the next two fiscal years, they are as follows:

- Ensure that provincial training systems reflect anticipated demand for key occupations
- Adopt a flexible, responsive, provincial approach to recruitment and retention
- Optimize the roles of health practitioners to increase their effectiveness within interdisciplinary teams
- Update funding and compensation models to support health system transformation
- Extend provincial workforce planning capacity

Based on the Provincial health Workforce Strategy and the unique challenges faced in the North, NH has identified seven nursing and allied health priority professions. These professions include:

- Registered Nurses
- Licensed Practical Nurses
- Health Care Assistants
- Physiotherapists
- Occupational Therapists
- Sonographers
- Pharmacy Technicians

IHHRP is an ongoing collaborative of provincial focus and will inform the provincial workforce strategy beyond 2020/2021.

[1] BC Ministry of Health. (2018). British Columbia Provincial Health Workforce Strategy 2018/19-2020/21. Victoria

Northern Health Human Resources Strategy

NH is developing a comprehensive HR Strategy that will fully align with provincial strategies and involves an approach to addressing priority issues facing the health workforce in the North. The overall purpose of the HR Strategy is to optimize, support, and retain the existing workforce. It involves continuous planning to achieve optimum use of the organization's most valuable asset – people.

Included in the NH HR Strategy, is a detailed profession plan for each of the seven nursing and allied health priority professions identified by NH. These profession plans include the unique challenges faced for each profession, as well as the strategic initiatives that are forthcoming or underway to address these challenges, aligning with the NH recruitment and retention philosophies.

Recruitment and Retention Philosophies

The recruitment and retention philosophies are as follows:

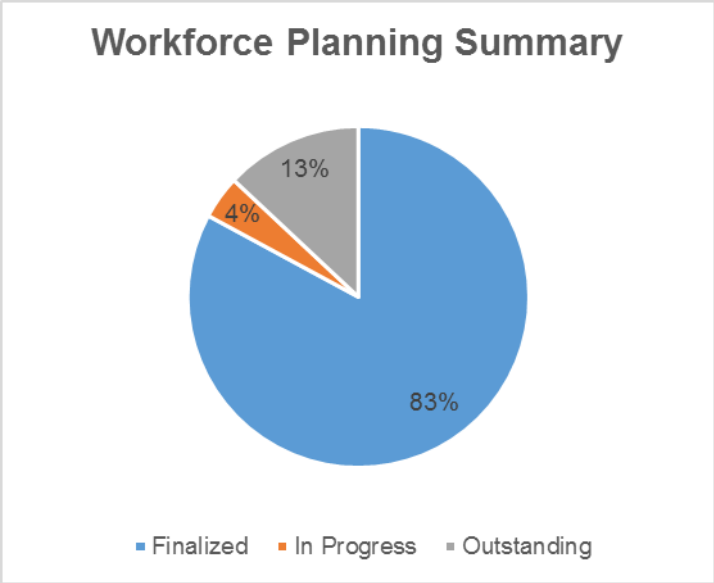
- Foster an "In the North, for the North" recruitment and retention philosophy
- Foster a culture of respect and cultural safety for Indigenous peoples
- Cultivate an organizational approach emphasizing "recruitment and retention – everyone has a role"
- Enhance multi-stakeholder engagement through purposeful partnerships and relationships in support of the recruitment and retention strategy (candidate, employee, community and key stakeholders)
- Identify and determine the metrics to evaluate and inform current and future recruitment and retention strategies

NH's workforce planning process is crucial in the successful recruitment and retention of our workforce. In the end, the overall goal is to have the right people, in the right place, at the right time.

Northern Health Operational Workforce Planning

To support and standardize workforce planning across the health authority, HR Planning and Analytics developed and implemented an innovative workforce planning process. The process facilitates information sharing and identifies leading workforce planning strategies to address workforce challenges. By implementing this strategy, NH is better able to understand our workforce. NH is also better positioned to plan its workforce for future needs enhance engagement with a wide variety of stakeholders (such as post-secondary institutions), and support a sustainable workforce.

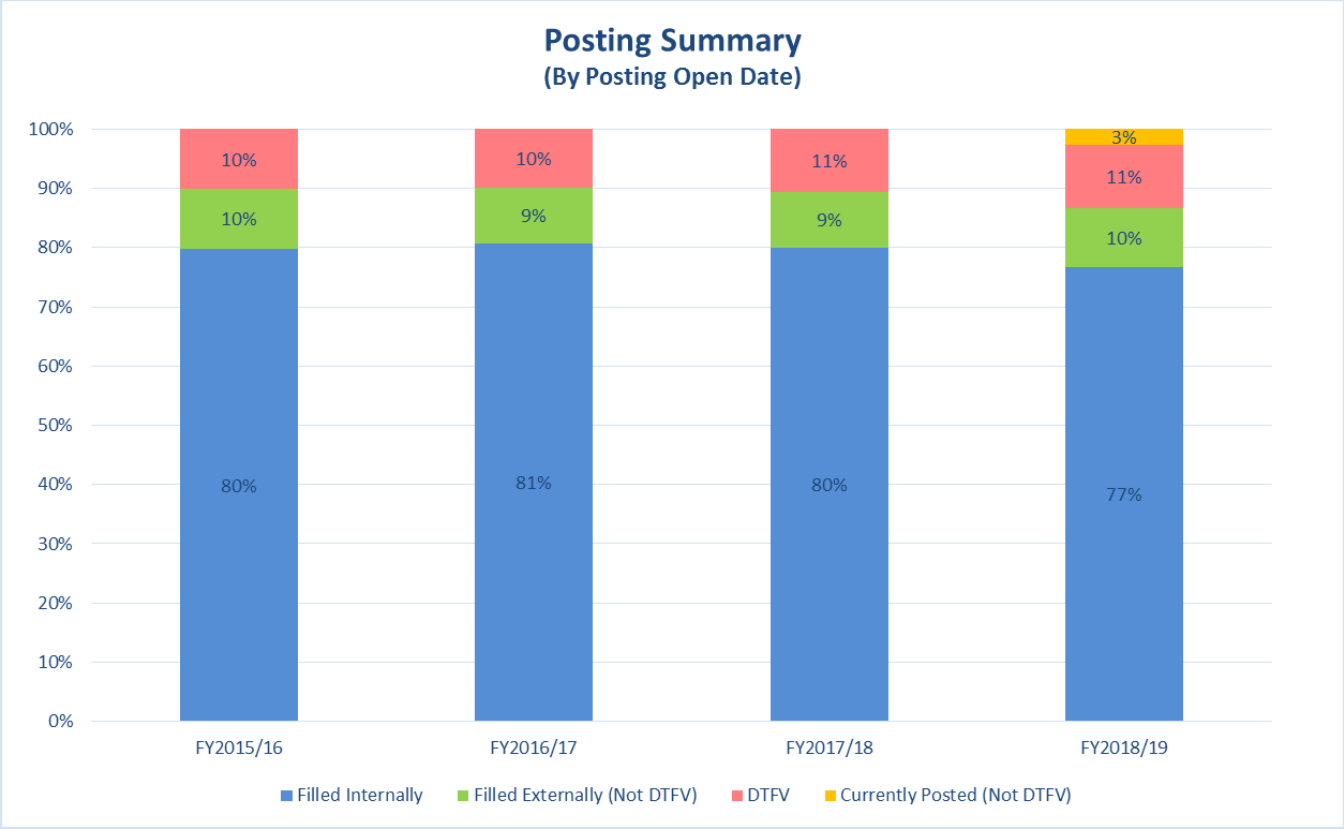
Workforce planning has been implemented in communities and regional programs throughout NH. At the end of the 18/19 fiscal year, 83% of departments had completed workforce planning and completion of the remaining departments is underway. The next phase of workforce planning will include the development of community workforce plans.



Northern Health Recruitment update

In fiscal year 2018/19, NH posted 3657 positions, 77% were filled by internal staff (existing regular and casual staff) and 10% were filled externally (qualified applicants from outside of NH) within 90 days. Some unfilled positions are currently in the competition phase. Positions that remain unfilled for more than 90 days become difficult-to-fill vacancies (DTFV). In addition to the postings that are filled externally, 11% of approximately 3000 external postings go to DTFV.

Casual hires are not reflected in this data. On average, NH hires 1,000 casuals per year, many of these staff successfully bid into permanent, ongoing positions through our internal posting process.



Difficult-to-Fill Vacancies

NH recruitment continues to focus on a variety of ongoing strategies to address difficult-to-fill vacancies. Recent successes of note include:

Position	Community Hired Into
Occupational Therapist	Prince Rupert
International Recruitment: • Registered Nurses	Tumbler Ridge Dawson Creek Prince Rupert Masset
Licensed Practical Nurse	Dawson Creek

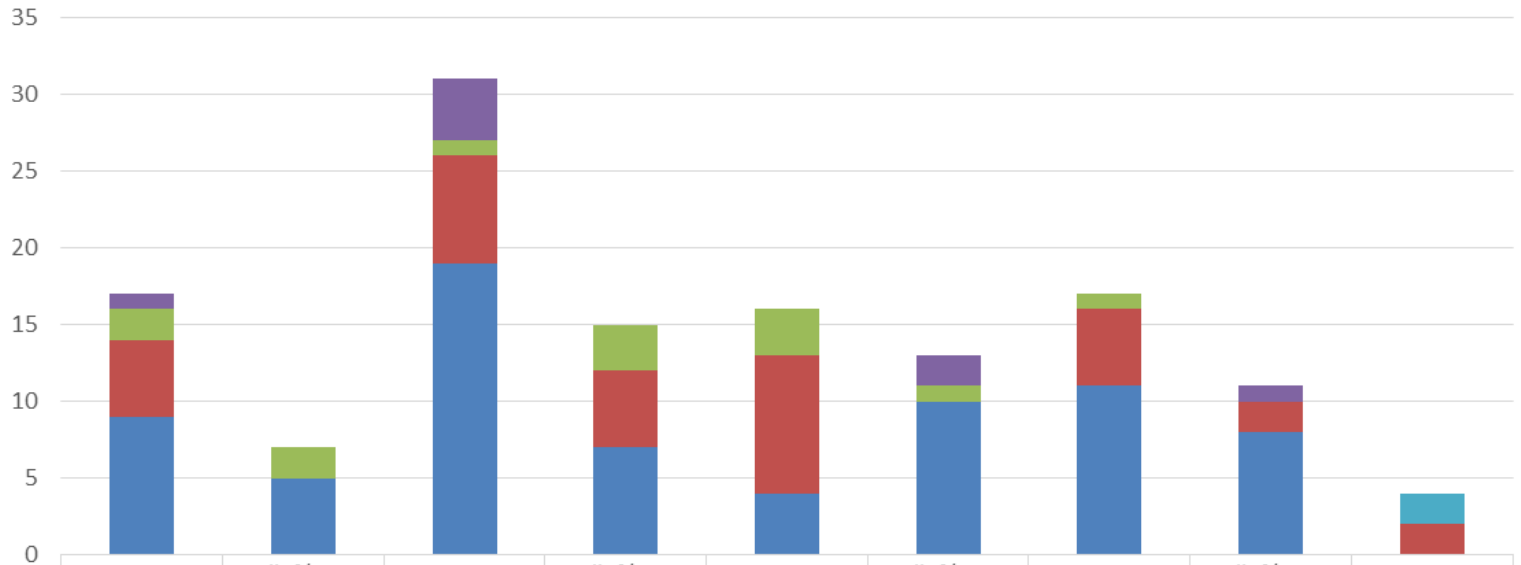
Recruitment strategies pertaining to the philosophies include:

Recruitment Philosophies	Strategies
Foster an "In the North, for the North" recruitment and retention philosophy	• NH has implemented a nurse travel pool serving Hazelton and Fort St. John. • NH collaborates with the Adventures in Health Care program that provides health science exposure through multi day, hands on activities in medical training facilities, colleges, and universities. • NH's "Grow Our Own" program is a program that encourages high school students in northern B.C. to pursue careers in health care in our northern communities. • To reach and engage with newly-graduated nurses, the recruitment team continues to enhance the New Graduate Application Process. o 127 new graduates applied o As of May 17th 83 have accepted positions
Foster a culture of respect and cultural safety for Indigenous peoples	• Collaborate with NH Indigenous Health and First Nations Health Authority (FNHA) and other health authorities to develop an Indigenous Recruitment Strategy
Cultivate an organizational approach emphasizing "recruitment and retention – everyone has a role"	• Implemented new Employee Referral process and program. Since March 2019, 9 employees have been hired through the program.

	• Multi-media recruitment strategies and enhanced branding which includes recently completed community recruitment videos for Mackenzie, and planned videos for Quesnel, Burns Lake, Hazelton, Fort St. John, Dawson Creek and Haida Gwaii. • Attend career and conference events targeting NH's most difficult-to-fill professions in partnership with Health Match BC and operations leadership.
Enhance multi-stakeholder engagement through purposeful partnerships and relationships in support of the recruitment and retention strategy (candidate, employee, community and key stakeholders)	• Leverage partnership with Health Match BC. Health Match BC is a health professional recruitment service funded by the Government of British Columbia. • Targeted strategies with the BC Nurses Union (BCNU) including a planned Pilot Introductory Housing Program and Traveling Nurse Pool. • Participate in the NH Education Programs Planning Collaborative committee that brings together program leaders from post-secondary institutions as well as NH Workforce Planning, Recruitment, and Education Services to develop a framework for communicating northern workforce needs and plan additional programming needs.
Identify and determine the metrics to evaluate and inform current and future recruitment and retention strategies	• Participate in the Workforce Planning Advisory Group to review metrics specific to priority professions. • Monitor changes in supply and demand. • Focused efforts to support recruitment of difficult-to-fill vacancies.

Current Open Difficult-to-Fill Vacancies (DTFV) by Posting Type

As at May 17, 2019



	NI Rural		North East		North West		Prince George		Regional
	Permanent	Relief/Term	Permanent	Relief/Term	Permanent	Relief/Term	Permanent	Relief/Term	Permanent
EXCLUDED									2
COMMUNITY SUBSECTOR	1		4			2		1	
FACILITIES SUBSECTOR	2	2	1	3	3	1	1		
HEALTH SCIENCE PROFESSIONALS	5		7	5	9		5	2	2
NURSES PROVINCIAL AGREEMENT	9	5	19	7	4	10	11	8	

The Face of Northern Health

As at May 17, 2019

Summary of Employees by Status	Headcount	%	FTE
Active: Total	7,933	100%	5,024
Full-time	3,764	47%	
Part-time	1,867	24%	
Casual	2,302	29%	
Non-Active: Total	819	100%	356
Leave	424	52%	305
Long Term Disability (LTD)	395	48%	51

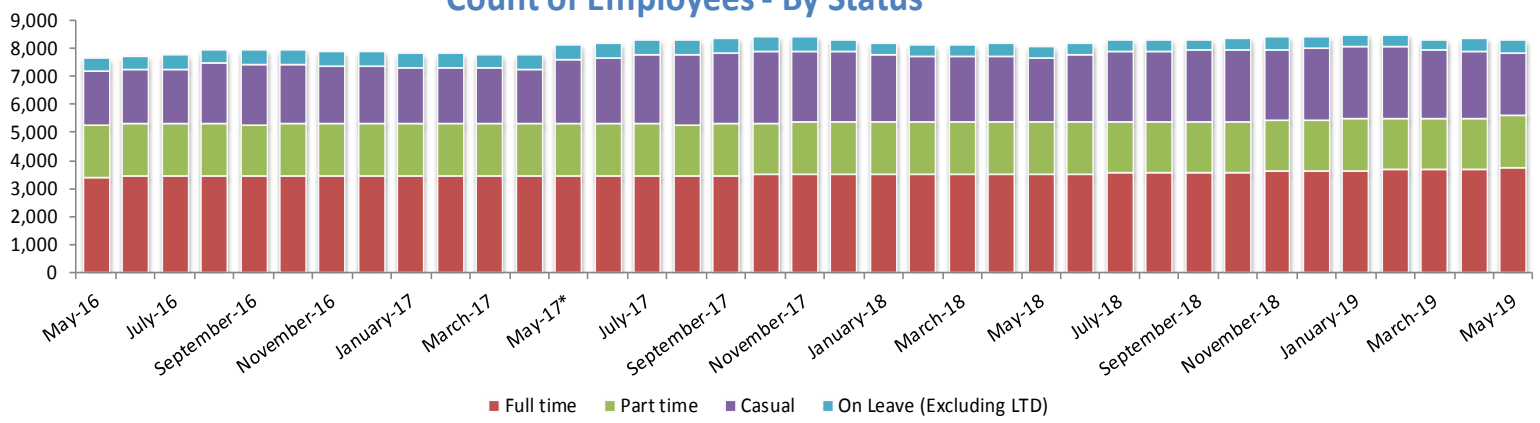
Active Employees by Region	Headcount	%
Active: Total	7,933	100%
North East	1,215	15%
North West	1,890	24%
Northern Interior: Prince George	2,471	31%
Northern Interior: Rural	1,132	14%
Regional	1,225	15%

Active Employees by Collective Agreement	Headcount	%
Active: Total	7,933	100%
Nurses	2,474	31%
Facilities	3,103	39%
Health Sciences	1,047	13%
Community	711	9%
Excluded	598	8%

Active Nursing	Headcount	%
Active: Total	2,474	100%
RN/RPN	1,833	74%
LPN	641	26%

Clinical vs. Support	Facilities	Community
Active: Total	3,103	711
Clinical	1,330	638
Non-Clinical	1,773	73

Count of Employees - By Status



BOARD BRIEFING NOTE

Date:	May 21, 2019	
Agenda item	2018-19 Year End Financial Statements (June Public Board Meeting)	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	Audit & Finance Committee / NH Board of Directors	
Prepared by:	Mark De Croos – VP, Finance & Chief Financial Officer	

Purpose:

To provide an update on the status of the audit of Northern Health's 2018-19 financial statements, and government requirements regarding disclosure of the audited financial statements to the general public.

2016-21 Strategic Plan:

Performance Management Reporting – disclosure of information to the general public on the status of yearend financial statement audit.

Background:

Northern Health ended fiscal year 2018-19 on March 31, 2019. The annual financial statements are being audited by PricewaterhouseCoopers (PwC).

- Upon conclusion of the audit, the audited financial statements will be presented to Northern Health's Board of Directors for approval.

- Following Board approval, the audited financial statements will be submitted to the Ministry of Health for its review and approval to release to the general public. Once Ministry approval is received, Northern Health's 2018-19 audited financial statements will be posted on its website – www.northernhealth.ca.

Recommendation:

For information only.

northern health
the northern way of caring

BOARD BRIEFING NOTE

Date:	May 21, 2019	
Agenda item:	Capital Public Note	
Purpose:	☐ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	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 2018-19 capital expenditure plan in February 2018, and amendments in June and November 2018. The updated plan approves total expenditures of $50.3M, with funding support from the Ministry of Health ($18.5M, 37%), Six Regional Hospital Districts ($16.4M, 33%), Foundations, Auxiliaries and Other Entities ($4.6M, 9%), and Northern Health ($10.7M, 21%).

In 2018-19, $37.9M was spent towards the execution of the plan as summarized below:

$ million	**YTD**	**Plan**
Major Capital Projects (> $5.0M)	4.0	0.9
Major Capital Projects (< $5.0M)	14.5	22.4
Major Capital Equipment (> $100,000)	4.7	7.4
Equipment & Projects (< $100,000)	7.0	8.0
Information Technology	7.6	11.5
	37.9	50.3

Significant capital projects currently underway and/or completed in 2018-19 are as follows:

Northeast Health Service Delivery Area (NE-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Fort St. John	Ultrasound	$0.21	Complete	Fort St. John Hospital Foundation, NH, PRRHD
Fort St. John	X-Ray Rad Rex Room #1	$0.35	Complete	PRRHD, MOH
Fort St. John	Medical Clinic – 3rd Pod Renovation	$2.05	In Progress	PRRHD, NH
Chetwynd	Automated Medication Dispensing Cabinet	$0.13	Complete	MOH, PRRHD
Dawson Creek	Medical Device Reprocessing Renovation	$2.08	In Progress	PRRHD, NH, MOH
Dawson Creek	Business Plan for redevelopment of DCDH Hospital	$5.00	In Progress	PRRHD
Dawson Creek	DCDH Ultrasound Machine Replacement	$0.22	Ordered	NH
Fort Nelson	Automated Medication Dispensing Cabinet	$0.15	Ordered	NRRHD, NH

Northwest Health Service Delivery Area (NW-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Smithers	BVDH CT Suite	$2.90	Ordered, Construction in Progress	Bulkley Valley Healthcare and Hospital Foundation, NWRHD
Smithers	BVDH Digital Mammography	$0.67	Complete	MOH
Smithers	BVDH Radiology Room #1	$0.81	Complete	NWRHD, NH
Terrace	MMH C-Arm	$0.21	Complete	Dr. REM Lee Foundation
Terrace	MMH Portable X-Ray	$0.20	Complete	NWRHD, NH

Community	Project	Project $M	Status	Funding partner (note 1)
Terrace	Business Plan for the redevelopment of Mills Memorial Hospital	$3.50	Submitted to Ministry of Health	NWRHD
Hazelton	Wrinch Boiler Upgrade	$0.30	Project Closing	NWRHD, MOH
Atlin	Clinic Replacement	$1.98	Planning	NH
Kitimat	KGH Fire Alarm System Panel	$0.29	Construction In Progress	NWRHD, NH
Kitimat	KGH General Radiographic Room	$0.87	Project Closing	NWRHD, MOH
Kitimat	KGH Phone System	$0.33	Ordered	NWRHD, MOH

Northern Interior Service Delivery Area (NI-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
McBride	Ventilation System	$1.43	Closing	FFGRHD, NH
Prince George	Parkwood Reverse Osmosis	$0.60	Ordered	MOH, NH
Prince George	Phoenix Outpatient Lab Renovation	$0.42	Construction In Progress	FFGRHD, MOH
Prince George	UHNBC C-Arm	$0.28	Ordered	FFGRHD, MOH
Prince George	UHNBC Hematology Autoimmune	$0.10	Complete	FFGRHD, MOH
Prince George	UHNBC Microbiology Blood Culture Analyzer	$0.11	Complete	FFGRHD, MOH
Prince George	UHNBC Microbiology Vitek 2XL	$0.20	Ordered	FFGRHD, MOH
Prince George	UHNBC Tomosynthesis	$0.19	Ordered	Spirit of the North Healthcare Foundation
Prince George	Jubilee Lodge/UHNBC Rehab Nurse Call System	$0.30	Complete	FFGRHD, MOH
Prince George	UHNBC Domestic Hot Water Upgrades	$1.03	Construction In Progress	FFGRHD, MOH
Prince George	UHNBC Electrical Supply Upgrade	$3.95	Complete	MOH, FFGRHD, NH
Prince George	UHNBC Inpatient Bed Capacity Project	$8.00	Construction In Progress	MOH, FFGRHD, NH

Community	Project	Project $M	Status	Funding partner (note 1)
Prince George	UHNBC Maternal OR	$0.88	Project Closing	Spirit of the North, FFGRHD, NH
Prince George	UHNBC OR Video Towers	$0.32	Complete	Spirit of the North Healthcare Foundation
Quesnel	GR Baker Urgent Primary Care Centre	$0.10	Project Closing	NH
Quesnel	GR Baker ER/ICU Addition	$27.0	Planning	MOH, CCRHD
Vanderhoof/ Southside	Phone Systems	$0.26	Complete	SNRHD, NH
Burns Lake	The Pines Cafeteria Expansion	$3.75	Construction In Progress	SNRHD, NH, MOH
Fraser Lake	FLC X-Ray	$0.53	Project closing	SNRHD, NH, MOH
Fort St. James	Primary Care Leasehold Improvement	$3.40	In Progress	SNRHD, NH
Fort St. James	Business Plan for redevelopment of Stuart Lake Hospital	$3.00	Planning	SNRHD

Regional Projects

Community	Project	Project $M	Status	Funding partner (note 1)
All	Health Link North: Cerner Upgrade	$4.5	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Community Health Record (Phase 3)	$4.90	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Clinical Interoperability	$1.0	Work In Progress	NH
All	PACS and Cardiology Information System	$3.48	Work In Progress	CCRHD, FFGRHD, NRRHD,

Community	Project	Project $M	Status	Funding partner (note 1)
				NWRHD, PRRHD, SNRHD, NH
All	MySchedule Enhancements	$0.19	Complete	NH
All	MySchedule – Smart Leave, Annual Vacation	$0.29	Work In Progress	NH
All	Northern Community Telehealth Expansion	$0.35	Work In Progress	Joint Standing Committee
All	Secure Texting	$0.79	Work In Progress	NH
All	Clinical Data Repository (CeDaR)	$1.53	Work 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 2018-19, NH spent $7.0M 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:

That Audit & Finance Committee recommend the following motion to the Board:

The Northern Health Board receives the Period 13 update on the 2018-19 Capital Expenditure Plan.

BOARD BRIEFING NOTE

Date:	June 10, 2019	
Agenda item	Overdose Prevention and Response Update	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	Northern Health Board of Directors	
Prepared by:	Kerensa Medhurst, Project Manager Overdose Prevention and Response	
Reviewed by:	Dr. Sandra Allison and Michelle Lawrence	

Background: Canada is facing a national opioid crisis affecting almost every region in the country. BC continues to see the highest total number of opioid related deaths and Northern BC remains one of the most impacted areas within BC. Fentanyl and other fentanyl-related substances continue to be a major driver of this crisis. This is a complex health and social issue requiring a response that is comprehensive, collaborative, compassionate and evidence-based.

The response has involved engagement with people with lived experience, public education and targeted information campaigns, enhanced data collection and analyses, increased access to evidence-based treatment for opioid use disorder and rapid distribution of naloxone to reverse overdoses. Early findings of the overdose response strategies have shown that many lives have been saved through these efforts. Despite these lifesaving activities, the BC Coroners Service reports that the number of deaths has continued to rise and remains at consistently high levels throughout the province.

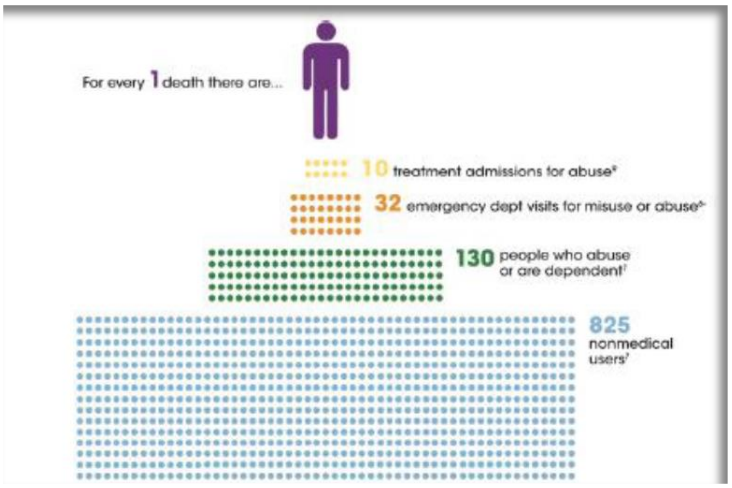
In just a few years the number of illicit drug deaths has surpassed the combined total deaths due to suicides, homicides and motor vehicle collisions and is now the leading cause of unnatural death in BC. The BC Coroners Service reports the number of deaths in BC due to illicit substance use continues to rise, from 1486 in 2017 to 1489 in 2018.[1] Despite Northern Health's focus on the public health emergency, from 2017 to 2018 NH saw a 35% increase in the number of illicit drug deaths within our region. NH also has the second highest rate of illicit drug deaths for 2018, with 31 deaths per 100,000, trailing behind Vancouver Coastal Health with 36 deaths per 100,000. Efforts underway are working to save lives; however, the number of northern British Columbians dying from and vulnerable to overdose remains unacceptably high.

[1] BC Coroners Service. (2018). Illicit Drug Overdose Deaths in BC January 1, 2008 – November 30, 2018. Retrieved from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and divorce/deaths/coronersservice/statistical/illicit-drug.pdf.

Illicit Drug Deaths in Northern Health[2]

	Northern Health	Northern Interior	Northeast	Northwest
2018	88	57	20	11
2017	65	35	22	8

Figure 1. Burden of Problematic Substance Use



Although the number of deaths is the most used indicator of the extent of this issue, it is important to remember that as demonstrated in Figure 1[3] opioid deaths represent the tip of the iceberg as to how far reaching the impact is. For every death, there are hundreds of non-medical users. For every death there are family members, friends, peers who are also greatly impacted. Another impact of an overdose is brain damage that is a severe life altering consequence leading to a significant burden of disability.

Provincially, the Ministry of Mental Health and Addictions has established an Overdose Emergency Response Centre (OERC) to oversee the provincial response. The OERC plan is built on eight core interventions:

[2]BC Coroners Service. (2018). Illicit Drug Overdose Deaths in BC January 1, 2008 – November 30, 2018. Retrieved from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and divorce/deaths/coronersservice/statistical/illicit-drug.pdf.
[3] Figure from a presentation by Catriona Remocker, Centre for Addictions Research of BC and Dan Reist, Centre for Addictions Research of BE.

Northern Health has established a Regional Response Team supported by Local Implementation Teams to develop regional and local level actions. Supporting the community based actions are community action teams (CATs) in Fort St John and Prince George which have been funded by the Ministry of Mental Health and Addictions to enable local action based strategies. Funding provided to the CATs as been extended for an additional year.

Overall, an effective response to this crisis requires a whole system approach, a broad spectrum of services, as well as an enabling environment. The following section will outline the current activities in these categories.

Current Activities:

1. Barrier Reduction

NH championed the nationally recognized *Stop Stigma, Save Lives* campaign. The campaign featured people with lived experience from Quesnel and Prince George, speaking to the realities of their every day. Following on the campaign, a new regional position has been created to address and reduce stigma within the Northern Health system of services. This new role will plan and develop an organizational assessment and implementation strategy aimed at creating more supportive health care environments for patients that use illicit substances.

2. Harm Reduction

Take Home Naloxone

A robust infrastructure has been created for the Take Home Naloxone (THN) program. NH has actively increased awareness of community THN programs through targeted communication campaigns to NH staff and through our external website to the general public. Partnerships have also strengthened existing relationships with First Nations communities, community-based organizations, pharmacies, corrections, housing providers and other stakeholders across our region.

Overdose Prevention Services/ Monitored Consumption

Services are provided in Prince George through the Prince George Needle Exchange. The overdose prevention site was opened in December of 2016, since then the average number of people using the site per week has increased by 81% and the staff at the site have responded to at least 171 overdoses and 13, 288 visits. Conversations continue regarding how these services may be expanded to serve a greater proportion of our northern population.

3. Treatment

Opioid Agonist Therapy (OAT) is a lifesaving intervention. Of approximately 5,000 people living in the Northern Health catchment with Opioid Use Disorder, about 500 are currently on OAT. Efforts are ongoing to increase providers of OAT, access to OAT and retention of patients on OAT. Further enhancements to service provision include collaborative models developed with the First Nations Health Authority to serve communities across the north such as the Mental Health and Substance Use Mobile Support Teams that seek to meet community needs in innovative ways.

4. Prevention

An often-neglected aspect of an addictions response is primary prevention for reducing the impact on future generations. Interventions include addressing the roots of addiction including trauma, social isolation, chronic pain, mental health and poverty. Prevention is better than treatment and even small early interventions can make a big difference.

Community Engagement

Peer Engagement

Currently there are four peer led organizations operating in the communities of Quesnel, Prince George, Terrace and Dawson Creek. All of these groups receive funding through external sources. Peers actively distribute harm reduction supplies, train and distribute naloxone as well as provide drug checking services. Much of this time is volunteered.

Wrap Around Services

Continuity of care for people who use substances is a crucial component of an overdose response, and work is currently underway to enhance linkages between Emergency Departments, community services, and first responders in a timely and measurable way. Initial focus is on the Emergency Department and active followup by community programs for individuals who have overdosed or who are identified to be at risk for overdose.

Community Inclusion

BC Centre of Disease Control in partnership with the First Nations Health Authority, provincial health authorities and peers continue to offer Compassion, Inclusion and Engagement (CIE) sessions in the north including in the communities of Terrace, Prince George, Quesnel and Fort St John. These sessions have supporting the further development of community relationships in order to bridge gaps in understanding. The clean team, a peer run service, in Quesnel was one successful program that came as a result of the CIE session there.

Gaps and Next Steps

In the face of this extraordinary emergency Northern Health has responded with evidence based solutions, commitment and innovation. However, there is much more work that needs to be done. Some key areas where work will continue to expand include:

- Ongoing strengthening of harm reduction and treatment services.
- Increased surveillance/ monitoring and evaluation including the development of regional and local targets.

- Focused chart reviews based on recently released identifiable data from the BC coroner to better understand the population at risk.
- Expansion of existing overdose prevention services (including mobile mental health service models)
- System changes involving policy, stigma reduction, and peer engagement

BOARD ROLE AND GOVERNANCE OVERVIEW V1 **BRD 200**

Introduction

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

Principal Stakeholders

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

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

Board Size

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

Deleted: comprised

Best Interest of Northern Health

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

Director's Terms

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

Deleted: Board Resourcing and Development Office (BRDO)

Terms of Reference

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

[1] This is the normal complement and can be more or fewer as circumstances warrant
[2] A Director's first term is usually a 1-year appointment. The final decision rests with the Minister of Health.
Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 12, 2017 (R)

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

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

Key Board Responsibilities

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

Board Committees

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

Author(s): Governance & Management Relations Committee
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Date Issued (I), REVISED (R), reviewed (r): June 12, 2017 (R)

Task Forces

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

Board Meetings and Agenda

1. The Board meets at least six times within the calendar year.
2. The Board may also meet at the call of the Board Chair or in his/her absence, the Deputy Chair or as provided for in the Bylaws. (Policy BRD600)
3. The GMR Committee develops the agenda for each Board meeting in consultation with the CEO and the Corporate Secretary.
4. Under normal circumstances, the agenda and meeting material will be distributed to Directors ten days[3] before the meeting.
5. It is normal Board practice for all agenda items to be considered at the appropriate committee meetings prior to being placed on the Board agenda. A Director or the CEO may, however, suggest urgent additions to the agenda through the Board Chair prior to adoption of the Board agenda. (Policy BRD530)
6. A consent agent package will be provided with materials for the interest of the Board members for information only. This information will not be discussed during the Board meeting; however, there will be opportunity at the beginning of each Board meeting to review the consent agenda material and move items to the regular agenda for discussion.
7. Article 6.9 of the Board by-laws indicates that meetings will be conducted in accordance with Robert's Rules of Order. The Board will, however, normally conduct its business based on consensus unless Robert's Rules of Order become necessary.

Public Board Meetings

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

Board Meetings without Management

1. Practices that provide opportunity to build relationships, confidence and cohesion among Directors are essential to allow the Board to develop an understanding of its role. One such practice is a regular meeting of Directors without management present, usually at a predetermined time scheduled during the regular Board meeting time period.

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

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 12, 2017 (R)

2. Such meetings can be used to provide feedback about Board processes, including the adequacy and timeliness of information being provided to the Board. At times, such meetings might also focus on substantive issues that may be more difficult for some Board members to discuss with management present. They can also provide opportunities for the Board Chair to discuss areas where the performance of the Directors could be strengthened.
3. It is important that these opportunities occur regularly, even if the meetings are short, so that they become a recognized and accepted governance practice. Any issues arising in these sessions that bear on the relationship between the Board and management should be communicated quickly and directly to the CEO by the Board Chair.

Non-Directors at Board Meetings

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

Board/Management Relations

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

New Director Orientation and Continuing Director Development

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

Deleted: and this component is to be included at every Board meeting

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

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 12, 2017 (R)

Assessing Board Performance

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

Outside Advisors for Committees and Directors

Occasionally, a committee or a Director may need the services of a consultant or an advisor to assist with matters involving their responsibilities. A committee or Director wishing to engage an outside advisor at the expense of Northern Health must first obtain the authorization of the Board Chair or the Chair of the Committee, normally in consultation with the CEO.

Transparency

The Board will publish, on the Northern Health website, the following:

a. The name, appointment term, and a comprehensive biography for each Director

b. In compliance with Treasury Board Directive 2/17, section 4.5.6, the compensation paid to each director for the preceding year

c. The records of activities and decisions of the Board, including agendas, minutes and board policies

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): June 12, 2017 (R)

CODE OF CONDUCT AND CONFLICT OF INTEREST GUIDELINES FOR DIRECTORS V.1 BRD 210

Introduction

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

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

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

Northern Health is continually under public scrutiny. Therefore, Directors must not only comply fully with the law, but must also avoid any situation which could be perceived as improper or indicate a casual attitude towards compliance. Directors must be familiar and compliant with the Integrated Ethics Framework[2], including using the ethical framework to guide Board decision-making.

Conflicts Of Interest

1. In general, a conflict of interest[3] exists for Directors who use their positions on the Board to:
    a. Benefit themselves, friends, relatives[4], or business associates, or
    b. Benefit other corporations, societies[5], suppliers, unions or partnerships in which they have an interest or hold a position, or

[1] Throughout this policy, when Directors are requested to seek clarification or make a declaration, unless specific direction is otherwise given, Directors shall consult with either the Board Chair, the CEO, or the Corporate Secretary.
[2] Northern Health Integrated Ethics Framework
[3] *Conflict of interest* can be real or apparent; direct or indirect.
[4] *Relatives* generally means a spouse, child, parent or sibling of a Director and can include other relatives, direct or through marriage.
[5] Refer to *Schlenker v. Torgrimson 2013 BCCA 9*

Author(s): Governance & Management Relations Committee
Issuing Authority: Northern Health Board
Date Issued (I), REVISED (R), reviewed (r): April 16, 2018 (R)

c. Benefit the interests of a person to whom the Director owes an obligation.

The above are hereafter collectively referred to as "Related Persons[6]".

2. A Director must not take personal advantage of an opportunity available to Northern Health unless the Board or management has clearly and irrevocably decided against pursuing the opportunity, and the opportunity is also available to other Directors or the public.
3. A Director must not use his or her position with Northern Health to solicit clients for the Director's business or Related Persons.
4. Every Director must avoid any situation in which there is, or may appear to be, potential conflict which could appear[7] to interfere with the Director's judgment in making decisions in Northern Health's best interest.
5. There are several situations that could give rise to a conflict of interest. The most common are accepting gifts, favours or kickbacks, or the passing on of confidential information and using privileged information inappropriately.

Disclosure

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

1. Full disclosure enables Directors to resolve unclear situations before any difficulty can arise.
2. At the beginning of each meeting of the Board, or of one of its Committees or Task Forces, there shall be a standing agenda item requiring each Director present to declare any conflict of interest he/she may have with any item of business on the agenda.
3. Outside of meetings, a Director must, immediately upon becoming aware of a potential conflict of interest situation, disclose the conflict in writing to the Board Chair. This requirement exists even if the Director does not become aware of the conflict until after a transaction is completed.
4. If a Director is in doubt whether a situation involves a conflict, the Director must immediately seek the advice of the Board Chair or the Chair of the Governance and Management Relations Committee (GMR). It may also be appropriate to seek legal advice.

[6] Not an exhaustive list, merely representative.

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

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5. Unless a Director is otherwise directed by the Board Chair, a Director must immediately take steps to resolve the conflict or remove the suspicion that it exists.
6. If a Director is concerned that another Director is in a conflict of interest situation, the Director must immediately bring his or her concern to the other Director's attention and request that the conflict be declared. If the other Director refuses to declare the conflict, the Director must immediately bring his or her concern to the attention of the Board Chair. If there is a concern with the Board Chair, the issue should be referred to the Chair of GMR.
7. A Director is required to disclose the nature and extent of any conflict at the first meeting of the Board after which the facts leading to the conflict have come to that Director's attention. After disclosing the conflict, the Director:
   a. must not take part in the discussion of the matter or vote on any questions in respect of the matter. However, the Director may be counted in the quorum present at the Board meeting.
   b. may, if the meeting is open to the public, remain in the room, but shall not take part in that portion of the meeting during which the matter giving rise to the conflict is under discussion, and shall leave the room prior to any vote on the matter giving rise to the conflict.
   c. must, if the meeting is not open to the public, immediately leave the meeting and not return until all discussion and voting with respect to the matter giving rise to the conflict is completed.
   d. must not attempt, in any way or at any time, to influence the discussion or the voting of the Board on any question relating to the matter giving rise to the conflict.

Outside Business Interests

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

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3. These restrictions apply equally to interests in companies that may compete with Northern Health in any of its areas of activity.

Confidential Information

1. Confidential information includes personal, proprietary, technical, business, financial, legal, or Director information, which the Board or management treats as confidential.
2. Directors may not disclose such information to any outside person unless authorized.
3. Similarly, Directors may never disclose or use confidential information gained by virtue of their association with Northern Health for personal gain, or to benefit Related Persons.

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

Investment Activity

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

Outside Employment or Association

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

Public Office

1. No one who holds public elected office[8] is eligible to be a Director of Northern Health unless otherwise directed by the Crown Agency Board Resourcing Office (CABRO).
2. A Director may run for provincial or federal public office while a member of the Board, and shall while campaigning:
    a. Take a paid leave of absence from the Board, or

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

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b. Attend Board and Board Committee meetings with the proviso that:

i. At the start of each meeting the Director's candidacy for elected office is declared and minuted, and

ii. The Director excuses[9] themselves from any discussion/vote that could be viewed as partisan, and

c. Not speak on behalf of Northern Health, and

d. Not refer to their work on the Board other than a factual declaration of Board membership in their biography.

3. If elected, the Director must resign immediately unless otherwise directed by the Board Resourcing Office.

Entertainment, Gifts and Favours

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

Use of the Authority's Property

1. A Director requires Northern Health's approval to use property owned by Northern Health for personal purposes, or to purchase property from Northern

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

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Health unless the purchase is made through the usual channels also available to the public.

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

Social Media

Directors' use of social media is appropriate; however Directors must be aware of the actual or potential effect of their comments or statements when they are recognised as Directors, regardless of whether the statements are made while acting personally or on behalf of Northern Health. Members of the public may be unable to distinguish the personal and fiduciary roles a Director holds, which can lead to an actual or apparent conflict of interest.

1. If participating in social media on behalf of Northern Health, prior approval and coordination must be arranged through the Northern Health Communications Department.
2. If participating in social media personally, Directors should:
    a. If identifying as a Northern Health Director, or discussing Northern Health interests, include a non-affiliation statement such as "The views expressed here are my own and do not necessarily reflect the views of Northern Health"
    b. Ensure confidentiality is not breached, by refraining from discussing patient personal information or other Northern Health confidential information.
    c. Avoid any activity that could bring Northern Health into disrepute, including defamation, discrimination, or harassment.
    d. Be respectful of copyright law

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3. Directors are encouraged to participate in official Northern Health social media channels by commenting and sharing posts for the purpose of celebrating and sharing positive stories about Northern Health.

Responsibility

1. Each Director must adhere to the standards described in this Code of Conduct, and to the standards set out in applicable policies, guidelines or legislation.
2. Integrity, honesty, and trust are essential elements of Northern Health's success. Any Director who knows or suspects a breach of this Code of Conduct and Conflict of Interest Guidelines has a responsibility to report it to the Board Chair.
3. To demonstrate determination and commitment, Northern Health requires each Director to review and sign the Code annually. The willingness and ability to sign the Code is a requirement of all Directors.

Breach of Code

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

Where to Seek Clarification

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

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DIRECTOR DECLARATION FORM

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

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

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

☐ None

_____

_____

_____

_____

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

☐ None

_____

_____

_____

_____

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

☐ Yes ☐ No

Describe:

_____

_____

_____

_____

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

☐ Yes ☐ No

Describe:

_____

_____

_____

_____

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

_____
Signature

_____ _____
Print Name Date

_____ _____
Corporate Secretary Date

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COMMUNICATION POLICIES V1 **BRD 220**

This document includes all Board policies that relate to communication:

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

1. BOARD INTERNAL COMMUNICATIONS POLICY

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

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

Critical or Politically Sensitive Information

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

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

On-going Major Regional Operations Issues Information

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

Duties and Responsibilities

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

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

Monitoring

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

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2. MEDIA RELATIONS PROTOCOL

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

Deleted: comprised

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

Guiding Principles for Directors (See BRD 140)

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

Communications Roles and Responsibilities

Board Chair:

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

Directors:

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

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

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

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CEO:

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

Communications Staff:

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

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

3. BOARD MEETINGS POLICY

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

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

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

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

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

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

Board Meeting Locations

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

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

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

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

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

In-Camera Board Meeting

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

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

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

Open Board Meetings

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

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

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

Open Board Meeting Procedures

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

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

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

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

Public Presentations

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

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

Requests to Address the Board

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

Instructions shall be posted on the Northern Health website.

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

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

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

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

Public Presentation Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

As follow up to any presentations made to the Board:

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

Regional Hospital District engagement

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

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

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

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

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

Community round table session

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

This meeting may:

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

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

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

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

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

Media availability

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

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

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

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

SCHEDULE A: Distance Access to Northern Health Board Meetings

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

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

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

Telecommunications Access to Northern Health Board Meetings

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

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

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

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

Procedure for Telecommunications Connection

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

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

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

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EXECUTIVE LIMITATIONS V1 **BRD 230**

Purpose and Scope

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

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

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

Policy Principles

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

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

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8. The Board authorizes the CEO to set travel expense reimbursement rates for excluded employee expenses, including but not limited to travel costs, per diem meal claims and mileage. Limitations should be set in consideration of Ministry of Finance Policy 10.0 Travel[2]. The Audit and Finance Committee is to be provided, as information, the NH Travel Expense Reimbursement policy at minimum annually or when a revision has been made.
9. The CEO is not authorized to approve financial transactions where the CEO has a conflict of interest or where there are reasonable grounds to believe that there may be or may be seen to be a potential conflict of interest. The CEO must not approve a transaction that might confer a personal benefit. This includes expenditures such as all expense reimbursement claims, conference fees, educational expenses, travel expenses, advances, membership fees, items that could be used personally, and items that are intended to be located within an individual's home.
10. The Chief Financial Officer (the "CFO"), or the CFO's delegate, is authorized to approve financial transactions related to regulatory payments, utilities and payroll deductions without limit
11. The CFO will maintain a listing of all financial transactions greater than $1 million and will report annually to the Audit and Finance Committee of the Board

Designations

The CEO may designate limits of spending authority to the CFO, Chief Operating Officers, Vice Presidents, and other senior management staff with specific areas of responsibility. A Signing Authority Policy[3] outlining any such designated spending authorities will be maintained.

[2] http://www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/10_Travel.htm
[3] DST 4-4-2-030
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APPENDIX 1

Restrictions of Authority

The CEO and any other personnel to whom authority and responsibility has been delegated, are restricted as to signing authority for the following[4]:

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

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

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

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

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

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

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

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

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

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4. Operating Expenditures

4.1. Routine operating expenditures within the Board approved Operating Budget may be authorized by the CEO or as designated in the Signing Authority Policy (DST 4-4-2-030)

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

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

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

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

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

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

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

5 Compensation and Benefit Programs

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

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

5.2 The CEO:

5.2.1 Shall provide to the Board for approval an annual compensation plan that ensures that compensation and benefits for non-contract staff are consistent with the Health Employees Association of BC ("HEABC") compensation plans

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

5.2.3 Shall not promise or imply lifelong employment to anyone

5.2.4 Shall not change his/her own compensation or benefits

6 Collective Agreements

6.1 Only the Board has the authority to ratify collective agreements.

7 Banking

7.1 The Board approves the appointment of the banking institution/s and the appointment of the signing officers for banking purposes[5]

8 External Auditor

8.1 The Board will appoint the external auditor

9 Non-Audit Services

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

10 Shared Services

10.1 The Board will authorize all shared services agreements

10.2 Agreements for shared services shall:

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

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

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

[5] See Banking Policy 4-4-6-040

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10.3 The CEO shall put processes in place to ensure that:

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

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

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

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

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

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FACILITY AND FUND NAMING POLICY BRD 240

POLICY

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

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

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

DEFINITIONS

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

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

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PROCEDURE

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

NAMING COMMITTEE – TERMS OF REFERENCE

1. **Standing members of the Naming Committee are:**
   - Vice President, Financial & Corporate Services/CFO
   - COO of applicable HSDA in which asset resides
   - Regional Director, Capital Planning and Support Services
   - Regional Director, Business Development
   - Chief Communications Officer/Regional Director, External Relations
   - Ad hoc members will be appointed to the Naming Committee as set out under the Approval by Asset Section of this policy.
   - Naming Committee Chair: Selected by committee members or appointed by CEO

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2. Duties and Obligations:

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

3. Evaluation Criteria (Applicable to all Naming Requests):

1. The naming of any asset must be compatible with NH's goals, mission, vision and values as articulated in NH's Strategic Plan.
2. No naming opportunity should be approved if it:
   a. May be inconsistent with Northern Health's legal obligations
   b. Is likely to result in an employee of a public sector body or an elected official receiving any benefit or personal gain
   c. Is likely to have a negative impact on the image or reputation of or damage public respect for NH or any of its affiliated Foundations and Auxiliaries.
   d. Conveys a message that might be deemed to be prejudicial to race, religion, gender, or sexual orientation, or cause offence to a community group.
   e. Is likely to be associated with an unhealthy lifestyle (e.g. alcohol or tobacco usage, obesity etc.)
   f. Implies endorsement of a partisan political, ideological or religious position. This includes use of the name of an elected official currently in office but does not preclude use of the name of an individual who has previously held public office.

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g. Implies endorsement of a specific commercial product. This does not preclude using the name of an individual or company that manufactures or distributes commercial products.

3. Naming associated with a particular facility or endowment will not preclude further naming within the facility, program or clinical area.
4. Naming opportunities supported by financial or in-kind gifts may be named after the donor or a third party at the request of the donor.
5. Except where the naming opportunity pertains to the recognition of distinguished service, donations must represent a significant portion of the cost of the facility or activity to be named and/or be critical for the completion of such facility or activity.
6. Where a naming request proposes to honour distinguished service of Board members, staff or physicians, it is recommended that at least three years has passed after the nominee has ended their service with Northern Health or an affiliated Foundation or Auxiliary.
7. Any revenue generated from a naming opportunity that is obtained through a capital campaign organized by a Foundation or Auxiliary affiliated with Northern Health or submitted to the Naming Committee by a Foundation or Auxiliary affiliated with Northern Health will be retained by such Foundation or Auxiliary and used in accordance with the donor's wishes. Final determination of any naming, however, remains with Northern Health. In all other cases, the Naming Committee will make a recommendation as to how revenue should be distributed (including, in the case of Northern Health, which department will receive all or any portion of the proceeds) provided that the donor's wishes will be honoured to the greatest extent possible.
8. When naming recognition has been extended for a gift received, it will be honoured in accordance with the agreement that is made with the donor. In the event of a change in circumstances that would preclude honouring of the donor's wishes, NH reserves the right to determine the form of name recognition in consultation with the donor, or donor's agent, when possible.
9. Where a naming request proposes to honour an individual, it is recommended that the Naming Committee obtain some form of documentation verifying that the person being honoured is in agreement with the proposal, or by a legal representative should the individual be deceased.
10. When the proposed naming of an entire facility would recognize an individual, the complete name of the individual will be used. The surname of the individual so honoured may be used in referring informally to the facility and may be used on a name plaque affixed to the facility.
11. For Class I naming requests, community consultation should be considered, including but not limited to: First Nations communities, local government and provincial political leaders, local support societies and advocacy groups

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4. Additional Criteria for Distinguished Service Nominations (Without Financial Consideration)

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

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

5. Internal Naming Requests

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

6. Process to Revoke or Change a Naming Right

A naming right may be revoked or changed at any time by the applicable approving agent upon recommendation of the Naming Committee. Any recommendation put

forward by the Naming Committee must provide the applicable approving agent with the following information:

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

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

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NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
Pricing	The Naming Committee will assess the value of a naming right in accordance with current capital and operating costs of the applicable asset, and/or other factors pertinent to the asset.					
Term	A defined period of time (normally not to exceed 35 years) or the life of the structure, whichever occurs first	A defined period of time (normally not to exceed 20 years) or the earlier of the life of the internal facility or the life of the building housing the internal facility, whichever occurs first	A defined period of time (normally not to exceed 10 years) or commensurate with funding support for the room, lounge or the length of the program, whichever occurs first	The length of the equipment's useful life	A period of time commensurate with funding support	Negotiable
Approving Agent	Northern Health Board, upon recommendation of the CEO and GMR Committee The CEO will consult with, and receive the recommendation of, the Naming Committee prior to submitting a final recommendation to the GMR Committee and the Board. Before submitting a name for approval to the Board, preliminary discussions should be held with the provincial government to		CEO, upon recommendation of the Naming Committee	COO responsible for the site(s) or clinical area(s) where the equipment will be used, upon recommendation of the Naming Committee	The Naming Committee will delegate the naming of a tribute marker to the appropriate Chief Operating Officer	

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NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
	ensure there will be no government barrier to approval.					
Additional Provincial Government Approval	Where the proposed naming of an entire facility, or significant portion thereof, is to receive Board approval, additional consultation with the provincial government is required to ensure compliance with government policy. Refer to "Government of British Columbia Naming Privileges Policy" (Appendix 2.) In some cases, further approval from Cabinet may be required. Prior to submitting recommendation for GMR and Board approval: For naming opportunities for all classes of asset that are accompanied by a financial or in-kind contribution, complete the "Naming Request Form" appended to the Government of British Columbia Naming Privileges Policy and submit to the applicable government Ministry. An additional step is required for Class I (entire facility) assets. Upon confirmation that the responsible government Ministry requires no further approval, further application must be made as follows:					

NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
	Hospital: This type of facility is designated under the *Hospital Act* by way of a Ministerial Order. Any change to an existing facility name requires the Ministry of Health to rescind the original designation and re-designate the facility with the new name. Residential Care Facility: This type of facility falls under the *Community Care & Assisted Living Act*. The facility is licensed by the Health Authority (therefore a Ministerial Order is not issued by government); the name of the facility is designated by way of the Health Authority's licensing process. As a courtesy, the Ministry of Health should be consulted during the naming process, prior to the facility being licensed. Upon consultation with the appropriate provincial government bodies, proceed with GMR recommendation/Board approval process.					

APPENDIX 1

ASSET NAMING NOMINATION FORM

**Format: Electronic fillable form linked above & Regular form attached next page*

APPENDIX 2

Government of British Columbia "Naming Privileges Policy"

APPENDIX 3

Government of British Columbia "Naming Request Form"

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northern health
the northern way of caring

Asset Naming Nomination Form

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Name of donor or sponsoring entity	Contact information

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

For proposed name honouring an individual (if applicable)

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

Consideration for naming opportunity (if applicable)

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

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

Association of proposed name to the asset being named

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

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

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

Source(s) of above information

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

10-300-7052 (LC - Appr - 05/15)

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CORPORATE CONDUCT **BRD 260**

Introduction

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

The Board is obliged to ensure that Northern Health establishes and maintains standards of conduct that all personnel are expected to follow, approved by the Public Sector Employers' Council, in order to address taxpayer accountability principles.

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

Policy Scope

Management shall ensure policies are developed for standards of conduct and other corporate issues[1] as deemed prudent and reasonable:

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

Compliance

The Board expects that management will:

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

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

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

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

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

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

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

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

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

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

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DIRECTOR EXPOSURE AND LIABILITY V1 BRD 510

Members of the Board of Directors of Northern Health (the "Board") act both as agents of Northern Health and as directors of Northern Health's assets. Directors[1] are responsible to act only within the authority given to them by governing legislation, regulations and policy, and Northern Health's by-laws. Directors are expected to exercise the care, diligence and honesty expected of a reasonable person, in similar circumstances.

If a director *knowingly* acts outside this authority, those actions may be invalid (doctrine of *ultra vires*[2]) and in some instances a Director may be held personally liable for the adverse consequences resulting to Northern Health.

Liability Coverage

Individually and as a group, Directors are exposed to actions under common law, civil law and, in some cases, criminal law. To reduce the risk of litigation for Directors, protection is provided by legislation, the *Health Authorities Act* and the Health Care Protection Plan's (HCPP) Directors' and Officers' Liability and Corporate Reimbursement Agreement.

The *Health Authorities Act* provides protection under Section 14 as follows:

> Liability of members
>
> **14** (1) No action for damages lies or may be brought against a member, officer or employee of a board because of anything done or omitted in good faith
>
> (a) in the performance or intended performance of any duty under this Act, or
>
> (b) in the exercise or intended exercise of any power under this Act.

The Directors' and Officers' Liability and Corporate Reimbursement Agreement is provided by the Health Care Protection Program (HCPP) through the Risk

[1] A Director is defined as: any person, who was, now is or shall become a duly elected or appointed Director of Northern Health, while acting within the scope of his/her duties as a Director of Northern Health.

[2] Ultra vires is a Latin phrase meaning literally "beyond the powers". If an act requires legal authority and it is done with such authority, it is characterised in law as intra vires (literally "within the powers"). If it is done without such authority, it is ultra vires. Acts that are intra vires may equivalently be termed "valid" and those that are ultra vires "invalid".

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Management Branch, Ministry of Finance. Covered parties include Directors of Northern Health.

Coverage is provided for a Director for all loss resulting from a claim for a wrongful act arising solely out of their duties. Examples of exclusions to this coverage include: any act, error or omission resulting from a Director failing to act honestly and in good faith in the best interest of Northern Health; any act, error or admission outside the course of the Director's duties with Northern Health; or any loss arising out of a dishonest, fraudulent, criminal or illegal act or omission of a Director. However, for the purposes of this exclusion, knowledge possessed by any one Director shall not be imputed to any other.

Accident Coverage

Directors are covered for injury sustained during the course of business, including travel to and from Board meetings, Board Committee meetings, Meetings with the Ministry of Health and any other public meetings at which they represent Northern Health. This coverage is procured annually by Northern Health Risk Management through the BC Health Services Group Travel Accident Insurance program.

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Issuing Authority: Northern Health Board
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BOARD BRIEFING NOTE

Date:	**May 15, 2019**	
Agenda item	**Northern Health Board Meeting Calendars**	
Purpose:	☐ **Information**	☒ **Discussion**
	☐ **Seeking direction**	☒ **Decision**
Prepared for:	**Northern Health Board of Directors**	
Prepared by:	**Desa Chipman, Executive Assistant CEO & Northern Health Board**	
Reviewed by:	**Cathy Ulrich, Chief Executive Officer**	

Issue:

Management is presenting proposed dates for the boards 2021 meeting dates. This falls in line with the calendars being developed two years in advance.

Background:

The 2021 meeting calendar has been developed with the structure remaining with meetings occurring on the Sunday and Monday.

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

Meeting location structure will remain as follows;

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

The exact dates may vary from the norm depending on statutory holidays, the timing of school breaks, and other factors deemed important by Directors, which is why a schedule is developed well in advance. The following table shows when and where the Board has met since 2005, with a proposal for the meeting locations in 2021.

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

Year			
PROPOSED			
2021	NI - Quesnel (Feb)	NW - Terrace (Apr)	NE - Chetwynd (June)
HISTORY			
2020	Burns Lake (Feb)	Prince Rupert (Apr)	Dawson Creek (June)
2019	Valemount (Feb)	Smithers (Apr)	Fort St John (June)
2018	Vanderhoof (Feb)	Terrace (Apr)	Chetwynd (June)
2017	Mackenzie (Feb)	Haida Gwaii (June)	Dawson Creek (Apr)
2016	Quesnel (Feb)	Smithers/Hazelton (June)	Fort St John (Apr)
2015	Burns Lake (June)	Prince Rupert (Apr)	Chetwynd (Feb)
2014	Valemount (Feb)	Terrace/Kitimat (Apr)	Fort Nelson (Jun)
2013	Vanderhoof (Feb)	Smithers (Apr)	Dawson Creek (Jun)
2012	Quesnel (Feb)	Terrace (Apr)	Fort St John (Jun)
2011	Burns Lake (Feb)	Prince Rupert (Jun)	Dawson Creek (Apr)
2010	Valemount (Feb)	Smithers (Jun)	Fort St John (Apr)
2009	Quesnel (Apr)	Terrace/New Aiyansh (Jun)	Fort Nelson (Oct)
2008	Prince George (Jan)	Kitimat (Jul)	Dawson Creek (Sep)
2007	Vanderhoof (Nov)	nil	Fort St John (Sep)
2006	Valemount (May)	Terrace (Jul)	Fort Nelson (Sep)
2005	Quesnel (May)	Smithers (Sep)	nil

Recommendation(s):

The Northern Health Board approves the 2021 Board meeting calendar

BRIEFING NOTE

Date:	**April 26, 2019**	
Topic	**Status of 2018-2019 Annual Report**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**GMR Committee and Northern Health Board of Directors**	
Prepared by:	**Anne Scott, RM, Corporate and Program Communications**	
Reviewed by:	**Steve Raper, Chief, Communications and External Relations**	

Topic:
Progress update and recommendation for the 2018-2019 Annual Report

Background:
This update provides the current status of the Annual Report for 2018-2019 fiscal year. We plan to continue last year's practice of producing only an electronic version of the annual report (no printed highlights document). There were no concerns about this last year.

We'll also follow last year's practice of producing an infographic summarizing the fiscal year (see Appendix 1 below). As well, we plan to redesign the report and introduce a more interactive "flip" version (similar to what's seen on Issuu for our staff magazine, for example).

Next steps for 2018-2019 Annual Report:
- May - July: Collect submissions; final edits and approval; create online version and infographic
- By July 31: To Government Communications and Public Engagement (GCPE) for approval
- By August 31: Report complete and posted on www.northernhealth.ca

Last year's report: (2017-2018 Annual Report) – see Appendix 2 for Google Analytics.

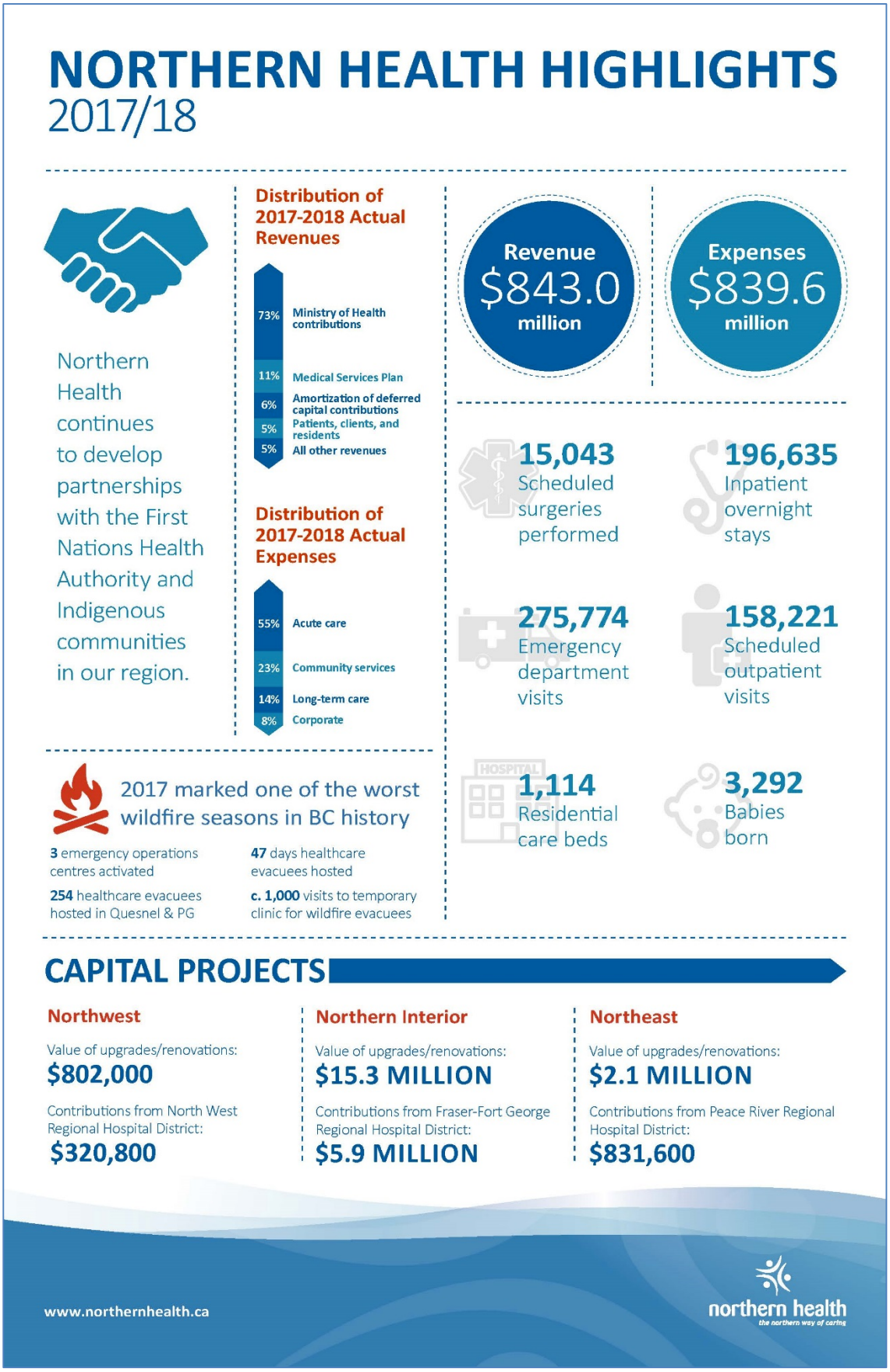
Consultation

Steve Raper, Anne Scott, and Rosemary Dolman (Communications); the NH Executive Team

Recommendation(s):

For information.

Appendix 1: Annual Report Infographic for previous fiscal year (2017-2018)



Appendix 2: Google analytics on last year's report

Annual Report Highlights 2017/18 has been downloaded 70 times since tracking for Northern Health's redesigned northernhealth.ca site began June 26, 2018.

HEMBC/Northern Health Emergency Management 2018 in review & plans for 2019

Date:	April 17th 2019	
Topic	HEMBC/NH's 2018 activity and operational initiatives for 2019	
Purpose:	☒ Information	☐ Discussion
	☐ Seeking direction	☐ Decision
Prepared for:	GMR Committee and Northern Health Board of Directors	
Prepared by:	Jim Fitzpatrick	
Reviewed by:	Steve Raper	

Issue:
Overall review of HEMBC, North's emergency management operations during 2018 and operational initiatives and system readiness for the upcoming 2019 wildfire/freshet season.

Northern Health (NH) 2016-21 Strategic Plan

Priority #1 – Healthy People in Healthy communities.

Priority #3 – Quality - Northern Health will ensure a culture of continuous quality improvement in all areas.

Background
Health Emergency Management, North (HEMBC) operational activities for 2018 were focused primarily on implementing quality improvement initiatives from lessons learned during the 2017 wildfire response. These activities included preplanning and preparation for the 2018 wildfire/freshet season.

For the second consecutive year 2018 wildfire season was unprecedented. Between August 1st and Sept 3rd 2018 there was significant risk to communities due to the wildfires within the NH region resulting in the declaration of local/ provincial "State of Emergencies" (SOLE). The wildfire season impacted hundreds of residents of rural, remote and First Nations' communities evacuating to neighboring towns and villages.

NH's involvement in the 2018 fire season was significantly different than in the 2017 Cariboo wildfires. NH's participation in 2017 was primarily supporting Interior Health Authority (IHA) by accepting evacuated patients. In 2018 the NH health care service delivery was directly affected by the wildfires.

Areas throughout NH saw an influx of evacuees from near-by towns due to evacuation orders and self-evacuees due to poor air quality. The movement of entire communities to neighboring towns and villages had the potential to negatively impact or overwhelm the local healthcare delivery system.

The NH senior leadership was tasked with two concurrent challenges: planning a "complete community/facility transfer" from Dease Lake, Quesnel, Ft. St. James and Burns Lake while preparing NH facilities to receive evacuees (Prince George, Vanderhoof, and Terrace).

Fortunately, only one NH site had to physically transfer patients to an alternate facility; as a result of an evacuation alert in the Village of Ft. St. James - a total of 14 NH patients were transferred to St. John's hospital in Vanderhoof and returning them once the evacuation alert was rescinded.

2018 Wildfire response - Impacts to the health care delivery system

Analysis of health care data, facility process reviews and a general After Action Review (AAR) were completed to understand the impacts to the health care system and to prepare for the recovery phase.

As a result of the learnings from 2017 the Cariboo Wildfires, NH Senior leadership concentrated on advanced planning efforts and the response process; the transfer of patients from Ft. St. James to Vanderhoof was extremely successful. The resultant transfer had a very calm, safe and carefully measured approach. Also due to the advanced planning, there were no apparent negative effects when the patients were returned once the alert was rescinded.

St. John's Hospital in Vanderhoof saw an increased workload requiring additional staff and resources; however, there were no apparent negative impacts to the healthcare delivery system. Other facilities in NH communities were busier than normal but did not appear to be impacted significantly. Additional staffing that may have been required was provided through the normal Human Resources staffing process.

The local government strategy to house evacuees in commercial lodging vs. centralized group lodging resulted in the distribution of evacuees all along the Central Interior Cariboo corridor thereby reducing the impacts to any single community and healthcare system.

The 2018 season allowed HEMBC, North to validate quality improvement initiatives (QI) arising from 2017 wildfire reviews and recommendations. Actions such as the redesign of NH's Emergency Operations Center (EOC) structure, advanced planning techniques, and the distribution of a facility evacuation guide proved to be very helpful in the response to the 2018 wildfires.

Preparations for system readiness for the 2019 wildfire/freshet season.

- **5 Min Drill initiative -** Drills on a single function of a code at a time to encourage an eventual systematic review of each code prior to the 2019 wildfire/freshet season

- **Coordination of NH facility/program table top exercises -**
  - City of Prince George (PG) community evacuation table top exercises (TTX)
  - NIHSDA – Partial or complete evacuation of Prince George and impacts on PG health delivery system
  - NWHSDA - Senior leadership team (SLT) TTX discussion for facility evacuations
  - PH Health Service (Community & Long Term Care included) UHNBC -Table top on partial or complete relocation of UHNBC PG Health Services including departmental specific plans (Evacuation – quick reference guide)
  - Omineca Region (Fort St James, Vanderhoof & Fraser Lake) will be participating in a combined table top exercise on a complete relocation of the St John's Hospital (Vanderhoof)
  - Mackenzie District Hospital & Health Center will be participating in a 3 part Emergency Operations Center training and table top exercise
  - NH & HEMBC, North will be participating in the Regional Districts community table top exercise on the evacuation of the community of Mackenzie, BC

- **Emergency Operations Center (EOC) preparedness training**
  - Continued orientation & training on Incident Command System and Emergency Operations Center (ICS/EOS) to sites throughout NH
  - Facility EOC contact information - review/update

- **Complete facility evacuation planning & response support**
  - **NH facility evacuation quick reference guide**
    - Comprehensive quick reference guide developed to support complete facility transfers due to community evacuations
    - Departmental evacuation plans & coordination (things to consider) to support frontline staff
  - **Evacuation quick reference guide companion documents in development**
    - **NH Facility receiving guide** – key concepts to consider while receiving evacuated patients from another health care facility (nearing completion)
    - **Community re-entry process guide** - In collaboration with the City of Prince George a three phase re-entry plan will be developed and templated for use as a guide for NH communities throughout the North returning to a previously evacuated community (preliminary discussions)
    - **NH Facility Repatriation Plan** - key concepts to consider when a facility prepares to and receives patients back to a previously evacuated facility (preliminary discussions)

- **Chemical Decontamination –** Continued **s**taff training to all acute care sites to have the capacity to decontaminate up to 5 self-presenting chemically contaminated patients. The decontamination capacity provides staff safety in the event of a chemical exposure as a result of a wildfire, flood or complications during an evacuation process.

Community engagement

- **Emergency Management BC (EMBC) Spring Readiness forums** - HEMBC, North & NH Population and Public Health (PPH) have participated in all five of the Northern sessions as members of a community evacuation panel to discuss roles & responsibilities during a community emergency. (March & April '19)
    - Reiteration of the importance of obtaining a clear line of site into evacuation order discussions & rescindments prior to public notification (#17 Abbott/Chapman report)
- **Northern Wildfire Resilience Conference – Burns Lake –** (April '19) – HEMBC, North staff will be participating in a readiness conference for the North West hosted by the Bulkley Valley Research Centre and BC wildfire services
- **Northern Emergency Support Services Training (NESST)** (April '19)
    - A Medical Health Officer will be presenting to inform / educate participants on NH's Population & Public Health's (PPH) responsibility/authority as it pertains to community emergencies in regards to public health and safety.

Resource Planning

- **HEMBC Coordinator position -** An additional PHSA funded coordinator position will be added to the HEMBC, North team this year; plans are in place to hire &orientate prior to 2019 wildfire/freshet season
- **Mutual aid - HEMBC Northern Health & Interior Health** - both teams met to discuss :
    - Mutual aid opportunities during an emergency response within the IHA/NH corridor
    - Orientation to health authority specific organizational and emergency command structures and response functionality to aid in ease of the provision of support
    - Opportunities for collaboration on similar projects; - i.e. both teams are designing "quick reference guides" to assist frontline staff during a facility evacuation

NH Emergency Response Plan & Assessment tool design/review

- **NH's Emergency Preparedness Application & Dashboard** (nearing completion) - will provide an objective measurement of the degree of each acute facility's preparedness to :
    - Prioritize those facilities most vulnerable to ensure emergency plans are current
    - Formulate an annual NH emergency preparedness education plan
    - Assess the organizations overall vulnerability and risk levels
- **Emergency response plan accountability matrix** - RACI document that clearly identifies departmental/program accountability for the maintenance of facility emergency response plans.

Quality Improvement initiatives from lessons learned (2018/2018 wildfires)

- **Quality improvement initiatives** - identified during After Action Reviews (AAR) conducted following an emergent event are methodically addressed through a NH/HEMBC emergency response recommendation tracking document
- **2017 Cariboo Wildfires After Action review recommendation stats**
    - 36 recommendations (short & long term objectives)
    - 97% have been actioned
    - 60% are considered complete

- **2018 Northern Wildfires After Action review recommendation stats**
  - 15 additional recommendations to the emergency response recommendation tracker (currently for executive review)
  - 35% have been actioned thus far

2018 Wildfire Recovery & NHA/FNHA collaboration

- **Event response** - lessons learned from 2017/18 wildfire season identified the continued need for collaboration and information sharing during a response
- **Post event recovery** - Creation of a combined (NH/FNHA) 2018 Wildfire Recovery Advisory Committee to ensure information sharing and collaboration during the recovery process
- **Provincial Disaster Recovery project** - HEMBC, North is an active member in the design of a sustainable consistent recovery strategy following a major event

NH Internal / external communication improvements (lessons learned from 2017/18 wildfires)

- **Recommendation from the 2017/18 wildfire season identified the need to improve internal communications during an emergent response**
  - SnapComms ® application was identified as a suitable platform for mass internal notification in the spring of 2018
    - Proof of concept - Pilot project for functionality assessment
    - Recommendation – Implement throughout NH for internal notification & ongoing situational awareness during an emergent event
- **Internal communications** - completion of emergency telecommunication protocols to formulate enterprise wide contingency plans in the event of telecommunications breach/failure during a wildfire or flood. (i.e. loss of the single fiber optic cable between Prince George and Prince Rupert)
- **External communications** - continued work on the development of partnerships and collaborative communications with external partners to formulate reliable pathways for information sharing during an emergent event

Non-emergency response related activities in 2018

The majority of 2018 HEMBC, North non response or recovery related operations were focused predominantly on:

- Designing, modifying and the implementation of an educational plan to disseminate NH's redesigned Emergency Response Structures to NH leadership from lessons learned over the past two years
- Completion of the NH acute care facility decontamination training and equipment dissemination initiative
- Formation of a PG community based emergency preparedness committee – and encouragement of similar linkages throughout the North through our involvement with the Spring readiness forums
- NH's Emergency Preparedness dash board - In collaboration with NH Information & Technology Services (ITS) – design & implement a dynamic tool that will easily display the current state of the facilities preparedness.