Meeting of the Northern Health Board
June 14, 2021

Due to COVID-19 Pandemic the Northern Health Board did not host a Public Board meeting on June 14, 2021 as originally scheduled.

The Northern Health Board met virtually to address regular Board business. Part of the meeting included a review of the material in this package.

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Northern Health Board
Public Package – June 2021

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Adjourned		

BOARD BRIEFING NOTE

Date:	May 31, 2021	
Agenda item	2020-21 Year End Financial Statements – Public Disclosure	
Purpose:	☒ **Discussion**	☐ **Decision**
Prepared for:	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 2020-21 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 2020-21 on March 31, 2021. 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 2020-21 audited financial statements will be posted on its website – www.northernhealth.ca.

Recommendation:

For information only.

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BOARD BRIEFING NOTE

Date:	May 31, 2021	
Agenda item:	Capital Public Note	
Purpose:	☐ **Discussion**	☐ **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 2020-21 capital expenditure plan in February 2020, and an amendment in February 2021. The updated plan approves total expenditures of $112.7M, with funding support from the Ministry of Health ($67.4M, 60%), Six Regional Hospital Districts ($32.4M, 29%), Foundations, Auxiliaries and Other Entities ($2.1M, 2%), and Northern Health ($10.3M, 9%).

For Fiscal Year ending March 31, 2021, $66M was spent towards the execution of the plan as summarized below:

$ million	YTD	Plan
Major Capital Projects (> $5.0M)	33.3	61.8
Major Capital Projects (< $5.0M)	6.4	14.7
Major Capital Equipment (> $100,000)	9.4	15.7
Equipment & Projects (< $100,000)	10.3	10.3
Information Technology	6.5	10.3
	65.9	112.7

Significant capital projects currently underway and/or completed in 2020-21 are as follows:

Northern Interior Service Delivery Area (NI-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Burns Lake	BLH FM Domestic Hot Water Heaters	$0.41	In Progress	MOH
Fort St. James	Stuart Lake Hospital Replacement	$116.12	In Progress	SNRHD, MOH
Granisle	Granisle Health Centre Leasehold Improvements	$1.15	In Progress	SNRHD, MOH
McBride	MCB Boiler Plant Upgrade	$0.40	In Progress	MOH
Prince George	UHNBC BioFire File Array	$0.27	Completed	MOH
Prince George	UHNBC Cardiac Services Department Upgrade Planning	$11.0	Planning	FFGRHD, MOH, NH
Prince George	UHNBC DI Interventional Fluoroscopy	$2.89	In Progress	FFGRHD, MOH, NH
Prince George	UHNBC CT 320 Replacement	$2.59	Complete	FFGRHD, MOH, NH
Prince George	UHNBC GenExpert XVI	$0.11	Complete	MOH
Prince George	UHNBC Integrated Fault Detection & Diagnostics	$0.17	In Progress	FFGRHD, MOH
Prince George	UHNBC LND Washing Machine 1	$0.73	In Progress	FFGRHD, MOH
Prince George	UHNBC Low Temperature Sterilizer	$0.13	Complete	FFGRHD, MOH
Prince George	UHN OR Electrical Upgrade and Lights	$0.46	In Progress	MOH
Prince George	UHNBC Panther Fusion	$0.83	In Progress	MOH
Prince George	UHNBC Pharmacy Fastpak Verifier	$0.17	In Progress	FFGRHD, MOH, NH
Prince George	UHNBC Phone System	$0.38	Complete	FFGRHD, MOH, NH

	Replacement Phase 1			
Prince George	UHNBC Phone System Replacement Phase 2	$0.91	In Progress	FFGRHD, MOH
Prince George	UHNBC – New Acute Tower Business Plan	$5.00	In Progress	FFGRHD
Prince George	UHNBC Sterilizer – Sterizone	$0.12	Complete	FFGRHD, MOH
Prince George	UHNBC – Sterile Compounding Room Upgrade Planning	$1.90	Planning	FFGRHD, MOH, NH
Prince George	UHNBC OR Microscope Replacement	$.27	Complete	MOH
Prince George	UHNBC Lab Chemistry Automation	$5.75	Planning	FFGRHD, MOH, NH
Prince George	Prince George Long Term Care Business Plan	$1.4	In Progress	FFGRHD
Quesnel	GR Baker X-Ray Replacement	$0.90	Closing	CCRHD, MOH, NH
Quesnel	GR Baker CT Scanner Replacement	$1.92	In Progress	CCRHD, MOH
Quesnel	GR Baker ER & ICU Addition	$27.0	In Progress	CCRHD, MOH
Quesnel	GR Baker Kitchen Renovation	$5.00	In Progress	CCRHD, MOH, NH
Quesnel	GR Baker Sterile Compounding Room Upgrade	$0.11	Complete	CCRHD, MOH
Quesnel	Quesnel Long Term Care Business Plan	$.90	In Progress	CCRHD
Vanderhoof	St. John Hospital Boiler Replacement	$0.80	Complete	SNRHD, MOH
Vanderhoof	St. John Hospital Heat Pumps and Coils	$0.59	In Progress	SNRHD, MOH
Vanderhoof	St. John Hospital Sterile Compounding Room Upgrade	$1.97	In Progress	SNRHD, NH, MOH

Northwest Health Service Delivery Area (NW-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Kitimat	Kitimat DI C-Arm Replacement	$0.19	Closing	MOH
Kitimat	Kitimat DI Mini C-Arm Replacement	$0.09	Complete	MOH
Kitimat	Kitimat Washing Machine Replacement	$0.39	In Progress	NWRHD, MOH
Kitimat	Kitimat OR Anesthetic Machine Replacement	$0.17	Closing	MOH
Kitimat	Kitimat LAB Chemistry Analyzer Replacement	$0.18	In Progress	NWRHD, MOH, NH
Terrace	MMH Hospital Replacement	$447.50	In Progress	NWRHD, MOH
Terrace	MMH OR Anesthetic Machines	$0.45	Closing	MOH
Terrace	MMH OR Automated Medication Dispensing Cabinet	$0.18	In Progress	MOH
Terrace	MMH OR Video System Tower 1 Replacement	$0.22	Complete	NWRHD, MOH
Terrace	MMH OR Video System Tower 2 Replacement	$0.24	Closing	MOH
Terrace	MMH – Ultrasound (unit 3)	$0.21	Closing	DR REM Lee Foundation, MOH
Hazelton	Wrinch X-Ray	$0.91	Closing	NWRHD, MOH, NH
Hazelton	Wrinch Anesthetic Machine Replacement	$0.16	In Progress	MOH
Hazelton	Hazelton Long Term Care Business Plan	$.60	In Progress	NWRHD
Northern Haida Gwaii	NHG Nurse Call System	$0.16	Closing	NWRHD, MOH

Northern Haida Gwaii	NHG Observation Room	$0.99	Planning	NWRHD, NH
Prince Rupert	PRRH Chemistry Analyzers Replacement	$0.59	In Progress	NWRHD, NH
Prince Rupert	PRRH Medical Device Reprocessing Department Equipment Replacement and Centralization	$0.74	In Progress	MOH
Prince Rupert	PRRH Sterile Compounding Room Upgrade	$0.65	In Progress	NWRHD, NH
Smithers	BVDH OR Anesthetic Machine	$0.10	Closing	NWRHD, MOH
Smithers	BVDH Sterile Compounding Room Upgrade	$1.24	In Progress	NWRHD, NH
Smithers	Bulkley Lodge Domestic Hot Water Heaters and Tank and Repiping	$0.55	In Progress	NWRHD, MOH
Smithers	BVDH – 2nd Ultrasound	$0.21	Complete	BVDH Hospital Foundation, MOH
Smithers	Smithers Long Term Care Business Plan	$.90	In Progress	NWRHD

Northeast Health Service Delivery Area (NE-HSDA)

Community	Project	Project $M	Status	Funding partner (note 1)
Chetwynd	CHT X-Ray Replacement	$0.58	Complete	PRRHD, MOH, NH
Chetwynd	CHT Chemistry Analyzer Replacement	$.20	In Progress	PRRHD, NH
Dawson Creek	DCDH OR Anesthetic Machine Replacement	$0.16	Closing	MOH
Dawson Creek	DCDH Automated Medication Dispensing Cabinet	$0.17	In Progress	MOH
Dawson Creek	DCDH Hospital Replacement	$377.86	In Progress	PRRHD, MOH
Dawson Creek	DCDH OR Video Towers Replacement	$0.21	Complete	MOH

Dawson Creek	DCH Portable X-Ray Machine 1 Replacement	$0.21	Complete	PRRHD, MOH
Dawson Creek	Rotary Manor Chiller Replacement	$0.25	Complete	PRRHD, NH
Fort Nelson	FNH – Ultrasound Machine Replacement	$0.14	Complete	Fort Nelson Hospital Foundation, NRRHD
Fort Nelson	FNH FM Domestic Hot Water Upgrade (CNCP)	$.21	In Progress	MOH
Fort St. John	Fort St. John Hospital Spect CT	$1.76	Closing	PRRHD, NH, MOH
Fort St. John	Medical Clinic – 3rd Pod Renovation	$2.05	Completed	PRRHD, MOH
Fort St. John	Fort St. John Hospital OR Anesthetic Machines Replacement	$0.20	Closing	PRRHD, MOH
Fort St. John	Fort St. John Hospital Sterile Compounding Room Upgrade	$0.46	In Progress	PRRHD, NH
Fort St. John	Fort St. John Lab Renovation Planning	$.58	Planning	PRRHD, NH
Fort St. John	Fort St. John Long Term Care Business Plan	$1.2	In Progress	PRRHD
Tumbler Ridge	Tumbler Ridge Health Centre Cooling System Replacement	$.60	In Progress	PRRHD, NH

Regional Projects

Community	Project	Project $M	Status	Funding partner (note 1)
All	Breast Imaging Electronic Reporting Solution	$0.17	Closing	MOH, PHSA
All	Community Health Record (Phase 3)	$4.90	Closing	MOH, CCRHD, FFGRHD, NRRHD, NWRHD,

				PRRHD, SNRHD
All	Clinical Interoperability	$0.62	Closing	NH
All	EmergCare	$4.35	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Endoscopy System Replacement Phase 1	$0.79	Work In Progress	MOH, PRRHD, FFGRHD, CCRHD
All	Physician eScheduling and OnCall	$0.49	Work In Progress	MOH, NH
All	Home Care Redesign	$1.29	Work In Progress	MOH
All	InCare Phase 1	$4.91	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	InTouch Virtual Care Clinic Platform	$0.12	Complete	MOH
All	MOIS/Momentum Interop	$0.16	Planning	MOH
All	MySchedule – Smart Leave, Annual Vacation	$0.36	Complete	MOH, NH
All	MySchedule – Partial Shifts, Prebooking	$0.18	Work In Progress	MOH, NH
All	Northern Lights – Personal Health Record and Portal	$1.20	Work In Progress	MOH, CCRHD, FFGRHD, NRRHD, NWRHD, PRRHD, SNRHD
All	Sharepoint Upgrade	$0.18	Work In Progress	MOH
All	Clinical Data Repository (CeDaR)	$1.53	Work in Progress	NH
All	DNS Replacement	$0.14	Work in Progress	MOH

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 2020-21, NH spent $8.9M on such items.

NH has also received one-time funding for COVID and Surgical equipment under $100,000. NH spent $2.9M 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:

It is recommended that the Audit & Finance Committee recommend the following motion to the Board:

> The Northern Health Board receives the Period 13 update on the 2020-21 Capital Expenditure Plan.

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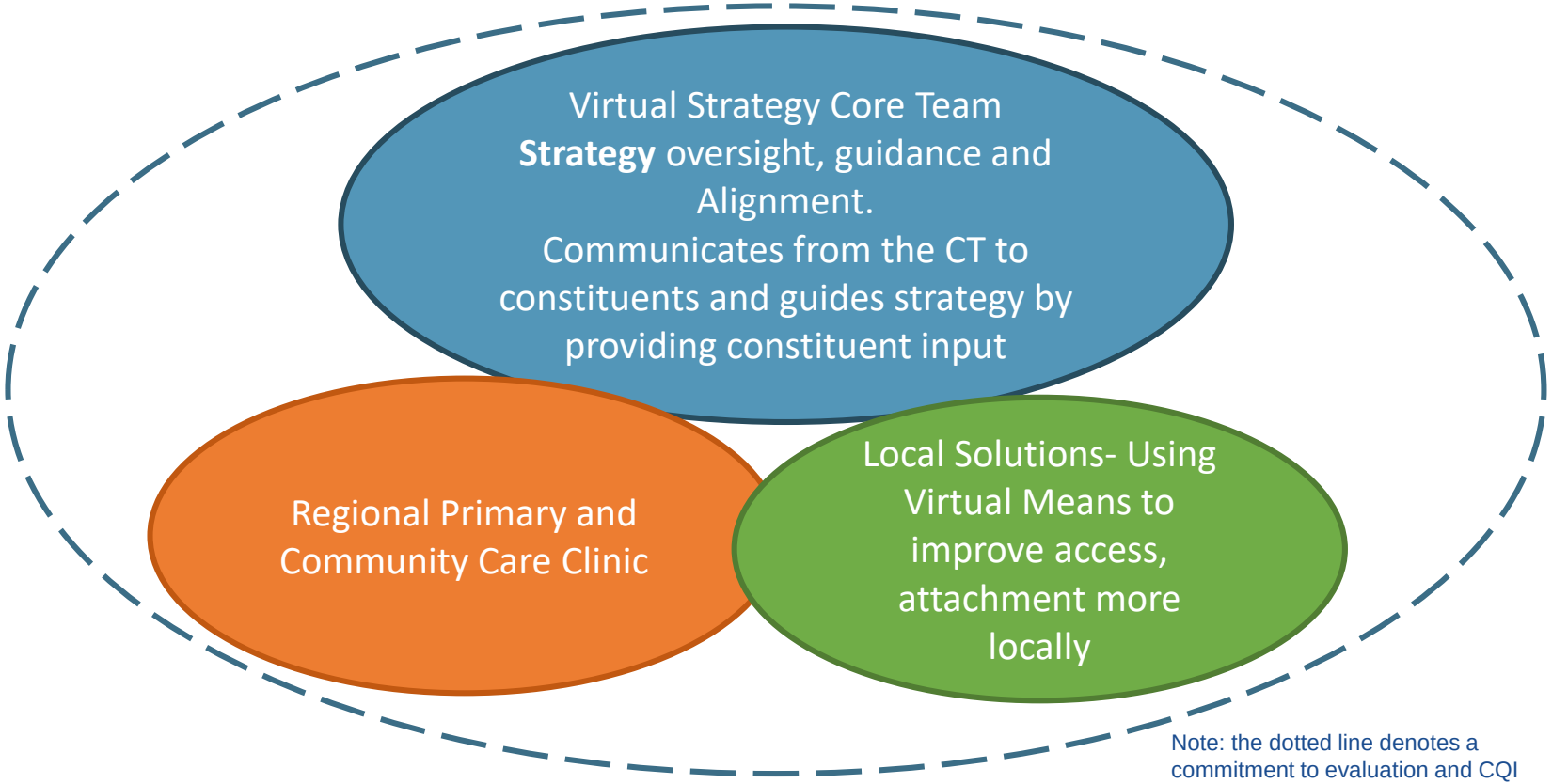
Northern Health Regional Virtual Primary and Community Care Clinic Update

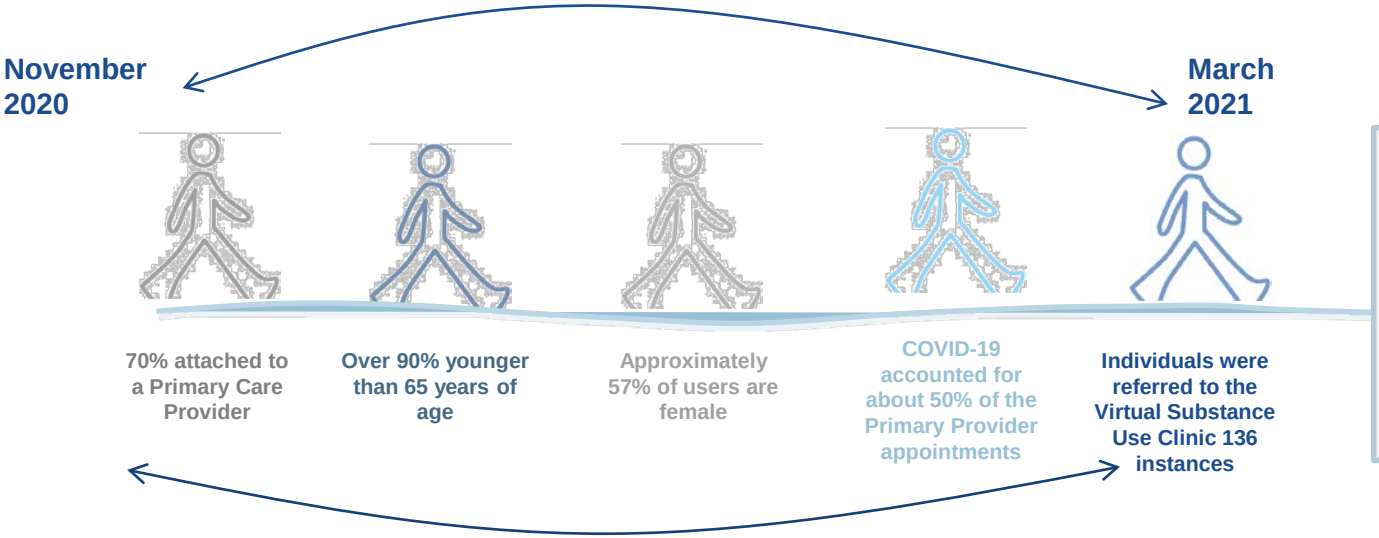
May 2021

Enhanced Access to Primary and Specialist Care Strategy



Note: the dotted line denotes a commitment to evaluation and CQI

Northern Health Virtual Care: Primary Care Provider Key Findings

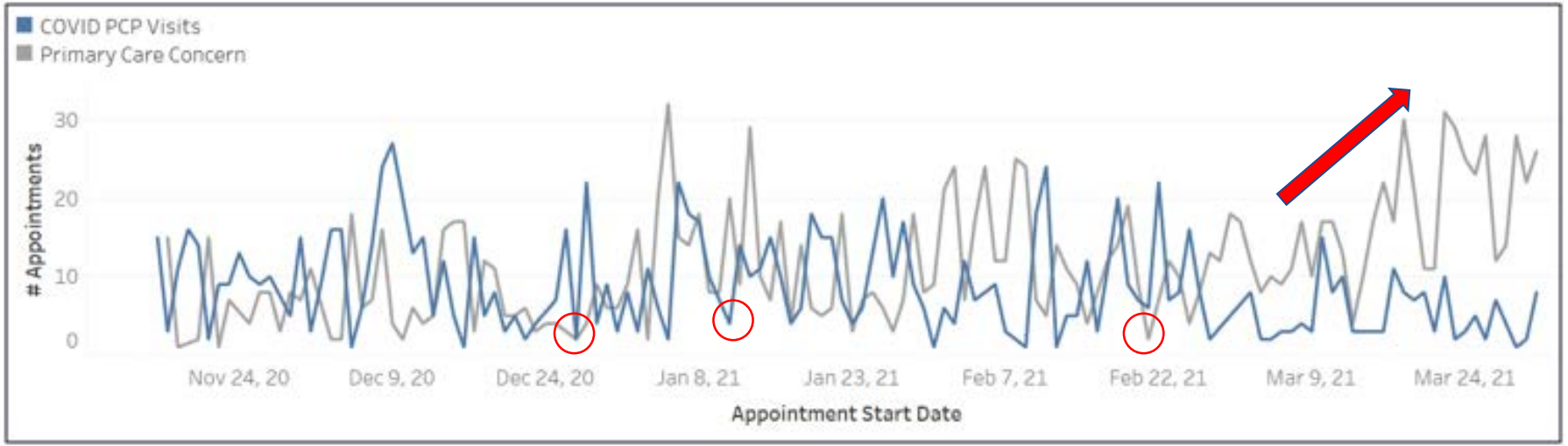


Non-COVID Primary Care appointments ranged from 0 – 32 appointments per day, with an average of 12 appointments per day during this time period

84% of appointments took place during daytime hours for both attached and unattached patients

Between November 16 2020 to March 31 2020
29,349 Nursing COVID-19 Assessments

Key Findings: Northern Health Virtual Clinic
PCP COVID-19 Appointment vs Primary Care Appointment

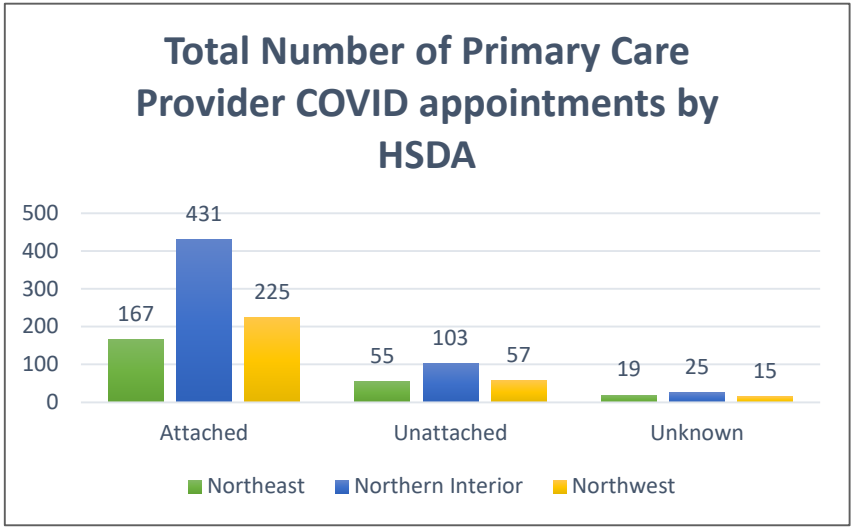


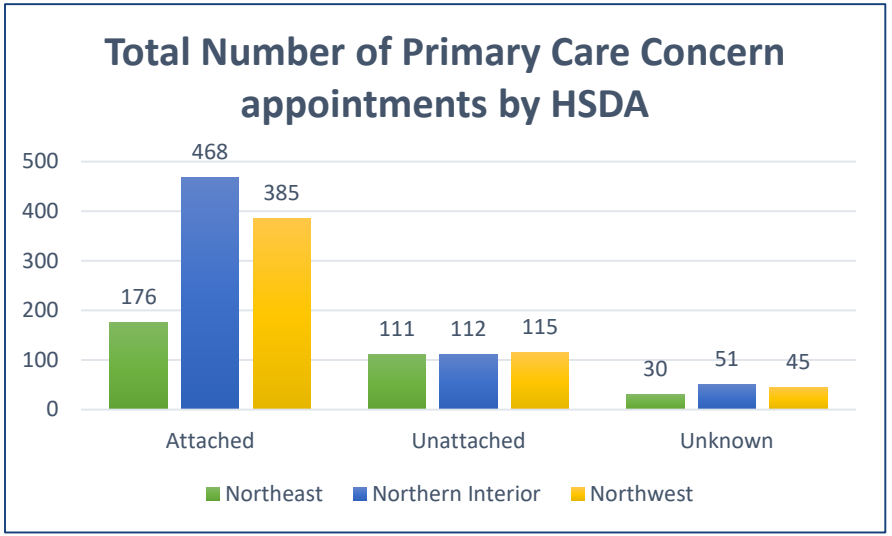
(Source: CeDar April 2021

Note:

- dip in numbers typically associated with the weekends
- Arrow show the Primary Care Concern visits on a steady rise during the month of March

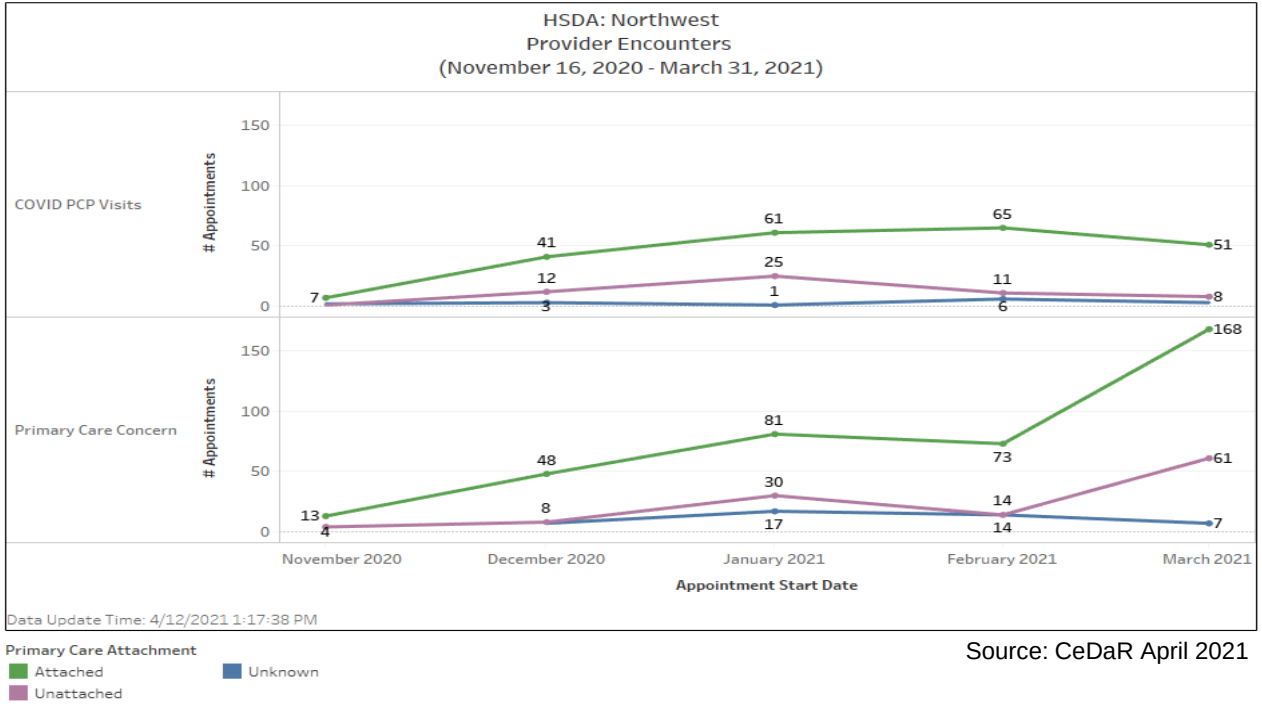
Key Findings: Primary Care Provider Appointments by attachment and HSDA





Total Number of Primary Care Provider appointments = 2589

Key Findings Northwest Utilization



Source: CeDaR April 2021

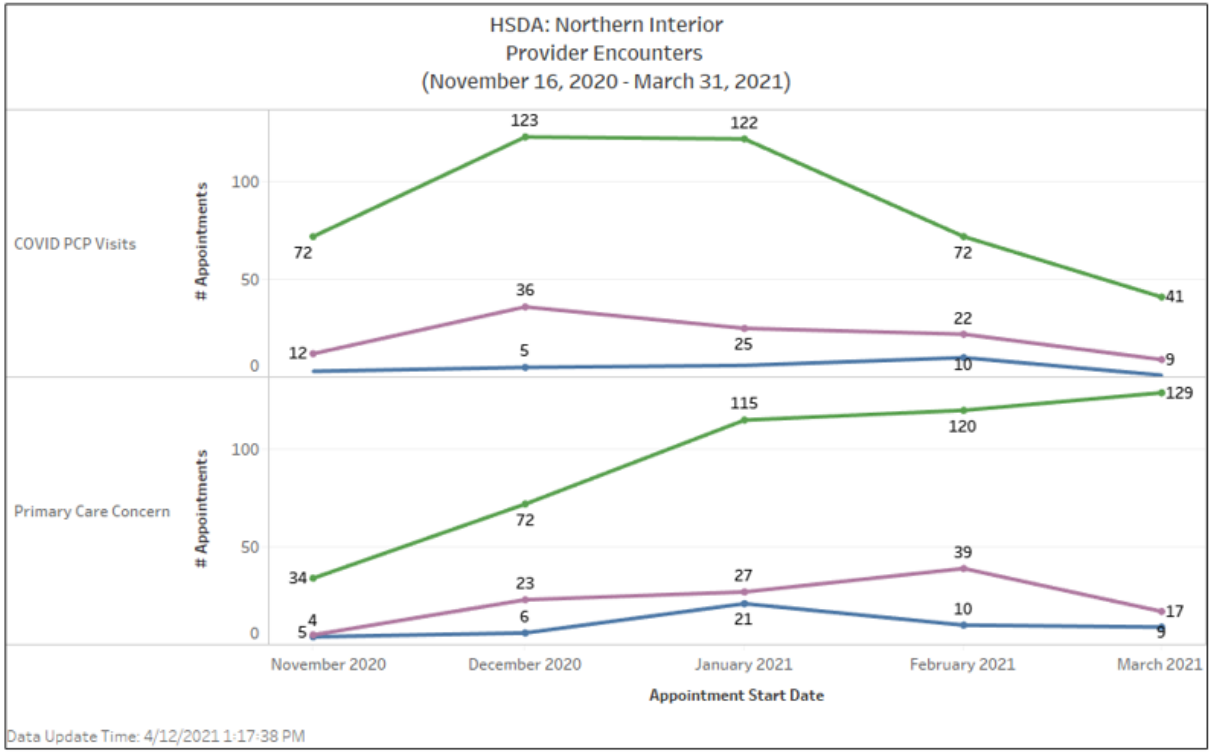
Between November 16, 2020 and March 31, 2021, the Virtual Clinic had a total of 841* unique provider appointments from 24 Northwest communities.

297 classified as COVID PCP
545 classified as PCC

610 self identified as attached
172 self identified as unattached
60 coded as unknown

* One appointment was coded both as COVID PCP and PCC

Key Findings Northern Interior Utilization



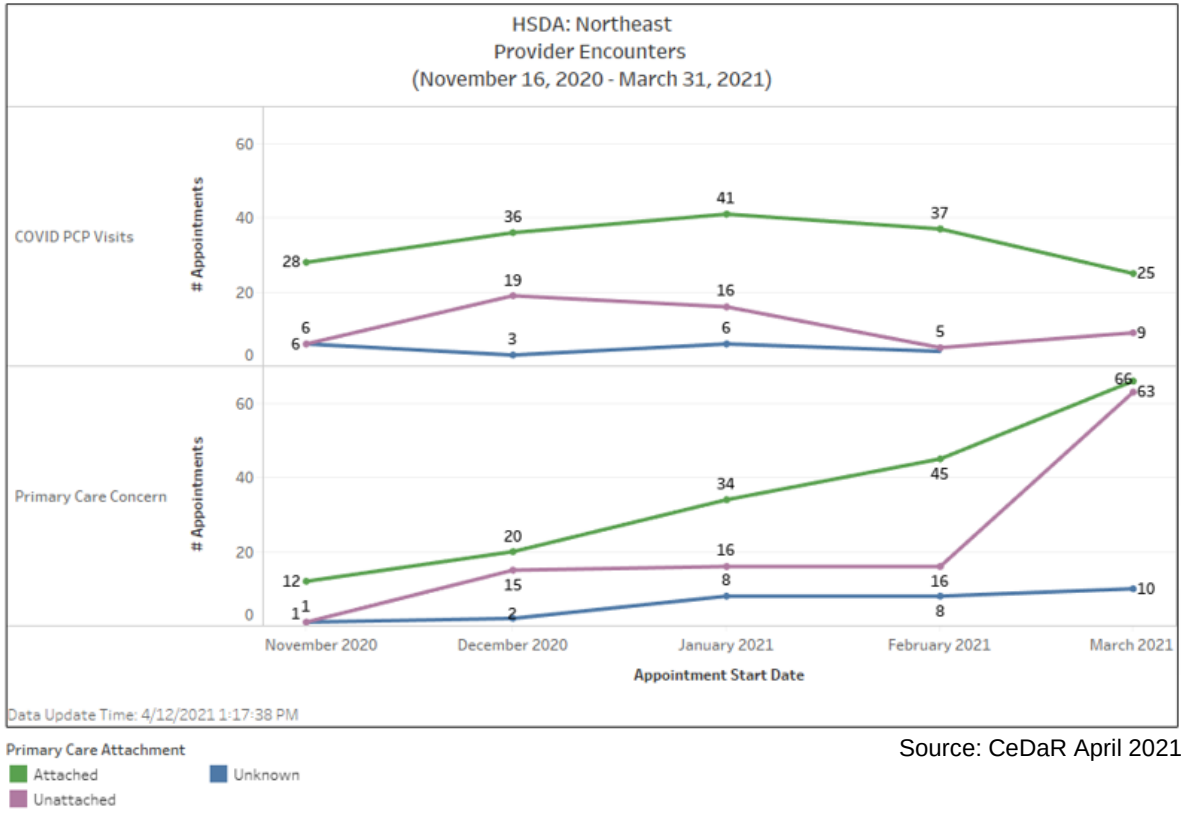
Source: CeDaR April 2021

Between November 16, 2020 and March 31, 2021, the Virtual Clinic had a total of 1190 unique provider appointments from 19 Northern Interior communities.

559 classified as COVID PCP
631 classified as PCC

899 self identified as attached
215 self identified as unattached
76 coded as unknown

Key Findings Northeast Utilization



Source: CeDaR April 2021

Between November 16, 2020 and March 31, 2021, the Virtual Clinic had a total of 558 unique provider appointments from 24 Northeast communities.

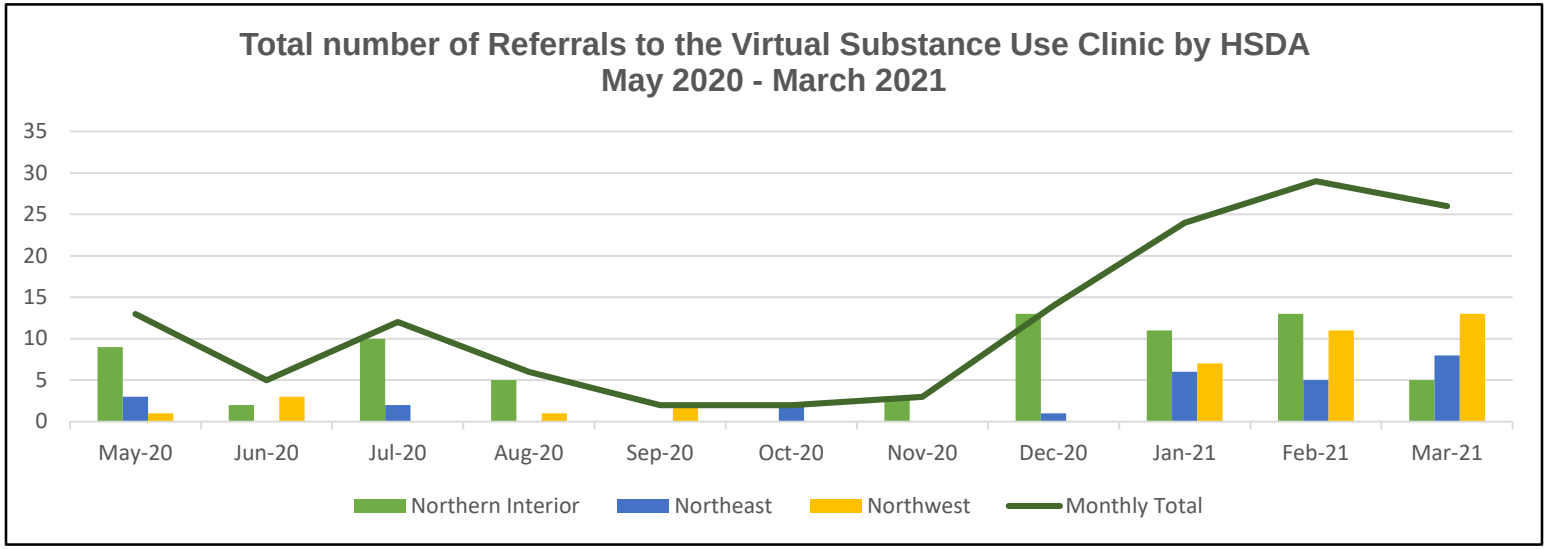
241 classified as COVID PCP
317 classified as PCC

343 self identified as attached
166 self identified as unattached
49 coded as unknown

Reason for Virtual Care Appointment

Clinical Grouping	Appointment Type / Primary Care Attachment: COVID PCP Visits			Primary Care Concern			Grand Total
	Attached	Unattached	Unknown	Attached	Unattached	Unknown	
COVID-19	828 31.1%	234 8.8%	67 2.5%	115 4.3%	45 1.7%	20 0.8%	1,309 49.2%
Head, Eyes, Ears, Nose, and Throat				216 8.1%	66 2.5%	15 0.6%	297 11.2%
Respiratory				201 7.6%	49 1.8%	27 1.0%	277 10.4%
General				110 4.1%	39 1.5%	16 0.6%	165 6.2%
Lymphatic				90 3.4%	25 0.9%	17 0.6%	132 5.0%
Gastrointestinal				59 2.2%	32 1.2%	11 0.4%	102 3.8%
Psychiatric				46 1.7%	28 1.1%	3 0.1%	77 2.9%
Musculoskeletal				37 1.4%	20 0.8%	3 0.1%	60 2.3%
Dermatology				41 1.5%	13 0.5%	6 0.2%	60 2.3%
Neurology				41 1.5%	8 0.3%	6 0.2%	55 2.1%
Genitourinary				28 1.1%	11 0.4%	1 0.0%	40 1.5%
Cardiovascular				27 1.0%	9 0.3%	2 0.1%	38 1.4%
Reproductive				17 0.6%	8 0.3%	2 0.1%	27 1.0%
Endocrine				8 0.3%	4 0.2%	5 0.2%	17 0.6%
Unknown				5 0.2%	3 0.1%	2 0.1%	10 0.4%
Grand Total	828 31.1%	234 8.8%	67 2.5%	1,038 39.0%	359 13.5%	136 5.1%	2,661 100.0%

Key Findings: Referrals to the Virtual Substance Use Clinic by HSDA



Northwest n = 71
Northeast n = 27
Northern Interior n = 38
Total n = 136*

*Graph does not include 2 referrals which were out of province/region

BOARD ROLE AND GOVERNANCE OVERVIEW V.1 BRD 200

Introduction

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

Principal Stakeholders

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

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

Board Size

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

Best Interest of Northern Health

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

Director's Terms

1. Directors are appointed for one-, two- or three-year terms[2].
2. Directors will normally be appointed for a maximum of six years. In order to achieve staggering of appointments, to avoid too many Directors leaving at the same time, terms may be for other lengths, and in extraordinary circumstances a request may be made to the Minister of Health through the 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.

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 8, 2020 (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
Issuing Authority: Northern Health Board
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Task Forces

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

Board Meetings and Agenda

1. The Board meets at least six times within the calendar year.
2. The Board may also meet at the call of the Board Chair or in his/her absence, the Deputy Chair or as provided for in the Bylaws. (Policy BRD600)
3. The GMR Committee develops the agenda for each Board meeting in consultation with the CEO and the Corporate Secretary.
4. Under normal circumstances, the agenda and meeting material will be distributed to Directors ten days[3] before the meeting.
5. It is normal Board practice for all agenda items to be considered at the appropriate committee meetings prior to being placed on the Board agenda. A Director or the CEO may, however, suggest urgent additions to the agenda through the Board Chair prior to adoption of the Board agenda. (Policy BRD530)
6. A consent agenda 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.
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,

[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 8, 2020 (R)

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.

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

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Assessing Board Performance

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

Outside Advisors for Committees and Directors

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

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~~20, section 4~~.5.6~~6.2, 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

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COMMUNICATION POLICIES 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:

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

The Board will endeavour to meet face-to-face whenever possible; however, meetings may occur virtually when required, as contemplated in the Organization and Procedure Bylaws (BRD 600).

When meeting face-to-face, the Board will normally schedule three meetings outside of Prince George in each calendar year - one meeting within each of the three Health Service Delivery Areas.

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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:

- 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.

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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.

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.

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Instructions shall be posted on the Northern Health website.

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 updates

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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 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
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

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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

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

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

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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

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

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

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

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

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

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

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

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

5. Internal Naming Requests

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

6. Process to Revoke or Change a Naming Right

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

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

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NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
Classification	External Facility (e.g. building, road, park)	Internal Facility (e.g. floor, wing, laboratory)	Program (e.g. clinical unit, health/wellness program, room, lounge)	Equipment	Research/Academic Position	Tribute Marker (e.g. plaque, medallion, other marker usually associated with feature such as tree, bench or small monument)
Ad Hoc Members (additional to standing members)	• Health Services Administrator (HSA) for the community where the applicable external facility resides • Senior representative from the Foundation representing the community where the applicable external facility resides		• If applicable, the manager responsible for the program itself or for the clinical area managing the program • If the program is site-specific, the HSA for the site and a senior representative of the	• 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	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**
			Foundation connected to the site	for the site where the equipment will be used		
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		CEO, upon recommendation of the Naming Committee	COO responsible for the site(s) or clinical area(s) where the equipment will be used, upon	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**
	Naming Committee prior to submitting a final recommendation to the GMR Committee and the Board. Before submitting a name for approval to the Board, preliminary discussions should be held with the provincial government to ensure there will be no government barrier to approval.			recommendation of the Naming Committee		
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,					

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NAMING COMMITTEE DECISION MATRIX						
Asset	**Class I**	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
	complete the "Naming Request Form" appended to the Government of British Columbia Naming Privileges Policy and submit to the applicable government Ministry. An additional step is required for Class I (entire facility) assets. Upon confirmation that the responsible government Ministry requires no further approval, further application must be made as follows: Hospital: This type of facility is designated under the *Hospital Act* by way of a Ministerial Order. Any change to an existing facility name requires the Ministry of Health to rescind the original designation and re-designate the facility with the new name. Residential Care Facility: This type of facility falls under the *Community Care & Assisted 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					

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

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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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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. - 06/16)

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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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Physician Quality, Engagement and Education
Corporate Office 4th Floor, 299 Victoria Street
Prince George, BC
(P) 250-645-6475

BRIEFING NOTE

Date:	**May 27, 2021**	
Agenda item	**Facility Engagement Initiative Update (Specialist Services Committee)**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Northern Health Governance and Management Relations Committee & Northern Health Board of Directors**	
Prepared by:	**Holly Hovland, Engagement Partner, Doctors of BC** **Janice Paterson, Specialist Services Committee Leader, Northern Health**	
Reviewed by:	**Dr. Ronald Chapman, VP Medicine & Clinical Programs, Northern Health** **Jessica Place, Executive Lead, Regional Chronic Diseases & Facility Engagement Initiative Sponsor, Northenr Health** **Cindy Myles, Director of Facility and Community Engagement, Doctors of BC**	

Topic:

The Facility Engagement Initiative, funded by the Specialist Services Committee, continues to grow across the North. This briefing note was developed collaboratively to provide an annual update on the current progress and initiatives of Facility Engagement in the North, including an overview of the program, themes of activities, COVID-19 response, and regional collaboration.

Background:

1) Overview of the Facility Engagement Initiative

- Facility Engagement is a provincial initiative under the Physician Master Agreement that aims to:
    1) Strengthen the relationship between physicians in facilities and health authorities,
    2) Help physicians improve their work environment, and
    3) Improve patient care delivery.

- Over the last year, one additional site was approved for start up funding by Facility Engagement. There are now 17 of 18 Northern Health sites engaged in this initiative with active Medical Staff Associations. See Appendix A.
- In June 2020, Doctors of BC announced a realignment that resulted in a change to the staff supports across the Joint Collaborative Committees (JCCs). The newly formed Engagement Partner role supports both Medical Staff Associations (MSAs) and the Divisions of Family Practice, improving MSA and Division local and regional engagement with health authority partners. This shift will also enable engagement between MSAs and Divisions to improve transitions of care and patient care that requires facility and community involvement.

2) Activity themes for Medical Staff Associations in Northern Health

The Facility Engagement Initiative tracks activities occurring at all sites in a database. Information pulled from this database highlights the number of activities and themes of projects occurring in Northern Health.

- There were 220 activities highlighted by Medical Staff Associations in the Northern Health region (as of end of fiscal year 2020/21)
    - 33% increase in activities over the 2019/20 fiscal year
- The top project themes identified by Medical Staff Associations in the North were:
    - Physician wellness and reducing physician burnout;
    - Cultural humility and safety;
    - Recruitment and retention activities (more rural sites);
    - Emergency Room/Operating Room optimization and protocol review;
    - Scheduling system optimization – patient flow and capacity;
    - Physician lounge improvements;
    - *New* Training and simulation; and,
    - *New* COVID-19 response.

3) COVID-19 Response

Many Northern Health Medical Staff Associations were involved in activities related to the COVID-19 pandemic response and supported through Facility Engagement. The themes remain the same as 2019/20 and include:

- Communication: Medical Staff Associations supported communications with their peers via WhatsApp forwarding updates from both Doctors of BC, Joint Collaborative Committees and the Health Authority. Several Medical Staff Associations were also involved in a provincial communication with media, to ensure coordinated messages were received and sent across the province;
- Meetings: Medical Staff Associations formed special COVID working groups, appointed representatives to meet with health authority staff and leadership, as well as participated in local Emergency Operation Centers;
- Planning: Some Medical Staff Associations developed COVID working groups and appointed physician leaders worked in partnership with Northern Health in establishing COVID-19 protocols and guidelines, designing COVID-19 units, workflow mapping, and workforce planning;
- Education: Physicians led education on appropriate Personal Protective Equipment (PPE) use, including simulations for respirator management and airways management;

- Wellness: Physicians provided peer support via Zoom; provided grab and go snacks, as well as relevant reading material in the physician lounges.

4) Opportunities to Collaborate with the Health Authority

Northern Medical Staff Association Presidents Council

In April 2020 the Northern Medical Staff Association Presidents expressed an interest to gather as a physician group to learn about what other communities in the North were working on in terms of COVID-19 response, planning, and consultation, and to hear COVID-19 updates from Northern Health. The group decided to leverage this space as a monthly platform for northern physicians to virtually gather together and network, discuss regional issues and opportunities for collaboration, and to hear updates from Northern Health and Doctors of BC. The Northern MSA Presidents' Council was formalized and met 8 times in 2020/21,with an average of 8/16 MSAs represented. Northern Health was invited to present at 5 of the 8 meetings on topics such as COVID-19 response, physician leadership training, SaferCare, and NH organizational culture.

In Fall of 2020, the Specialist Services Committee Facility Engagement Working Group (provincial oversight body for the Facility Engagement Initiative) approved a Facility Engagment "Regional Engagement Framework." Goals of regional engagement are to enhance networking and relationship building between MSAs and Health Authority, to identify shared priority setting between MSAs and Health Authority, and to encourage MSA representation and input into Health Authority system priorities at a regional level. The Framework takes a flexible and adaptable approach to meet physicians and Health Authority readiness, preference, and capacity (i.e., adapting or building upon existing structures). Northern Health has expressed interest in regional engagement through this new framework. Currently the MSA Presidents' Council is in its early stages of development including forming lines of communication with Northern Health. The supports from Doctors of BC and the Joint Collaborative Committee's staff are working with the Presidents' Council and ready to support regional engagement.

Spread

Also in Fall 2020, the Physician Services Committee provided direction to the SSC to pivot their one-time funding investments to prioritize "spread" of quality improvement projects within the health authority, addressing larger scope system change with existing and successful quality improvements. The intention is to address the sentiment that there is already an abundancy of quality improvement projects in every region of the province that need some additional supports to achieve their longer term intended impact. To support this collaborative endeavour, the Northern Health Physician Quality Improvement (PQI) Steering Committee is transitioning to a broader mandate committee, NH/SSC PQI & Spread, ensuring appropriate tri-party representation from the health authority (medical and operational leaders), clinically active physicians, and the SSC. As part of this transition, successful quality improvement projects that originate at the local Medical Staff Associations will be eligible for consideration for spread support.

Collaboration amidst COVID 19

Building and maintaining a solid foundation between the health authority and the physicians has allowed both groups to come together quickly and collaboratively throughout the COVID-19 response, as highlighted in the experiences of Northern Health administrative leaders and medical leaders, as well as MSAs in the attached "Coming Together" publication (See Appendix B). Gratitude and celebration of partnered achievements is featured as a theme. The stories

showcase effective teamwork, resourcefulness, and innovation. This coming together resulted in prepared care teams who actively co-created processes for the effective management of patients at all ages and levels of care in communities across our region. Their shared achievements are sure to have lasting benefits for patients going forward in the Covid-19 Pandemic and beyond.

Acknowledgements: Thank-you to the Facility and Community Engagement staff (Gemma Fletcher, Erin Smith Friesen, Monicque Jacobs, Susan Schienbein) and DoBC staff (Holly Pastoral) for providing information and data for this update.

Appendix A. Facility Engagement NH Site Status as of April 23, 2021

Site Name	Status	Funding Available Per Year
UHNBC	Fully Funded	$400,000
Mills Memorial (Terrace)	Fully Funded	$150,000
Haida Gwaii Hospital and Health Centre (Queen Charlotte)	Fully Funded	$50,000
Bulkley Valley District Hospital (Smithers)	Fully Funded	$65,000
Wrinch Memorial Hospital (New Hazelton)	Fully Funded	$50,000
Stuart Lake Hospital (Fort St. James)	Fully Funded	$35,000
Prince Rupert Regional Hospital	Fully Funded	$150,000
St. John Hospital (Vanderhoof)	Fully Funded June 2018	$65,000
Northern Haida Gwaii Hospital and Health Centre (Masset)	Fully Funded December 2018	$35,000
Dawson Creek and District Hospital	Fully Funded October 2018	$150,000
Kitimat General Hospital	Potential	$65,000
Chetwynd Hospital and Health Centre	Fully Funded October 2018	$35,000
Lakes District Hospital and Health Centre (Burns Lake)	Fully Funded March 2020	$50,000
Mackenzie and District Hospital and Health Centre	Fully Funded December 2018	$35,000
GR Baker Memorial Hospital (Quesnel)	Fully Funded March 2020	$150,000
McBride and District Hospital	Fully Funded March 2020	$35,000
Fort Nelson General Hospital	Start up Funding March 2021	$50,000
Fort St. John General Hospital	Fully Funded October 2018	$150,000

Appendix B. Coming Together: COVID-19 Success Stories

See Attached Document

COMING TOGETHER: COVID-19 SUCCESS STORIES

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On the cover: *Practicing a COVID-19 Code Blue drill (cardiac arrest) at Xaayda Gwaay Ngaaysdll Naay Hospital in the Village of Queen Charlotte. L – R: Norm Wager, paramedic with BC Ambulance Service (BCAS); Dr. Caroline Shooner; Dave Schroeder, BCAS paramedic.*

Photo: *Kerry Laidlaw, Site Administrator, Xaayda Gwaay Ngaaysdll Naay Hospital*

Introduction

Despite the many obstacles that our region has faced during the COVID-19 pandemic, a quick scan of the region highlights a number of good news stories related to teamwork, physician engagement, and the power of collaboration.

This pandemic has brought our teams closer together and sparked collaboration in planning, developing, and implementing initiatives that will have lasting positive impacts on our region.

Despite the situation, it's important that we take time to pause and reflect on the efforts of physicians, health authority staff, and administration. Join us as we celebrate and highlight examples of collaboration between the health authority and physicians that facilitated this unparalleled success.

We couldn't include every success story, but we hope these examples will inspire everyone to continue to look for opportunities to work together in partnership.

Physicians and nurses on Haida Gwaii doing simulation drills.
Photo: *Kerry Laidlaw, Site Administrator, Xaayda Gwaay Ngaaysdll Naay Hospital*

Message from VP Medicine

This pandemic has affected all of us; we have been faced with challenges and turmoil that have impacted all aspects of our lives. I want to recognize and thank you all for your efforts.

The events of 2020 thus far have impacted us in ways that we have never felt before. This has demonstrated the importance of coming together, sharing, and supporting one another. I have been, and continue to be, inspired by the stories of physicians partnering with staff, administration, and community to provide care, support, and empathy to our patients. It is this collaborative approach and partnership that will help us through this challenging time.

I am also thankful for the co-leadership approach that has been demonstrated throughout our organization, as well as the physician leadership that has been shown thorough the medical staff associations and divisions. We are thankful to our partners at the joint collaborative committees for providing these opportunities and resources to support physician engagement.

On behalf of Northern Health, we want to thank you all for your continued efforts and for demonstrating Northern Health's values of empathy, respect, collaboration, and innovation.

Sincerely,
Dr. Ronald Chapman

VP Medicine
Northern Health

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Haida Gwaii

Across **Haida Gwaii**, the pandemic brought teams together. At the two hospitals, physician leaders and staff from administration and nursing could be found each morning taking part in “huddles.” During these informal meetings, they shared situational updates and coordinated the distribution of oxygen, personal protective equipment (PPE), and other resources.

Throughout the pandemic, physicians took the lead on providing informational webinars and acting as a resource to the **Council of the Haida Nation**.

At **Xaayda Gwaay Ngaaysdll Naay Hospital** in the Village of Queen Charlotte, physicians led the development of protected intubation protocols and education drills for both physicians and nurses. As well, physicians worked with administration to create locally relevant COVID-19 treatment protocols.

In addition, physicians participated in the Village of Queen Charlotte’s emergency operations centre, and took the lead on developing a video for the public that explained how to access care at the hospital and what to expect when being screened.

One physician also mentored and coached colleagues on using virtual platforms to see patients.

Charlotte Houston, a paramedic with the BC Ambulance Service, practices a COVID-19 Code Blue drill (cardiac arrest) at Xaayda Gwaay Ngaaysdll Naay Hospital in the Village of Queen Charlotte.

Photo: *Kerry Laidlaw, Site Administrator, Xaayda Gwaay Ngaaysdll Naay Hospital*

Terrace

At **Mills Memorial Hospital** in Terrace, physicians and administration needed to come together quickly to reorganize patient flow in the hospital, set up an infectious disease unit, and create a special unit in the emergency room.

The site leadership team has been impressed with the collaboration between physicians, staff, and administration. Service was seamless as the three groups worked together as a team.

Mills Memorial also saw a clinical group develop across multiple disciplines to create new workflows, diagrams for patient flow, and screening criteria. Throughout the hospital, management meetings included physicians as leaders. Daily leadership huddles took place, and physician leaders were an integral part of decision-making and strategy development.

> “We feel because our co-leadership roles have evolved and we have trust in how we work, we came into this pandemic in collaboration. We were able to show the teams that this is the way we work every day -- with physicians as partners.
>
> We have an established relationship that allowed us to move fast and be consistent and clear in our messaging. Everyone on a local level was on the same page. Physicians and nurses showed up to do ventilator training together. We all showed up at meetings and everyone contributed.
>
> This pandemic showcased how strong collaboration across administration, staff, and physicians can have a positive impact on our everyday work.”
>
> - HSA Chris Simms & Chief of Staff Dr. Dawid Van Rensburg

Everything happened so quickly at Mills Memorial that nobody had a chance to go to the medical staff association with a formal request. However, Health Service Administrator Chris Simms and Chief of Staff Dr. Van Rensburg agreed that this didn’t matter: “The barriers between us disappeared, and we were working together as a team.”

The medical staff association was quick to support physicians with reimbursement for the time they spent planning and reorganizing the hospital. The association also organized discussions outside the hospital, providing space to have important discussions between administration, physicians, and other staff about next steps. They created an environment that facilitated sharing and cohesion.

Physicians and nurses on Haida Gwaii doing simulation drills.

Photo: *Kerry Laidlaw, Site Administrator, Xaayda Gwaay Ngaaysdll Naay Hospital*

Smithers

During the early weeks of the pandemic in March and April, medical staff in **Smithers** worked with the local Northern Health team to coordinate a response. During weekly medical staff meetings, physicians and local Northern Health leaders talked through challenging operational decisions to prepare for worst-case scenarios.

As the situation progressed, local physicians helped communicate to the community, asking for everyone’s help in flattening the curve. Physicians also took on many lead roles, including ventilator training, equipment selection, emergency room and inpatient preparation, PPE usage, and supply chain management.

Burns Lake

Physicians and nurses on Haida Gwaii doing simulation drills.
Photo: *Kerry Laidlaw, Site Administrator, Xaayda Gwaay Ngaaysdll Naay Hospital*

Physicians and administration in **Burns Lake** worked together throughout the pandemic, creating processes to keep staff and clients safe. Physicians also worked with staff and administration to assess the effectiveness of these new processes and work towards continuous quality improvement. Physicians provided ongoing insight, were active in all levels of planning, and helped to create a recovery plan that guided the restart of services for the community.

> "It was great to hear from the physicians regularly to help understand the challenges they face in their practice." - Vicky Rensby, Health Service Administrator for Burns Lake

Prince George

Dr. Jamil Akhtar, Clinical Assistant Professor, Anesthesia, UBC DSSL, Discipline-Specific Site Lead, UNBC/UBC, simulating intubation of a COVID-19 patient at UHNBC in Prince George.

Photo: *Hannah Lloyd, PACU Nurse, UHNBC, Prince George*

At the **University Hospital of Northern British Columbia** (UHNBC), physicians and NH leaders met weekly to plan, troubleshoot, and allocate resources. This included collaboration between formal medical and administrative leadership, as well as approximately 11 other physicians, including representatives from the medical staff association (UPIC) and the local Division of Family Practice.

The development of this team approach was the impetus for several major successes, including the use of the Urgent Primary Care Centre for COVID-19 testing, and the co-development of a strategy for discharging patients from the hospital to keep patients safely at home.

This team also implemented a comprehensive plan to organize patients that helped adjust hospital services according to the guidance provided by the province. Together, this team of physicians and administration reorganized patient flow and planned for COVID-19 patients using simulations for the operating room, obstetrics and pediatrics.

Similarly, Northern Health partnered with various physicians from critical care, anesthesia, and emergency to develop a proposal for an airway team and airway protocol.

Physicians and nurses on Haida Gwaii working with BC Ambulance Service (BCAS) paramedics to simulate a COVID-19 cardiac arrest. L–R: Dr. Caroline Shooner; Charlotte Houston, BCAS paramedic; RN Rhonda Hall; Dr. Tamara Delorme.

Photo: *Kerry Laidlaw, Site Administrator, Xaayda Gwaay Ngaaysdll Naay Hospital*

Physicians and administration worked together to establish the development of the respiratory emergency room stream, a COVID-19 palliative care strategy, and additional ICU capacity for COVID-19 patients across Northern Health.

Several collaborative efforts at UHNBC had regional impacts as well. Together, physicians and administration co-developed guidelines for managing obstetrical patients and pediatric patients during COVID-19. There were multiple instances of collaboration between the medical staff association (UPIC), the Division of Family Practice (community-based groups of family physicians working together to achieve health care goals), and Northern Health administration. Examples:

- A virtual psychiatry meeting with the Northern Interior Rural Division that facilitated the co-development of a referral pathway, a set of criteria for virtual care, and a new workflow.

- The development of a virtual COVID-19 ward for home monitoring and virtual visits. This work included the creation of the Community COVID-19 Monitoring Assessment Algorithm for Physicians, which was made available across the region. This initiative focussed on keeping patients at home, rather than in the hospital. This has the potential to grow into further work to support the management of COPD and pneumonia patients at home.

SURVEY SHOWS THE VALUE OF COLLABORATION

Over the course of the pandemic, UPIC actively supported physician engagement and collaboration at UHNBC. A recent survey highlighted the value of this collaborative approach; comments from respondents included:

COLLABORATION:

- “Great collaboration amongst stakeholders in the fight against COVID-19 was made possible by this initiative”
- “Improved collaboration between physicians and non-physician staff”
- “Improved collaboration between specialist and primary care physicians”

OTHER TOPICS:

- “Promotes consistency, evidence-based management plan – so that all are on the same page to managing the pandemic and patient care”
- “Better organized to manage these patients”
- “Improved teamwork”
- “Improved communication between healthcare providers”
- “Super valuable programs were created”

McBride & Valemount

One of the major successes in the **Robson Valley** was planning and training together to prepare for the pandemic. Simulation drills were co-created to prepare for potential cases of COVID-19. The whole team participated in these simulations, which were held on alternate days to accommodate all physicians and staff. There were effective learning and team-building opportunities in both McBride and Valemount during this time. This preparation for the pandemic and the opportunity to learn together brought everyone closer.

Northeast

> "The engagement has been very positive … this work has pulled us all forward together."
> - Angela De Smit, Chief Operating Officer

Across the **Northeast**, physician leaders set up weekly morning phone calls for all physicians (each community had its own day). These weekly discussions, along with daily Northern Health updates, were able to ease some of the anxiety and create clear communication channels between the health authority and physicians.

"Meetings enabled physicians to raise their concerns and receive answers right away," said Angela De Smit, Chief Operating Officer, Northeast.

"This led to confidence and assurance as to the direction of NH and the province in how to manage the COVID-19 response. I believe these weekly meetings have improved relationships and will build ongoing engagement moving forward. The engagement has been very positive. Initially it was quite fragmented, with different approaches being proposed by both physicians, administration, and other health disciplines, but this work has pulled us all forward together."

Team working with BC Emergency Health Services in Vanderhoof simulating CPR in their personal protective equipment.

Photo: *Laine Smith, Educator for BC Emergency Health Services*

Fort St. John

The entrance to the emergency department at Fort St. John Hospital. **Photo:** *Northern Health*

The **Fort St. John Emergency Operations Centre** was open to all physicians, and included health authority administration and physician leaders, as well as representatives from the Fort St. John Medical Staff Association.

The group enabled consultation and collaboration, and was able to make decisions quickly at each meeting to respond to the rapidly changing situation. The MSA also formed a COVID-19 working group to discuss evolving concerns.

Within the units at **Fort St. John Hospital**, Neil Evans, the Manager of Inpatient Services, says that COVID-19 instigated the most collaboration and physician engagement that he has seen in his 14 years with the organization.

He explained that early in the pandemic, everyone got together to kick-start planning and this is when he really started to see physician engagement. He highlighted that there was an urgency that instigated that collaboration, but also that the physician leadership from the Chief of Staff, Deputy Chief of Staff, and MSA President helped facilitate engagement throughout the pandemic.

Everyone came to the table to reorganize the hospital and set up a patient placement plan and infectious disease unit. Significant work came from smaller focussed working groups that included both physicians and administration. This work has supported ongoing benefits for discharge planning and keeping occupancy rates below 90%. The hospital has now developed a plan to “build back better”, which includes strong collaboration and physician engagement.

Fort St. James

In **Fort St. James**, the Medical Staff Association, the Fort St. James Primary Care Society, and Northern Health worked together throughout the pandemic on a number of initiatives. Physicians from the association met with the hospital nursing staff and designed modifications to the hospital that would change patient flow, protecting both long-term care patients and inpatients at the hospital.

The medical staff associate, the Fort St. James Primary Care Society, and the Northern Health interprofessional team established a drive-through COVID-19 testing site at the health centre, along with an isolation room for patients who couldn't arrive by car.

A co-leadership planning workshop for Smithers. L – R: Dr. Mary Knight, Deputy Chief of Staff; Cormac Hikisch, Health Service Administrator; Dr. Sandra Vestvik, Chief of Staff.

Photo: *Candice Manahan, Regional Director - Physician Quality, Engagement and Education*

A weekly community meeting was organized to keep everyone informed, and a community document was created that everyone had access to. The Fort St. James Primary Care Society, the MSA, and the NH interprofessional team worked closely with First Nations community health centres to determine how to care for all of our patients, both in person and virtually.

Vanderhoof

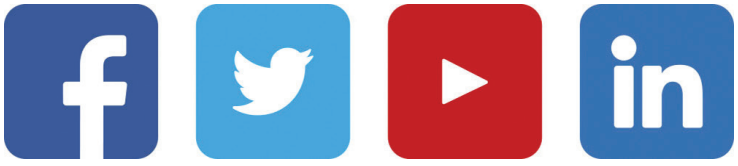
The collaborative effort between physicians, hospital administration and staff to plan for COVID-19 at St. John Hospital began when they decided to enlist the support and expertise of two physicians who had recently left the community to come back and coordinate a plan.

One physician led a COVID-19 hospital working group that met regularly to discuss hospital flow planning and issues around procedures, personal protective equipment – such as masks and gloves – and other issues. This group included the health service administrator, the clinic manager, and representatives from nursing and other areas of the hospital as needed.

Specific physicians from different areas of the hospital were called upon for their thoughts on best practices and patient flow. This group worked through many of the issues around safety, space, and supplies to create flow plans that covered each area of the hospital. They also created communications to help the community understand how to continue to access health care in Vanderhoof.

Another physician lead focussed within the community and was instrumental in helping to form the Omineca Regional Response, a community-based group that included government leaders from the region, First Nations leaders, Search and Rescue, paramedics, community counselling and outreach service providers, faith-based members, the Chamber of Commerce, industry representatives, and more.

This group focussed on gathering information from members to share with the rest of the community through a Facebook page, a website, and various social media channels. This group continues to meet on a regular basis to check in on the overall COVID-19 response plan for the local region.



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BRIEFING NOTE

Date:	**May 4, 2021**	
Topic	**Energy and Environmental Sustainability Portfolio**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Governance and Management Relations**	
Prepared by:	**Rosalynn St Pierre, Manager, Energy & Environmental Sustainability** **Arzan Balsara, Energy Specialist** **Ken Van Aalst, Director, Facilities Maintenance, Engineering and Environmental Sustainability**	
Reviewed by:	**Mike Hoefer, Regional Director Capital Planning and Support Services**	

Issue:

Annually, the Board's Governance and Management Relations (GMR) Committee receives Northern Health's (NH) Energy and Sustainability Portfolio Briefing Note for information.

2020-2023 Strategic Plan

The activities under the Energy and Environmental Sustainability Portfolio are aligned with Northern Health's strategic priorities:

- *Communications, Technology, and Infrastructure.*
  NH's efforts related to carbon neutrality are part of building, maintaining and managing facilities and infrastructure in support of service delivery.
- *Healthy People in Health Communities*
  Reducing our greenhouse gas emissions and managing our resources contributes to healthy communities and environments.

Background:

NH's energy initiatives, described more fully in the Strategic Energy Management Plan (SEMP), outlines a series of actions designed to produce long term, sustainable reductions in our overall energy consumption, primarily natural gas, electricity, propane, and water. These efforts are led

by the Energy & Environmental Sustainability team with the support of Facilities Maintenance, Capital Planning & Support Services.

NH's work towards Energy & Environmental Sustainability align with the Climate Change Accountability Act which includes legislated targets for reducing greenhouse gases, a climate change accountability framework, and requirements for the provincial public sector.

The following provides highlights of the 2020/21 fiscal year (F2021) and plans for the 2021/22 fiscal year (F2022).

Demand Considerations

In F2021, NH experienced the following new demand pressures:

COVID-19 Pandemic: The COVID-19 pandemic was declared by the World Health Organization on March 11, 2020. In response:

- Staff were asked to work from home when possible
- Elective surgeries were postponed
- Where possible, air handling units were to bring in as much outside air as possible

Decrease in Floor Area: The Atlin Health Centre replacement added 236 m^2 of owned facility area in 2020. The Atlin project replaced a leased space of 115 m^2. The Dawson Creek Mental Health Residence was closed in 2020 as well, removing 1,618 m^2 of space. The net change in floor area for 2020 was 1,497 m^2 decrease.

Changes in Weather: Taking a weighted average[1] of heating degree days (HDD) across our region, there was negligible difference between 2019 HDD and 2020 HDD.

Energy Efficiency, Energy Reduction, and the Effect on Carbon Costs

Carbon Offsets Reporting: NH continues to be carbon neutral through the purchase of carbon offsets as per provincial legislation. The price is $25/tonne of CO_2 equivalents (tCO_2e), which for natural gas works out to $1.28/GJ. All government entities are required to self-certify the data submitted through a declaration by a Designated Representative. Northern Health's Designated Representative is Mark De Croos, VP Finance/ CFO.

Due to COVID-19, the Climate Action Secretariat issued a statement allowing the reporting of calendar year 2019 emissions to be delayed from April 30, 2020 to September 30, 2020. For this reason, the purchase of 2019 carbon offsets was calculated based on 2018 reported emissions, and adjustments (credits/charges) against the offset purchases were made once 2019 data was received in full after September 30, 2020.

For the 2020 calendar year, NH will purchase approximately 22,400 tonnes of carbon offsets at an estimated cost of $560,000 (plus applicable taxes); about a 1% increase from 2019.The

[1] Communities that consume more energy are given more weight in the HDD average than communities that consume less energy.

increase in carbon emissions, despite decrease in floor area, is likely due to increased heating demand of more outdoor air as ventilation requirements responded to the COVID-19 pandemic.

Carbon Tax: BC's F2022 carbon tax rate is $45/tCO$_2$e, which for natural gas works out to $2.31/GJ. The carbon tax is collected by the utilities on behalf of the Province on each invoice. The carbon tax rate is expected to increase in F2023 to $50/tCO$_2$e on April 1, 2022 ($2.56/GJ on natural gas). The F2022 combined cost of carbon (tax plus offsets) on natural gas is $3.58/ GJ, or $70/tCO$_2$e.

Climate Change Accountability Report (CCAR): As in previous years, NH will submit a report (previously titled the Carbon Neutral Action Report (CNAR)) to CAS on our actions toward reducing our carbon footprint. This report highlights work identified in this Briefing Note. The report is signed by NH CEO and is posted on the BC Government website along with reports from other government agencies.

Carbon Neutral Capital Program (CNCP): The CNCP program provides capital incentives to help implement projects to reduce our carbon footprint. NH's F2020 CNCP allocation was $560,000. The CNCP allocation was increased to $1.96 M for F2021 and F2022. The F2022 (and a few of the F2021) projects have applied for a 40% funding contribution from the Regional Hospital Districts. Below is a summary of the CNCP projects completed and planned between F2020 to F2022.

Site	Project	Budget	Year	Energy Savings (eGJ/yr)	Carbon Savings (tCO$_2$e/yr)
Fort Nelson General Hospital	Domestic hot water upgrade	$212,000	F2021	90	5
McBride & District Hospital	Boiler upgrade	$404,000	F2021	360	20
UHNBC	Integrated fault detection and diagnostic software and controls	$168,000	F2021	2,420	105
St John Hospital	Heat pump and air handling unit coils	$591,000	F2021	2,970	170
Lakes District Hospital	Domestic hot water upgrade	$411,000	F2021	1,220	60
Bulkley Lodge	Domestic hot water upgrade	$547,000	F2021	600	30
	F2021 Total	**$2,855,000**		**7,660 GJ**	**390 tCO$_2$e**

Cont'd from above

Fort Nelson General Hospital	Heating boiler upgrade and heat recovery	$744,000	F2022	2,170	109
Chetwynd General Hospital	Boiler upgrade	$611,000*	F2022	380	18
Dunrovin Park Lodge	Boiler upgrade	$632,000	F2022	600	30
Houston D&T Centre	Air handling unit upgrade	$862,000	F2022	670	34
Prince Rupert Regional Hospital	Domestic hot water upgrade	$452,000*	F2022	320	16
	F2021 Total	**$3,294,000**		**4,140 GJ**	**207 tCO_2e**

**estimated budget and subject to change*

NH Energy Management: Currently the Energy and Environmental Sustainability portfolio is managed under the Director of Facilities Maintenance, Energy & Environmental Sustainability. BC Hydro partially funds the Energy Manager and FortisBC partially funds the Energy Specialist under this portfolio. NH has brought both the Energy Manager and Energy Specialist positions in house as of July 2020 after nearly a decade of contracting out these positions to consultants.

Energy Awareness: NH continues to participate in an Energy Wise Network program focusing on energy saving behaviour by staff. There is ongoing support from the Energy & Environmental Sustainability team to support Green Working Groups/Champions at interested sites.

CleanBC Electrification Project: In 2019, NH started a 2 year $1.4 M CleanBC electrification project (with a $200,000 incentive agreement) at St John Hospital, Vanderhoof. This project consists of condensing boilers and a heat pump system. The amount of energy saved and offset by this project is expected to be approximately $100,000/year.

BC Hydro and FortisBC Incentives: With the increase in F2021 and F2022 CNCP funding, NH was able to implement a number of energy projects that attracted incentives from both BC Hydro and FortisBC. About $410,000 in incentives were earned in F2021 and $476,000 were earned in F2022.

Provincial Environmental Technical Team (PETT): NH participates on a provincial health authority environmental committee reporting to the BC Health Authorities Service Delivery Steering Committee. Among the guiding principles going forward are Climate Change, Mitigation, Adaptation, resiliency, and LEED Gold Buildings. This committee has standing representation from Provincial Health Services Authority Supply Chain, Ministry of Health, Climate Action Secretariat, BC Hydro, and FortisBC.

Recommendation(s):

For information only

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BRIEFING NOTE

Date:	**May 4, 2021**	
Topic	**Climate Change Accountability Report – Executive Summary**	
Purpose:	☒ **Information**	☐ **Discussion**
	☐ **Seeking direction**	☐ **Decision**
Prepared for:	**Governance and Management Relations**	
Prepared by:	**Rosalynn St Pierre, Manager, Energy & Environmental Sustainability** **Arzan Balsara, Energy Specialist** **Ken Van Aalst, Director, Facilities Maintenance, Engineering and Environmental Sustainability**	
Reviewed by:	**Mike Hoefer, Regional Director Capital Planning and Support Services**	

Issue:

Annually, the Board's Governance and Management Relations (GMR) Committee receives Northern Health's (NH) Climate Change Accountability Report (CCAR) executive summary for information.

2016-21 Strategic Plan

The activities under the CCAR are aligned with Northern Health's strategic priorities:

- *Communications, Technology, and Infrastructure.*
  NH's efforts related to carbon neutrality are part of building, maintaining and managing facilities and infrastructure in support of service delivery.
- *Healthy People in Health Communities*
  Reducing our greenhouse gas emissions and managing our resources contributes to healthy communities and environments.

Background:

The Carbon Neutral Government program requires public sector organizations (PSOs) to submit a CCAR, legislated under the Climate Change Accountability Act. The purpose of the CCAR is to provide an annual update on PSO progress towards carbon neutrality. The CCAR was

formerly known as the Carbon Neutral Action Report (CNAR). The CCAR is due May 31, 2021 and the draft report is submitted for NH executive review a few weeks prior. The Carbon Neutral Government confirmed that this year, final carbon offset amounts will not be invoiced until May 31, 2021, thus creating a potential for small (<1%) adjustments to the CCAR reported numbers and the final carbon offset owed amount. In previous years, carbon offset invoices were received by May 15, thus allowing finalized offset numbers to be published in the report.

2020 CCAR Executive Summary

Northern Health is pleased to submit our new 2020 Climate Change Accountability Report to communicate on the progress and actions underway to reduce our carbon emissions. This past year has seen many new challenges and opportunities. There were challenges responding to the COVID-19 pandemic, however, we also realized opportunities that allowed us to make great strides in our energy management and environmental sustainability work. Being responsible stewards by reducing our greenhouse gas emissions to improve our future climate, aligns with our top strategic priority of Healthy People in Healthy Communities.

The COVID-19 pandemic affected all aspects of Northern Health operations immensely. The way that facilities operated in response to the pandemic affected energy use in some ways that competed with our carbon reduction goals, and in some ways helped with energy conservation. Overall for 2020, we saw an approximate 2.6% increase in carbon emissions and we will purchase approximately 22,900 tonnes of carbon offsets at a cost of $571,800.

Under the CleanBC Plan, Northern Health received enhanced funding for Carbon Neutral Capital Projects in 2020. This allowed us to initiate six energy projects that are projected to save 390 tonnes of CO_2 equivalents (tCO_2e) annually, equating to approximately 1.7% reduction annually in our overall emissions. As part of the 2020 energy project portfolio, we continued work at St. John Hospital in Vanderhoof with a heat recovery system that is projected to reduce the hospital's emissions by almost 50%. A further five capital energy projects are planned for 2021 that have the potential to save over 200 tCO_2e per year. An additional benefit to these energy projects is increased redundancy and reliability for Northern Health's facilities and enabling our buildings to be more resilient to changing future climate.

Another highlight to the work towards climate change accountability is that we brought on two new, internal, full time, team members to the Energy & Environmental Sustainability portfolio.

As we continue to respond to the COVID-19 pandemic, and adapt to the changing world, it is important that we pay close attention to how Northern Health's operations impact our carbon footprint. We must continue to carry out innovative projects and initiatives that will help mitigate climate change impacts and lay the foundation for ongoing greenhouse gas reductions. Northern Health remains committed to sustainable actions and leaving a healthy environment for the future populations of Northern BC.

Recommendation(s):

For information only

2020 Climate Change Accountability Report

Skeena River – Ashley Ellerbeck, Northern Health

MAY 31, 2021

Arzan Balsara
Energy Specialist
Rosalynn St. Pierre
Manager, Energy & Environmental Sustainability

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Executive Summary

Cathy Ulrich, President and Chief Executive Officer

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Another highlight to our work towards our climate change accountability is that we brought on two new, internal, full time, team members to our Energy & Environmental Sustainability portfolio.

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_____

May 31, 2021
Cathy Ulrich
President and CEO, Northern Health

Contents

Declaration Statement

This Climate Change Accountability Report for the period January 1, 2020 to December 31, 2020 summarizes our emissions profile, the total offsets to reach net-zero emissions, the actions Northern Health has taken in 2020 to reduce our greenhouse gas emissions, and our plans to continue reducing emissions in 2021 and beyond.

Retirement of Offsets

In accordance with the requirements of the *Climate Change Accountability Act* and Carbon Neutral Government Regulation, Northern Health is responsible for arranging the retirement of the offset obligation reported in Table 1 for the 2020 calendar year, along with any adjustments reported for past calendar years (if applicable). The Ministry of Environment and Climate Change Strategy (the Ministry) ensures that these offsets are retired on Northern Health's behalf, and Northern Health remunerates the Ministry in an amount equal to $25 per tonne of offsets retired on its behalf plus GST.

Table 1. Northern Health 2020 Emissions and Offset Summary Table

Northern Health 2020 GHG Emissions and Offsets		
Total Emissions	22,902	tCO_2e
Total $BioCO_2$	30	tCO_2e
Total Offsets	22,872	tCO_2e
Offsets Adjustment	0	tCO_2e
Grand Total Offsets to be Retired for the 2020 Reporting Year	22,872	tCO_2e
Offset Investment ($25 per tCO_2e)	$571,800	

2020 Greenhouse Gas Emissions

Northern Health reports its organizational carbon emissions based on guidelines provided by the Carbon Neutral Government Regulation (CNGR) and the Climate Action Secretariat (CAS).

Greenhouse gases (GHGs) from various sources have been converted to metric tonnes of carbon dioxide equivalent (tCO_2e) for comparison. Figure 1 below summarizes the breakdown of our 2020 GHG emissions by source. Our total carbon footprint offset in 2020 was 21,920 tCO_2e.

Stationary fuel consumption accounted for 93% of our GHG emissions and electricity consumption contributed 3%. Vehicle fleet accounted for 3% of our GHG emissions and paper accounted for 1%.

Breakdown of GHG emissions by source:

- Fuel + Electricity: 21,847 tCO_2e
- Fleet: 696 tCO_2e
- Paper: 29 tCO_2e

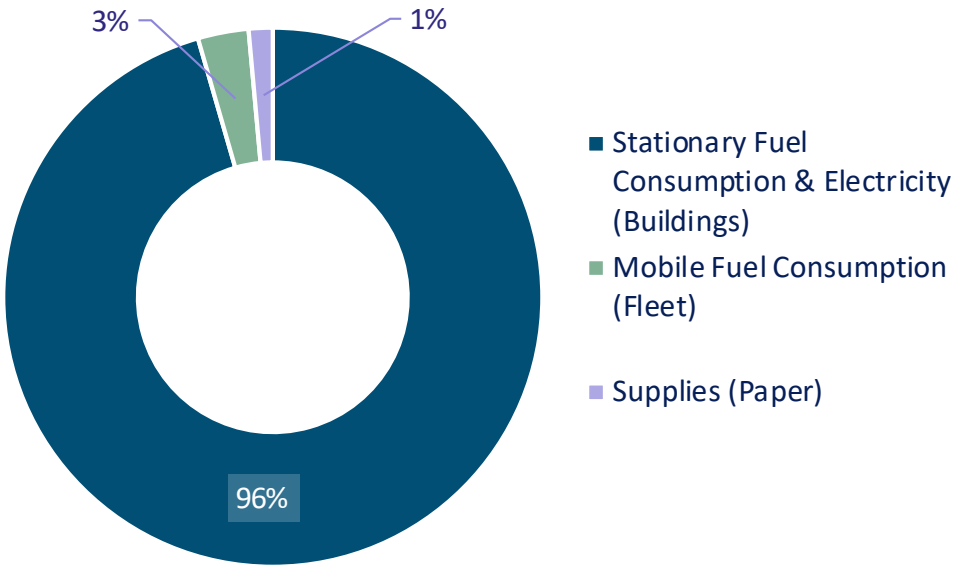


Figure 1. 2020 Northern Health GHG Emissions by Source

Greenhouse Gas Reduction Actions

Northern Health's strategies to reduce greenhouse gas emissions are detailed in our annual Strategic Energy Management Plan (SEMP). The SEMP is developed by the Energy & Environmental Sustainability team with involvement from Capital Planning, Facilities Maintenance, and Support Services. The SEMP is evaluated by a third party for its alignment in key focus areas such as commitment, situational analysis, and actions.

Commitment

We show our commitment to reducing greenhouse gas emissions a number of ways.

1. Set carbon reduction goals and targets
   Our target is to reduce electricity consumption by 500,000 kWh year over year, and fossil fuel consumption by 4,000 GJ year over year. This works out to roughly a 1% reduction in energy use each year.
2. Allocate dedicated resources towards energy management and environmental sustainability
   Northern Health internalized the Manager, Energy & Environmental Sustainability and the Energy Specialist positions in 2020, after 10 years of contracting these positions out. This commitment to having full time, permanent resources dedicated to Energy & Environmental Sustainability will allow Northern Health to plan carbon reduction actions more strategically.
3. Observe our Energy & Environmental Sustainability policy
   Align our operations to our carbon reduction goals.

Situational Analysis

In order to improve, we need to measure and analyze key performance indicators (KPIs) related to energy use, building performance, energy project performance, and waste generation. Collecting these KPIs is an important aspect of our work that guides our actions and informs our decisions around greenhouse gas reduction projects and initiatives.

Actions

Buildings

Northern Health currently owns and operates over 300,000 m^2 of clinic, acute care, and long term care floor space. We work to reduce greenhouse gas emissions from our buildings by using our full allocation of Carbon Neutral Capital Project (CNCP) funds each year. CNCP funds are used towards projects that lower building greenhouse gas emissions.

Lakes District Hospital, Burns Lake 2015
AME Group, 2021

The types of CNCP energy projects that were pursued in 2020 included:

- Heating boiler upgrades with high efficiency condensing boilers
- Upgrades to domestic hot water systems that took advantage of on demand heating,
- Heat recovery and heat pump technology
- Integrated fault detection and diagnostic software
- LED lighting upgrades

Lakes District Hospital, Burns Lake 2015
Infrastructure BC, 2021

In 2020, approximately 10% of our sites received minor energy retrofits such as caulking, lighting, adding insulation, etc. Another approximately 10% of our sites received major or deep retrofits,. Major retrofits include replacing windows, doors, equipment such as boilers, etc., and deep retrofits include replacing roofs, replacing heating, ventilation, and heat recovery etc.

No new buildings were completed in 2020, so we have no updates to our LEED gold portfolio to report this year. Additionally, as with previous years, no refrigerant gases category and refilling volumes were recorded.

The following projects are highlighted in this report for their excellent contribution to Northern Health's carbon emission targets.

St. John Hospital, Vanderhoof – Heat Pump

Condensing boilers
St. John Hospital, Vanderhoof

Heat pump
St. John Hospital, Vanderhoof

St. John Hospital in Vanderhoof received five new condensing boilers in 2019 along with pumps, piping and duct work to support heat recovery coils and reheat coils. In 2020 a new air to water heat pump was added to take heat from air handling exhaust, releasing heat into the low temperature heating loop for air handling pre heat coils. This allows the use of large natural gas boilers to be offloaded in low load and shoulder seasons.

This project is expected to save the hospital:

- **50%** of its greenhouse gas emissions (408 tCO_2e per year)
- **$100,000** per year in energy costs
- **7,000 GJ** in equivalent natural gas usage

Integrated Fault Detection & Diagnostics (IFDD)

University Hospital of Northern BC located in Prince George is Northern Health's largest hospital and was selected as a good candidate to optimize the building system controls through Integrated Fault Detection and Diagnostic (IFDD) software. This project also incorporates CO_2 and temperature based occupancy sensors to help inform the control strategies. The IFDD programs will allow building operators to quickly find alarms and faults in the building systems that could lead to wasted energy if not corrected. The IFDD programs also assist the operators in troubleshooting alarms and faults to correct over heated or over cooled zones.

Screenshots from the IFDD program at Univeristy Hospital of Northern BC, 2021

This project is expected to save the hospital:

- **104 tCO_2e** of greenhouse gas emissions per year
- **$30,000** per year in energy costs
- **2,500 GJ** in equivalent natural gas usage

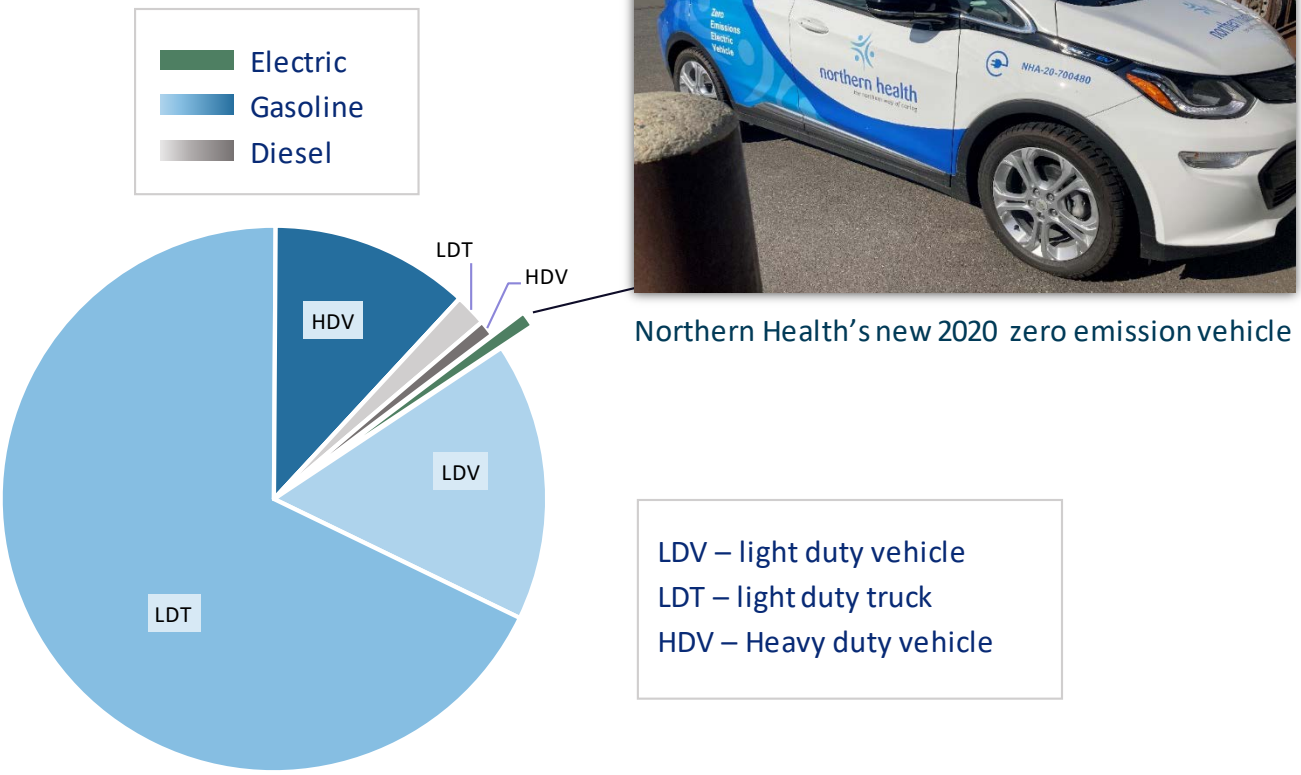
The payback of this project is expected to be under 6 years

Vehicle Fleet

Northern Health's vehicle fleet contains over 200 vehicles, two of which are fully electric. We have two level 2 charging stations installed at our facilities. Fleet emissions account for approximately 3% of Northern Health's total carbon emissions, at just under 700 tCO_2e emitted in 2020.

In 2020, we reduced our fuel consumption by approximately 43,000 L compared to 2019. This equates to roughly 100 tCO_2e of carbon emission reduction from our fleet.

Currently we do not use E100 in our gas vehicles or B100 in our diesel vehicles.



Northern Health's new 2020 zero emission vehicle

Figure 2. Breakdown of Northern Health's fleet by vehicle and fuel type

Paper/Green Procurement

In 2020, Northern Health participated in drafting a briefing note for Provincial Health Services Authority Supply Chain on the benefit of purchasing post consumer (PCR) paper. Northern Health also participated in the PHSA Supply Chain RFP for Paper and Stationary, which included a specification for 30% and 100% PCR paper.

Northern Health is also giving some attention to green procurement. Starting in late 2019, Northern Health, Interior Health, Island Health, Fraser Health, and Vancouver Coastal Health reached out to support and encourage PHSA to embed environmental criteria in their processes for future procurements. PHSA is responsible for managing the supply chain for the health authorities. This initiative is known as Environmentally Preferable Purchasing and our goal is to implement formal processes in our Supply Chain to weigh products and services against environmental criteria.

Waste

Northern Health makes an effort to recycle waste streams as feasibility permits and the resources available in the communities. In 2020, Northern Health implemented a sharps recycling program in over a dozen of their sites. It is estimated that this program will divert approximately 17 tonnes of plastic from the landfills.

Greenhouse Gas Reduction Plan

Buildings

Northern Health will continue to identify retrofit projects at our sites that will reduce greenhouse gas emissions. We will continue to use our full allocation of Carbon Neutral Capital funds to implement these energy projects. In 2021, we are planning more boiler and domestic hot water upgrades, as well as more heat recovery and re-commissioning, which would ensure that our building heating and cooling systems are interfacing as efficiently as possible.

Haida Gwaii Hospital & Health Centre 2016
BKL Consultants Ltd, 2021.

We will also work with FortisBC and BC Hydro to use their incentive programs to help with upgrading HVAC systems and lighting. We plan to increase our participation in the BC Hydro/FortisBC Continuous Optimization program to conserve energy through building operation and controls. We will continue to participate in the BC Hydro Energy Wise Program by implementing campaigns to increase awareness of energy saving strategies for facility operations and support services staff. When seeking new building retrofit opportunities, we conduct building energy analysis and consult

our Facility Maintenance & Operations team to determine which sites and building systems would gain the most from retrofits. We also carry out a number of energy studies through a vast network of energy consultants to help identify new opportunities as well.

Vehicle Fleet

The Northern Health region covers almost two-thirds of BC's geographic area, including the northern most parts of the province. Due to the terrain, climate, and distance between our sites, Northern Health is cognizant of the challenges that face fleet electrification. That being said, options are being strategically explored to continue to electrify our fleet and add more charging stations at our facilities. As fleet vehicles retire, zero emission vehicles will be considered for replacement. As funding comes available, charging infrastructure feasibility studies will be carried out and charging infrastructure to support fleet electrification will be installed.

Northern Health region

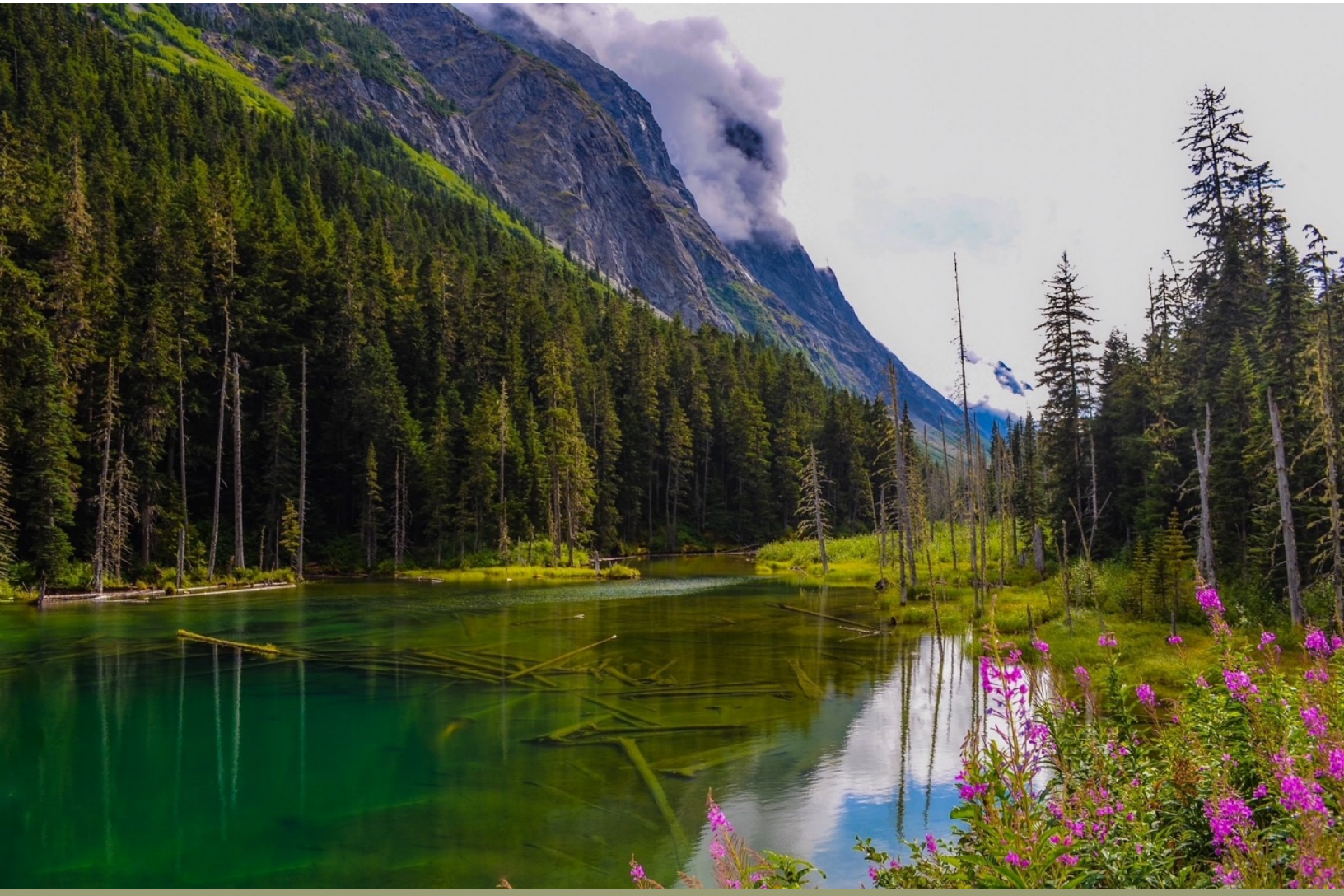
Paper/Green Procurement

Starting in 2021, Northern Health will partner with the other BC Health Authorities to work with PHSA to further Supply Chain's processes to embed environmental criteria in future procurements. The goal of this environmentally-preferable purchasing initiative is to implement formal processes in our Supply Chain to weigh products and services against environmental criteria. Some awareness building progress has been made with our Supply Chain partner, however, this is a longer-term systems change initiative requiring the endorsement of multiple health authorities and PHSA Supply Chain leadership.

Northern Health will continue to work with the other health authorities in 2021 to encourage and support PHSA Supply Chain to work with suppliers and vendors to identify post consumer (PCR) paper options at reasonable prices. We will continue to work with PHSA Supply Chain to find a way to formally increase volume of PCR paper in inventory. Northern Health will also support user PCR pilots and behaviour change campaigns as needed and feasible.

Waste

Northern Health continues to develop and build our Green Working Group initiative to partner with internal teams, including physicians, support staff and facilities maintenance to identify opportunities to either reduce, recycle or sustainably handle waste at our facilities.



Telkwa Pass Trail – Jennifer Klassen, Northern Health

northern health
the northern way of caring

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

HR REPORT

Workforce Planning

The Human Resources Planning and Analytics (HRPA) team is responsible for the development and implementation of a workforce planning strategy for Northern Health (NH). Over the past five years, the HRPA team has been working on various initiatives to support NH's enabling priority Our People; with a focus on understanding our workforce and planning for future needs within the context of a Northern population.

Some of the focused areas of work include:

- Increased automation of workforce analytics
- Improved collaborations with internal and external partners
- Contributing to the pandemic response
- Development and refresh of the Health Human Resources Strategy
- Participation in provincial Integrated Health Human Resources Planning Process
- Development of a sustainable framework for operational workforce planning with NH leaders.

Workforce Analytics

Our workforce is our greatest asset and workforce analytics allows our organization to recognize trends, more efficiently address challenges and make informed decisions. HRPA has been developing more automated and accessible reporting, with a focus on predictive analytics and efficiency gains. This reporting is in the form of dashboards that are available to any leader at any time with up-to-date metrics and analytics relevant to their span of management. This includes reporting on the following:

- Demographic Profiles
- Turnover & Churn Reporting
- Time-to-Fill and Difficult-to-Fill Reporting
- Vacancy Reporting
- Vacation Planning Calendar
- Overtime Hours Analysis
- Hours for Regularization Review
- Casual Workforce Analysis
- Workforce Forecasting Model
- Staffing Key Performance Indicators

Collaborations

HRPA has been collaborating with several internal and external teams to improve the accessibility to HR information and metrics, and to assist with workforce planning needs. This includes:

- Participation in the Northern Health Education Programs Planning Collaborative (NHEPPC) which is a collaboration between NH and partners including the First Nations Health Authority (FNHA) and post-secondary institution (PSI) partners across the North. The Collaborative was established in 2018 to identify synergies in health human resource planning, support student success, develop a framework for communicating health care education needs, and foster collaboration.
- Collaboration with internal partners on the development of reporting and modelling needs to merge financial and clinical data with the health human resource data. Increased lines of communication and collaboration have led to more unified base of reporting for the organization.
- Partnership with Recruitment on the new grad initiative by providing analytics to support the creation of Advanced Hire positions to improve recruitment measures, resulting in the most successful new grad season to date.

Pandemic Response

Over the past year, there has been urgent need to provide focused attention and resources to the COVID-19 pandemic response. HRPA has played a key role in the following areas:

- Participation in the single site working group to ensure compliance with the Provincial Health Officer (PHO) Single Site Order[1] and ongoing monitoring and reporting of the workforce at impacted sites.
- Collaboration with executive leads for COVID-19 Pandemic Response to plan and develop a targeted workforce plan for critical care services aligned with epidemiological modelling, bed and equipment inventory, patient transfer processes and site pandemic plans.
- Development of reports to monitor employee sick and self-isolation hours trending, as well as completion of immunization competency training to inform human resource clinic operation plans for the vaccine clinics.
- Providing relevant workforce and forecasting information to support staffing needs for staff redeployment and outbreak management.
- Collaboration with the pandemic response team on the vaccine roll out priority groupings for staff and progress reporting.

[1] **Province of British Columbia. (2020). Order of the Provincial Health Officer Facility Staff Assignment Order**

Integrated Health Human Resources Planning

Led from Ministry of Health (MoH), 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.

In June 2021, NH will be providing both quantitative and qualitative information that is used to guide provincial investment and decision making with respect to health workforce areas such as: education and training; labour and collective agreements; policy; legislation and regulation; and provincial support for recruitment and retention. The scope of this project includes physician, nursing, and allied health workforce planning. HRPA contributions will be focused on our nursing and allied health workforce and Medical Affairs will be specific to physicians and medical staff.

The desired outcomes of these processes will be an updated Provincial Workforce Strategy that will include comprehensive analysis of prevailing factors affecting the health workforce, supply and demand projections, in-depth priority profession and service area analysis, and workforce development plans aligned with strategic priorities.

Health Human Resources Strategy

To align with the provincial workforce strategy, NH has developed a comprehensive HR Strategy to address the challenges facing our health care workforce in the North, and other key areas of HR that require attention such as workforce planning, recruitment and retention, education and training, and health and safety.

Included in the NH HR Strategy, is a detailed profession plan for each of the nursing and allied health priority professions that were identified by the MoH IHHRP. It also includes a profession plan for Pharmacy Technicians which have been identified as a profession of focus for the north. 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.

In 2020, the MoH added Social Worker, MRI Technologist and Medical Laboratory Technologist to the list of priority professions. NH is also reviewing additional professions (such as Environmental Health Officers) that could be added as

professions of focus for the north. New health human resource profession plans are under development for each of these professions.

Operational Workforce Planning

The operational workforce planning processes facilitates information sharing, supports evidenced based decision making and identifies leading workforce planning strategies to address workforce challenges.

Operational workforce planning will be a focus for the 2021-2022 calendar years. An implementation plan is currently in development. Roll out will include:

- One to one support and training for leaders on utilization of the new automated dashboards.
- Collaboration from stakeholders from multiple teams on the development of a workforce plan for the department or unit.
- Knowledge transfer of planning strategies across region/units with similar workforce challenges.

HRPA continues to support the organization with any additional information requests to support workforce sustainability and evidenced based decision making.

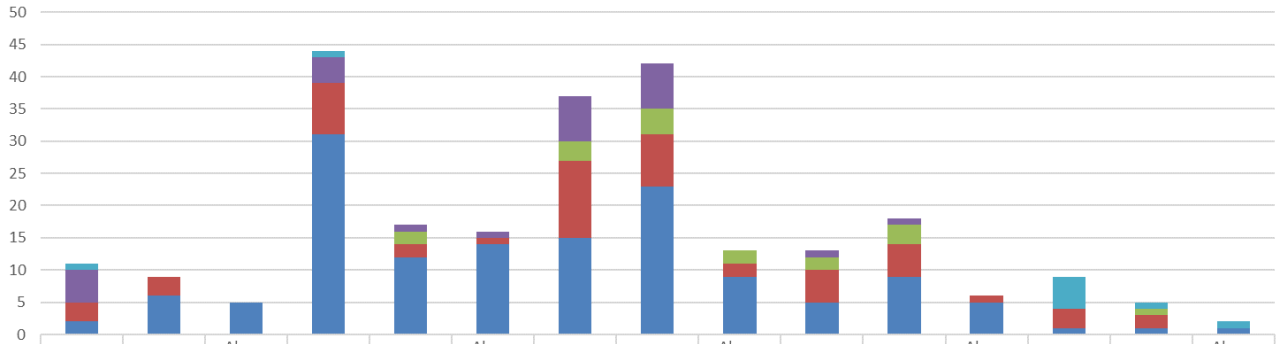
Northern Health Recruitment Updates/Charts

Posting Information: In fiscal year 2020/21, Northern Health has posted 4463 non-casual positions. This is 28.54% higher than the past 3 year average, driven by additional positions related to Pandemic Response and increased Health Care Assistant positions posted in support of the Provincial Health Career Access Program (HCAP) initiative. Of these postings, 73% have been filled by internal staff (existing regular and casual staff) and 11% have been filled externally (qualified applicants from outside of NH) within 90 days. Positions that remain unfilled for more than 90 days become difficult-to-fill vacancies (DTFV). Annually, approximately 11% of our postings become DTFV. Some unfilled positions are currently in the competition phase.

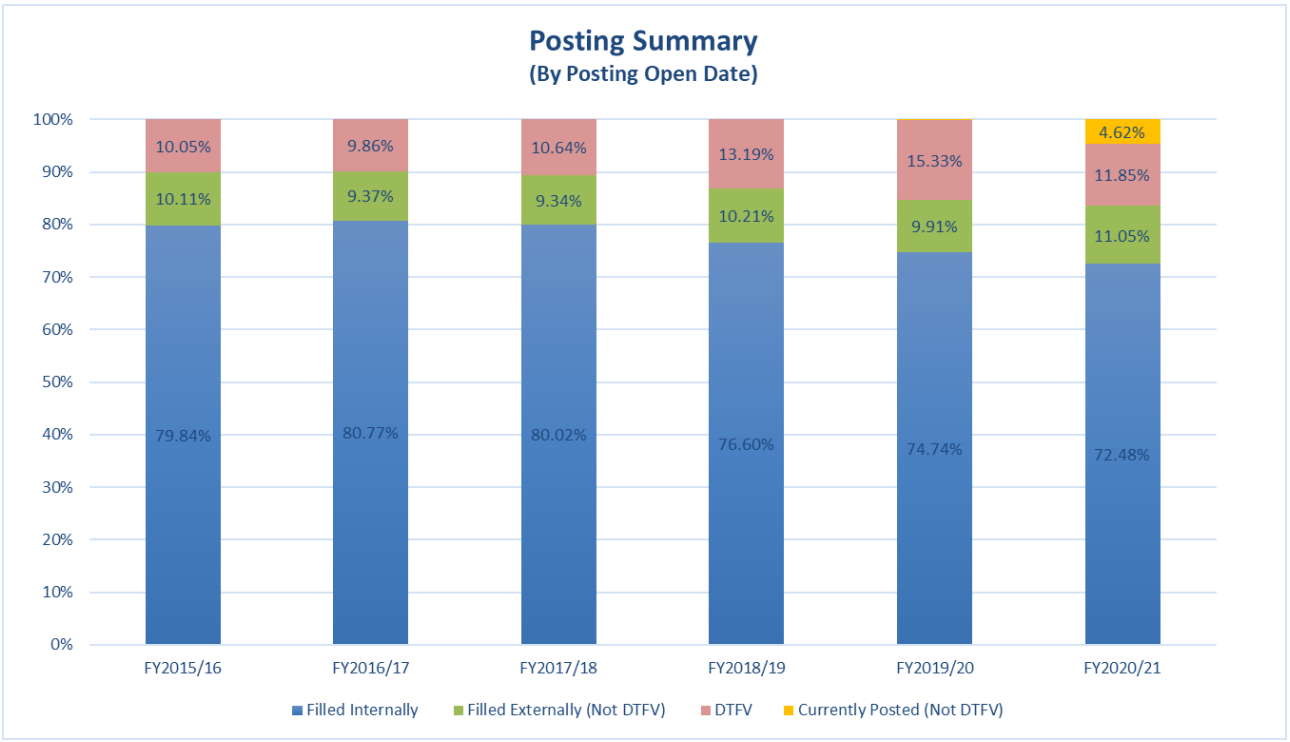
Casual hires are not reflected in this data. On average, NH hires 1,000 casuals per year, many of these staff successfully bid into permanent, ongoing positions through our internal posting process.

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

As at May 14, 2021



	NI Rural			North East			North West			Prince George			Regional		
	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term	Above Baseline	Permanent	Relief/Term	Above Baseline
EXCLUDED	1			1									5	1	1
COMMUNITY SUBSECTOR	5			4	1	1	7	7		1	1				
FACILITIES SUBSECTOR					2		3	4	2	2	3			1	
HEALTH SCIENCE PROFESSIONALS	3	3		8	2	1	12	8	2	5	5	1	3	2	
NURSES PROVINCIAL AGREEMENT	2	6	5	31	12	14	15	23	9	5	9	5	1	1	1



The Face of Northern Health

As at May 14, 2021

Summary of Employees by Status	Headcount	%	FTE
Active: Total	8,900	100%	5,411
Full-time	4,060	46%	
Part-time	1,984	22%	
Casual	2,856	32%	
Non-Active: Total	963	100%	760
Leave	576	60%	415
Long Term Disability (LTD)	387	40%	345

Active Employees by Region	Headcount	%
Active: Total	8,900	100%
North East	1,362	15%
North West	2,087	23%
Northern Interior: Prince George	2,803	31%
Northern Interior: Rural	1,212	14%
Regional	1,436	16%

Active Employees by Collective Agreement	Headcount	%
Active: Total	8,900	100%
Nurses	2,711	30%
Facilities	3,538	40%
Health Sciences	1,098	12%
Community	839	9%
Excluded	714	8%

Active Nursing	Headcount	%
Active: Total	2,711	100%
RN/RPN	2,017	74%
LPN	694	26%

Clinical vs. Support	Facilities	Community
Active: Total	3,538	839
Clinical	1,544	472
Non-Clinical	1,994	367

Count of Employees - By Status