OCCHA Accreditation Annual Review Summary

Health Unit: Middlesex-London Health Unit	**Date of Review:** October 1, 2012	**Date of Original Survey:** September 29, 2010

Section I - Summary of Findings from Annual Questionnaire (2012)

The Health Unit completed the Annual Questionnaire and provided all required documentation. No new gaps were identified upon review of the questionnaire.

Section II – Outstanding Items from Accreditation Report (i.e., Requirements, Recommendations, Suggestions)

Standard #	Standard	Year 1 Findings – 2010	Year 2 Findings - 2011	Year 3 Findings – 2012
1A	The agency shall work with the governing body, staff and community partners to ensure the development, implementation and monitoring of a strategic plan.	There is an approved strategic plan, which includes the vision/mission statements, principles and values and governance and mandate of the Health Unit. The strategic plan also includes an area of focus for 2008/2009. A review of evidence indicates that there was also an area of focus for 2006/2007. There is a strategic planning policy, ADMIN 1-010, which states that, each year, the strategic plan will be formally reviewed by management and the Board of Health. Evidence indicates that, while informal review of the strategic plan has been conducted by the Directors Committee and updates provided to the Board of Health, formal review and approval of the areas of focus has occurred every two years. By OCCHA definition, the strategic plan is an action oriented document used by the organization to achieve stated long-term goals and objectives (quantifiable statements that establish realistic levels of future performance including timeframes and quantifiable levels of performance.	The Board of Health approved the Ten Year Vision and Three Year Strategic Directions of the Health Unit on June 16, 2011. The strategic planning process included input from staff, board members and community partners and clients. The health unit has begun work on operationalizing these directions through the development of indicators and goals and assigning roles and responsibilities. ***The health unit has addressed the recommendation in the establishment of a vision and strategic directions. In year 3, the survey team will review the work completed towards the implementation of these directions.***	The health unit has established six Strategic Achievement Groups (SAG's) to facilitate implementation of the strategic directions for 2012-2014. Terms of reference and operational plans for each of these groups have been developed. There was ample evidence of ongoing monitoring of progress towards implementation of strategic directions. ***No specific follow-up is required as monitoring of the strategic plan is included in the annual accreditation review process.***

		Evidence indicates that these objectives are identified within the service area operational plans. Evidence and interviews also identified the need to link the strategic plan with the operational plans in a more explicit way to inform program planning and implementation towards achievement of stated long term goals and objectives/areas of focus. The process for the development of a new three year strategic plan (based on a ten year vision) is underway; a working group has been established with Board of Health representation. The process also provides for consultation with community partners, key stakeholders and staff. The strategic plan is scheduled to be completed by the end of March, 2011. **RECOMMENDATION:** The Health Unit is encouraged to continue their efforts towards the development and implementation of a strategic plan that links with operational planning and is reviewed on a regular basis, in a manner consistent with identified timelines and agency policy.		
3C	The general administrative body shall establish processes/mechanisms to ensure that all programs, services and projects, including research, are coordinated, planned, implemented, monitored and evaluated. Where agency committees (e.g., program planning committee, program	The Directors Committee meets regularly, minutes are taken and pertinent information is communicated to staff. The agency has also established several standing committees of the Directors Committee to facilitate achievement of goals and objectives. There is a policy, ADMIN 1-031, re: Health Unit Committees that indicates that Terms of Reference for all standing committees shall be approved by the Directors Committee and that an annual report summary shall be completed and submitted to the Directors Committee.	Terms of reference were provided for all new planning/coordinating committees noted in the annual questionnaire and the Directors Committee has identified a schedule for review of standing committee terms of reference. In January of 2011, the Directors Committee supported the practice of verbal updates/presentations by standing committees in lieu of formal written annual reports. However, the policy on Health Committees (Admin 1-	There was evidence that the health unit has reviewed the inventory of internal committees and the process for reporting to the Director's Committee. Changes have been made to the policy in support of the internal review. ***No further follow-up is required.***

	advisory committee, program support committees, etc.) are established to facilitate achievement of this objective, terms of reference shall be developed, which include responsibilities and lines of communication/authority.	Evidence indicates that these committees have Terms of Reference and meet regularly. However, not all committees have had the terms of reference approved nor are annual summaries completed for all of these committees. **RECOMMENDATION:** That the Health Unit strengthen its efforts to ensure that terms of reference are formally approved and annual summaries completed for all applicable committees in a manner consistent with agency policy.	031) has not been revised to reflect this change of practice, although the need to update the policy has been identified. ***In year 3, the survey team will review the policy on Health Unit Committees to confirm that the policy has been updated to reflect approved practice.***	
5F	The governing body shall adopt practices consistent with government regulations related to the protection of human resources and the general public	There is a multi-site Joint Health and Safety Committee and approved terms of reference which include composition, function and meetings. The committee meets regularly and minutes of meetings are made available to all staff. The health and safety policy is posted and is reviewed regularly and first aid stations are identified. A review of evidence indicates that monthly workplace inspections have not been consistently conducted in all of the health unit offices in a manner consistent with legislation or agency policy. Interviews indicate that this was in large part due to a misinterpretation of the legislation as it relates to workplace inspections. Evidence however, does indicate that this was identified by the health unit, and improvements have been made in the past 12 months. **REQUIREMENT:** The health unit continue its ongoing efforts to ensure that monthly workplace inspections are conducted in a manner consistent with agency policy and legislation.	Evidence indicates that the health unit has strengthened efforts to ensure monthly workplace inspections are conducted in all offices. A review of inspection reports indicates that, in the past year, all but two monthly inspections were conducted across all offices. ***In year 3, the survey team will confirm that monthly inspections are conducted for all offices.*** Current WHMIS inventories (MSDS binders) have been developed specific to each service area, which will serve as the basis for WHMIS training. A general WHMIS orientation module was provided to new hires in May 2011. Service area re-training began in September 2011 and was completed in three service areas. Evidence and interviews indicate that the health unit will be conducting re-training, specific to each service area for all staff on an annual basis. Service areas will be	Inspections reports were reviewed for all office sites for the past 12months. Evidence indicates that monthly workplace inspections are being conducted in a consistent manner. ***No further follow-up is required.*** WHMIS inventories have been created for each service area. A review of evidence indicates that 94% of staff members have completed the re-training as of September 2012 and a plan is in place for the remaining 6% (casual and/new staff members). ***No further follow-up is required.***

		Evidence and interviews indicate that initial WHMIS training is generally conducted upon hire as part of the orientation process. However, while training is conducted annually in some program areas, evidence indicates that an annual assessment of training needs is not conducted for all staff members. In addition, a review of the MSDS binder indicates that it is out of date. Interviews indicate that an external review was conducted by the Health Unit related to WHMIS education, training and inventory updates and a plan is under development to implement the recommendations contained in the review. **REQUIREMENT:** That the Health Unit should continue its efforts to ensure that WHMIS needs are assessed annually and that it implement the recommendations contained in the WHMIS review. Further, the Health Unit shall ensure that the MSDS binder is updated.	required to provide documentation that re-training has been conducted. ***The health unit has demonstrated progress towards addressing this requirement. In year 3, the survey team will confirm that service WHMIS inventories are current and that re-training for all staff has been completed in a manner consistent with agency policy/practice.***	
7C	The general administrative body shall ensure that there are written position descriptions for all positions, which are reviewed on a regular basis, revised as appropriate and made available to each staff member. Position descriptions shall include a specific statement of duties/responsibilities, level/type of required education, training and	There are current written positions for all staff. Interviews indicate that staff members are aware of the existence of their position descriptions and their location. Health Unit policy notes that position descriptions are to be used in the performance evaluation process. However, interviews indicate that not all staff members are made aware of reviews and/or updates to their position description. Further, interviews also indicate that not all staff feel that there is a linkage between the position description and the performance evaluation process. It was noted that position descriptions are under review as a result of the recent	As noted in the 2010 accreditation review, the health unit has undergone organizational changes resulting in some delays in the implementation of internal strategies. At the time of the annual review, there was no specific evidence of enhanced communication strategies for informing staff of changes to position descriptions. However, it was noted that, while the policy on position descriptions (5-015) references the linkage between position descriptions and performance evaluation process, the policy on performance evaluations does not clearly identify the linkages between the two.	The local public school board has recently introduced new requirements for staff members working in schools and has requested the development of task-focused position descriptions for these staff members. This has further delayed the progress towards the development of competency based position descriptions. ***During the next accreditation review in 2013, the survey team will review the progress to-date towards review of the position descriptions and communication to staff members.***

	related work experience and should be considered during the performance evaluation process.	organizational changes to the agency. **SUGGESTION:** The Health Unit is encouraged to consider more formal mechanisms to update staff on changes to their position description and to establish a linkage between position descriptions and the performance evaluation process.	***In year 3, the survey team will review the development of strategies and/or tools to enhance the process of communicating changes to the position description.***	
9B	Performance evaluations shall be completed in a manner consistent with agency policy. Staff shall be provided the opportunity for input into the performance evaluation process. All performance evaluations shall be dated and signed by both the staff member being evaluated and the appropriate signing authority(ies). The original signed performance evaluation shall be kept in the personnel file.	There is a policy and procedure for performance evaluations, including a performance evaluation template. Evidence and interviews indicate that performance evaluations have not been conducted in a manner consistent with agency policy. **REQUIREMENT**: While the OCCHA Board of Directors recognizes that the re-organization and response to H1N1 have had some impact on activities over the past year, the Health Unit shall ensure that performance evaluations are completed in a manner consistent with agency policy.	Evidence indicates that the health unit has made significant progress toward ensuring that performance evaluations are being conducted in a manner consistent with policy. A new tool for has been developed and implemented for public health nurses. ***In year 3, the survey team will review the ongoing efforts of the health unit in ensuring that performance evaluations are being conducted in a manner consistent with agency policy.***	A review of evidence indicates that the health unit continues to make progress towards ensuring that performance evaluations are conducted in a manner consistent with agency policy. There were some outstanding evaluations due to changes in management staff, leaves of absence or illness, but there was documentation of follow-up. ***No specific follow-up is required.***
12B	Program/service policies and procedures shall be regularly reviewed, with staff consultation, and revised, as required. Dates of all review and revisions shall be recorded.	Policy and procedure manuals exist for all service areas and are available to staff. A review of program policies and procedures indicate that the policy for review varies across service areas, from annual to every three years. Further, review logs indicate there have been some minor inconsistencies in reviews being conducted in a manner consistent with service area policy. Interviews indicate that some of these service area manuals will be reviewed	The health unit policy on policy development and review (Admin 1-060) was revised in June 2010. This policy indicates that directors/designates are responsible for the development, distribution, maintenance and bi-annual review of policies and procedures that relate to the work of their Service Area. Interviews indicate that the health unit will be looking at strategies to streamline and ensure consistency	The health unit has reviewed its protocols for administrative and service area policy manual review. Program areas will continue to review their manuals using existing processes, but all manuals will be reviewed on a 2 year cycle. ***No further follow-up is required.***

		as part of the re-organization. **SUGGESTION:** The Health Unit is encouraged to consider options to facilitate a more consistent approach to review of service/program policy and procedures manuals.	between agency and service area policies and procedures. It was also noted that a leave of absence has resulted in the delay of some service area policies. ***In year 3, the survey team will review the efforts of the health unit to streamline policies and procedures and ensure a consistent approach to review across all program areas.***	
12G **12H**	There shall be an annual written operational plan for each program/service which identifies, at a minimum: activities (implementation and monitoring); time-lines; responsibilities, and expected outcomes. Operational plans shall be the basis of program/service implementation and shall be reviewed and revised, as required, to reflect changing priorities, financial and program developments.	Interviews indicate that program teams meet regularly and use these meetings to provide for coordination amongst programs. Staff input, community needs and health status information are used to inform program planning and coordination. Operational plans do exist for all programs and the Health Unit uses a planning template which includes activities; timelines, responsibility/resources; projected outcomes and a reference to the relevant Ontario Public Health Standard. The planning template also provides for the documentation of review and revisions dates on the cover page. Review of the operational plans noted that projected outcomes are, for the most part process indicators, rather than measurable short or long term program outcomes. In addition, the documentation of review and revision dates is not consistent across all programs; although interviews indicate that this is done regularly by program areas. **SUGGESTION:** The Health Unit is encouraged to consider a review of the planning template to identify short and long term program objectives, not just process	A review of evidence indicates that a revised planning tool is under development for use as an on-line planning module. The Agency Questionnaire indicated that operational plans for IT and Special Projects were in the process of developing operational plans to reflect changes in organizational structure and health unit priorities. ***In year 3, the survey team will review the implementation of the new planning template across all service areas.***	Operational plans for 2012 were developed for all service areas using the planning template. ***No further follow-up is required.***

		objectives and encourage programs to clearly document review and revision dates.		
15C **15F**	Programs/services shall regularly monitor activities as identified in the operational plans, and evaluate, document and disseminate program/service outcomes, both short-term and long-term. Programs/services shall ensure that all monitoring, surveillance, evaluation and results are considered in subsequent program planning and implementation.	There was evidence that monitoring and evaluation occurs across program/service areas and there was evidence of outcome reports, although most were process based. In addition, there was no consistent documentation used to demonstrate how monitoring and evaluation activities and results inform subsequent program planning and implementation. During the previous accreditation survey, it was noted that the planning template did include a component to demonstrate how activities impact on future operational planning; although this was consistently used by all program/service areas. **SUGGESTION:** As previously noted in Standard 12, the Health Unit is encouraged to review the planning template and revise to encourage a more consistent approach to documentation of how monitoring and evaluation activities inform subsequent program planning and implementation.	As noted above, the new operational planning template is still under development. (See 12G). ***In year 3, the survey team will review the use of the planning template, including documentation of actual achievements/outcomes.***	Given that the new planning template was implemented in 2012, the survey team was not able to review documentation of actual achievements/outcomes using this template. There was evidence that monitoring and evaluation is occurring across all programs areas. ***The survey team will review the use of the planning template to document service outcomes during the next accreditation review.***

Section III – Program Standards						
Std	**Component**	**Content**	**Applicable Programs**	**Year 1 - 2010**	**Year 2 - 2011**	**Year 3 - 2012**
10B	Collaboration	Programs/services shall share best available evidence with community partners, priority populations and target groups to increase community capacity	CDP, PISM, SH/STI	CDP – Middlesex County Advocacy Initiative 2009-2010 (Middlesex-London in motion) – re: Physical Activity	PISM – Healthy Communities Partnership – Middlesex-London Community Picture	SH/STI – Adventures in Sex City Game
10C	Collaboration	Programs/services shall collaborate with community	IDPC, TBPC, SH/STI	SH/STI – Youth Engagement	IDPC – Infection prevention and control workshop for hospitals,	TBPC – Hepatitis C Health Care Provider Workshop -

		partners, priority and target groups to develop, plan and implement programs/services and policies		Strategy and Sexual Health Campaign (Mind Your Mind)	long-term care homes and retirement homes providing training, fostering and implementation of disease prevention programs/services.	education of physicians and other health care providers
13A	Health Promotion	Programs/services shall provide opportunities for education and skills development to community partners and priority populations.	CDP, PISM, SH/STI, VPD, FS, SW.	CDP – CINOT Program Expansion SW – London-Middlesex Children's Water Festival	VPD - The HPV Vaccine Campaign - to female grade eight students, their parents/guardians and teachers. FS – Cook It Up! Cooking pilot program for at-risk youth	SH – Sex Workers Forum PISM – SafeGrad Workshop aimed at reducing harm due to drug/alcohol misuse
13B	Health Promotion	The agency shall work with community agencies, partners and organizations to identify and develop strategies to create and enhance support environments.	CDP, RH, CH, PISM, SH/STI	RH – Community Collaboration PISM – Golf Course Alcohol Liability and Risk Management Workshop	SH/STI – Hep C Conference for individuals who work with clients with HC – to foster an improved and supportive environment for clients PISM – Helmets on Kids Partnership	FH – Youth Create Healthy Communities Initiative CH – City of London Child and Youth Network to improve well-being of children and youth
13C	Health Promotion	The agency shall model and develop strategies to promote, support and/or implement healthy policy, both internally and within the community.	CDP, RH,CH, PISM, VPD, HH	PISM – BeCAUSE campaign – distracted driving module CH – Internal Breastfeeding Working Group Staff Education Plan	RH – Community Prenatal Health Services Provider Network CDP – Ontario Coalition for Smoke Free Movies	HH – The Environmental Land Use Planning program CDP – Child Safety – bike helmet advocacy.

Section IV – Areas of Follow-up in support of continuous quality improvement				
Standard	**Component**	**Year 1 Findings and Follow-up 2010**	**Year 2 Findings and Follow-up 2011**	**Year 3 Findings and Follow-up 2012**
4B	The general administrative body shall ensure that each program/service has an organizational structure that is outlined in an organizational chart which delineates the lines of authority and formal lines of communication within that program/service and which is made available to staff.	The Health Unit has recently made changes to its organizational structure, resulting in the need to update and approve existing organizational charts for several program/service areas. ***In year 2, the survey team will review the progress to-date towards completion and approval of revised organizational charts.***	Approved current organizational charts were provided for all service areas. ***No further follow-up is required.***	***N/A***
6B	The records of the agency and each program/service shall be maintained in a manner consistent with applicable legislation and agency policy.	There are policies for records management, which include creation, access, maintenance retention and disposal. There is a Records Management Project Group and the agency has developed an operational plan for Access/Privacy which includes strategies for assessment, priority privacy projects, consultation, education and awareness, reporting and incident response. While many of the components are ongoing, some activities have implementation/completion dates of December 2010. ***In year 2, the survey team will review the progress to-date towards the implementation of the***	In May 2011, the Directors Committee reviewed the status of the recommendations from the Privacy Risk Assessment as well as a comprehensive operational plan status report. The five core recommendations of the assessment have been fully implemented. Work continues on the implementation of activities/strategies as identified in the operational plan. ***As operational plans for all service areas are reviewed annually as part of OCCHA's process, no further follow-up related to this item is required.***	***N/A***

		components/strategies as indicated in the Access/Privacy Operational Plan.		
11A	The governing body shall approve a written policy on research/evaluation activities, including requirements for methodological and ethical review.	As previously noted, the Health Unit has recently undergone organizational changes, with the closure of REED Services. There were policies and procedures related to research and knowledge exchange, as well as coordination across program areas within REED Services policy manual. In addition, the inventory of research projects was maintained by this division. Interviews and evidence indicate that these policies and procedures are currently under review towards alignment with the current organizational structure. ***In year 2, the survey team will review the status of the realignment of policies and procedures and their incorporation into appropriate agency and/or service manuals.***	As part of the health unit's re-organization of service areas, REED functions have been decentralized, with an Epidemiologist(s) in each of the program service areas to support their planning, implementation, monitoring and evaluation. As part of the policy and procedure review process, REED policies wil be incorporated into the Administration Manual. The terms of reference for the Research Advisory Committee are under review. An inventory of research activities is maintained by the Special Projects Manager. ***No further follow-up is required.***	***N/A***

Section V – Summary of Annual Review Findings

A review of the Annual Questionnaire and all evidence indicates that the Health Unit has demonstrated significant progress towards addressing most of the requirements, recommendations and suggestions contained in the original accreditation report and has demonstrated ongoing compliance with the OCCHA accreditation standards.

As approved by the OCCHA Board of Directors on November 7, 2012	**The Middlesex-London Health Unit is encouraged to continue its efforts to address any outstanding items in support of compliance with the OCCHA accreditation standards.**