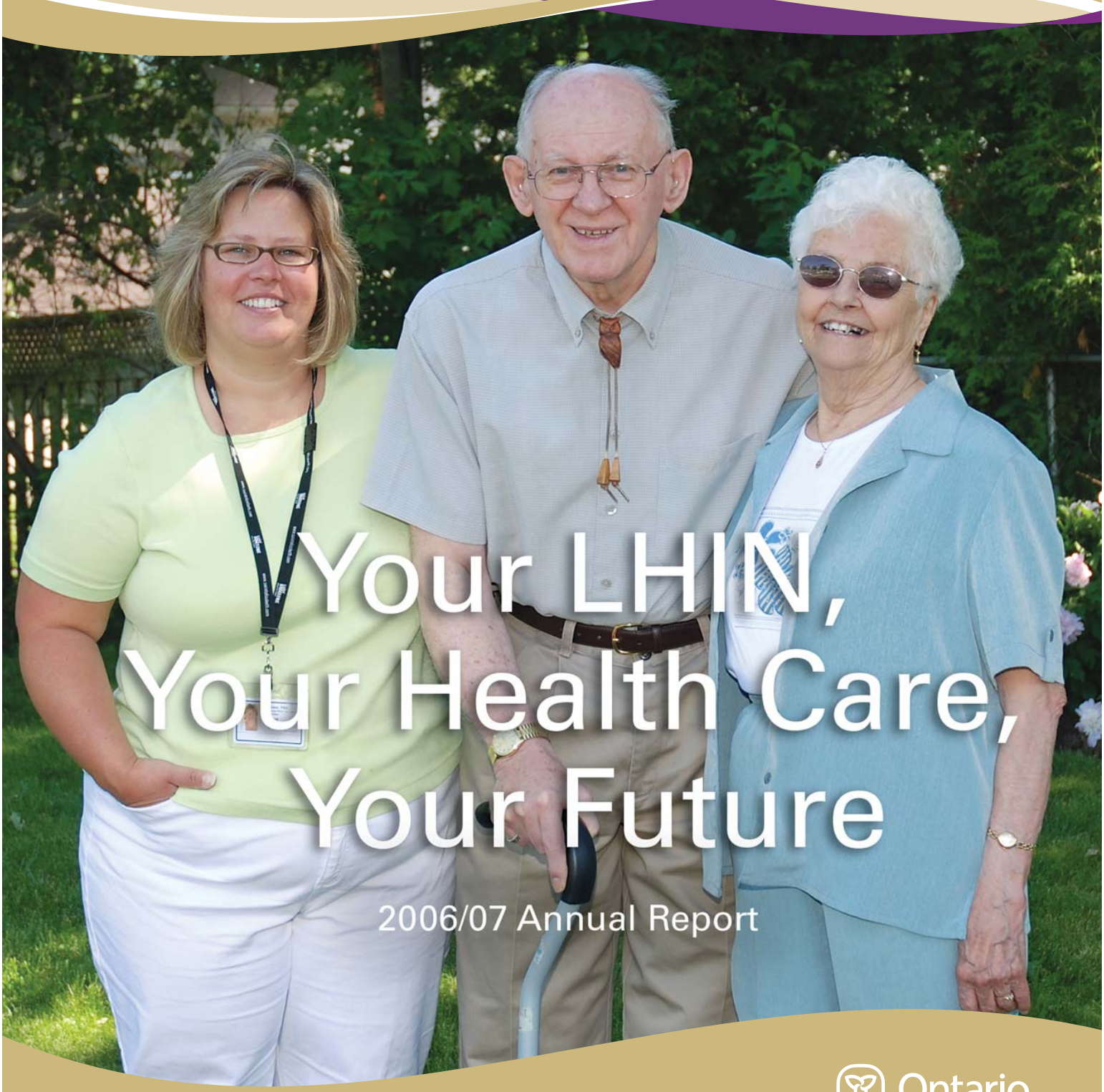
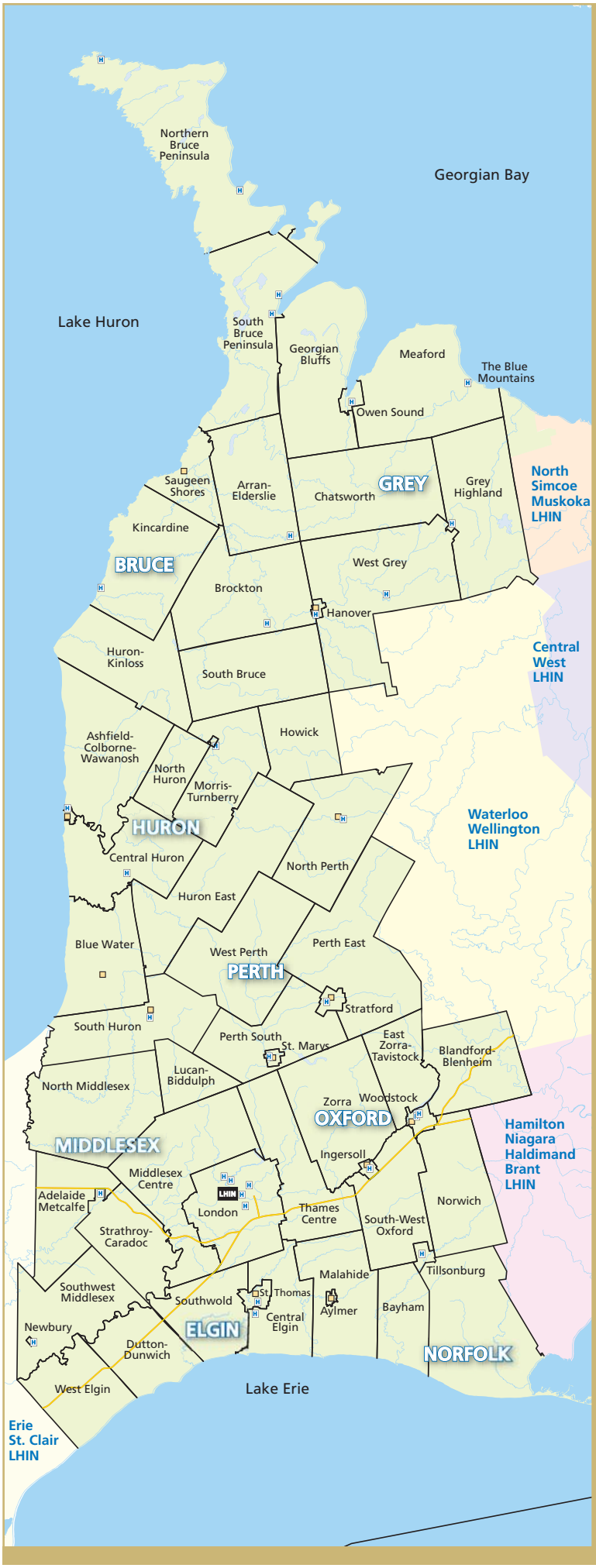
South West
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Sud-Ouest



Your LHIN, Your Health Care, Your Future

2006/07 Annual Report

Ontario



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On our cover (left to right): Personal Support Worker Dianne Machay with Jack and Isabel Gillies. Jack, who is recovering from a stroke, receives radiation therapy daily and personal support services at home from the South West Community Care Access Centre.

A sustainable health care system

Left to right: University of Western Ontario medical students Marvin Chum and Hanga Agoston with Angie Nicholson, HealthKick Summer Programs Leader, and Laura Overholt, HealthKick Huron Manager, and medical student Karenina Aguilar. HealthKick Huron, an innovative recruitment program for health professionals, is featured on page 9.

Ontario's Local Health Integration Networks

Local Health Integration Networks (LHINs) are a fundamental component of the government's plan to build a stronger health care system in Ontario. Passed in March 2006, the *Local Health System Integration Act* is intended to create a health care system that keeps people healthy, cares for them when they are sick and will be there for their children and grandchildren.

The provincial plan for making that vision a reality has three priorities: Healthier Ontarians, reduced wait times, and better access to doctors and nurses. These priorities will be supported by initiatives to improve the planning, management and coordination of services through the 14 LHINs that were established in 2005. LHINs determine the health care priorities and services required in their local communities, reflecting the reality that a community's health needs and priorities are best understood by those familiar with the community.

The South West LHIN is a crown agency responsible for the planning, integration and funding of more than 200 health service providers, including hospitals, long-term care homes, mental health and addictions agencies, community support services, community health centres, and the South West Community Care Access Centre. The South West covers an area from Lake Erie to the Bruce Peninsula and is home to almost one million people. For more information visit www.southwestlhin.on.ca.

Message from Norm Gamble, Chair of the Board of Directors

I realize our story is, in a sense, a series of stories – stories about exceptional people who share common goals, support one another, and achieve great things. This report tells some of those stories.

During 2006-2007, the Board reached its full complement of nine members. Our Board members are experienced, knowledgeable, committed and hard working – true partners in the future of health care in the South West. It is an honour to lead such a group, and to benefit from their wise counsel. My sincere thanks to each one of them for their contributions over the past year.

We said a regretful farewell to Bob Habkirk this year, but are in the process of recruiting a new Board member who will join our team in 2007-2008.

Throughout 2006-2007, the Board held regular public meetings across the South West, established two board committees, attended a variety of community meetings and events, and championed the creation of the *Integrated Health Service Plan* and the launch of the Priority Action Teams.

Recently the Board created a plan to build strong relationships and formal linkages with the boards of health service providers in our area. We are committed to working together with integrity, openness and respect. This dialogue will create another forum through which integration opportunities can be identified and implemented, and ensure that the experience and local knowledge of our health service providers' boards inform decisions made at the system level.

It has been my pleasure to meet many members of health service provider boards across the South West, and I am deeply impressed by the passion and wisdom they bring to their responsibilities. The process of talking directly with provider boards is now under way and we hope to have reached most of them by later in 2007/2008.

Over the past year, Tony Woolgar and the staff of the South West LHIN have provided exceptional leadership to the LHIN and support to the Board. We recognize with gratitude their many contributions. Above all, I express my thanks to the thousands of providers and consumers who participated in shaping our organization and our vision for the future.

Please read on and share the stories of the South West LHIN.

Norm Gamble
Chair of the Board of Directors

Message from Tony Woolgar, Chief Executive Officer

This annual report tells the story of the journey we embarked upon in 2006/07, working with health service providers and local communities, to create the first-ever three-year *Integrated Health Service Plan*. In so doing, we were able to begin to focus on the importance of maintaining and enhancing the health and wellness of our residents, as well as on the treatment of illness and disease.

What we realized as we met with over 400 health service providers in May 2006 was that there were already many great examples of outstanding clinical practice and patient care delivery across our system.

The next step, a program of 68 community engagement meetings held throughout the summer, proved to be a richly rewarding experience as we hosted discussions with local citizens in 29 different locations across the South West LHIN. Their interest, passion and personal insight into what they experienced and what they wanted from their local health care system was invaluable in helping us to complete the first *Integrated Health Service Plan*.

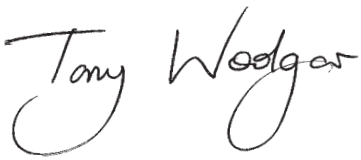
Publishing the *Integrated Health Service Plan* at the end of October was only the beginning. We then had to design an implementation process that would achieve measurable improvement in health care service delivery and in the health status of our population.

Once again, the response from health care providers and community volunteers to our invitation to participate was overwhelming, enabling us to establish nine of the ten Priority Action Teams, comprising over 250 people, to lead the implementation of our integration priorities. We are already beginning to see the impact of this work in the area of chronic disease prevention and management with the development of a Diabetes Quick Start Program in three pilot sites that offers patients access to truly integrated packages of care.

This demanding schedule of the past year was only possible through the tremendous effort and dedication of the LHIN staff and Board members. I am very proud of the small but dedicated and effective team we have brought together. They continue to show commitment, enthusiasm and an endless capacity and passion for the important work we are undertaking.

As I look forward to 2007-2008 I am struck with a sense of optimism and excitement. With the operation of our full mandate from April 2007, which now includes responsibility for the funding and allocation to health service providers, we can start to build a program of performance management and quality improvement across our health care system.

I hope you will see how the stories in this annual report help to confirm my belief that by working together with health service providers and our local communities, we will make our vision a reality.



Tony Woolgar
Chief Executive Officer

Population health profile

To better understand local needs and challenges, the South West LHIN recognizes three geographic areas: North (Grey and Bruce counties), Central (Huron and Perth), and South (London-Middlesex, Oxford, Elgin and part of Norfolk). The North is home to 16.8% of the South West LHIN population, with 14.7% in Central, and 68.5% in the South.* More than 30% of the population of the South West is rural, presenting unique challenges for health care delivery and access.

Our population

- The South West LHIN is home to 910,386 people, representing 7.5% of the population of Ontario. Between 2001 and 2006, the population increased by an average of 1.3% each year, a somewhat slower rate than the overall provincial increase of 6.6%.*
- There are five First Nations Reserves in the South West. Aboriginal communities face greater risk factors and higher prevalence rates for chronic disease, and a variety of challenges to accessing care.
- The "dependency ratio" – the ratio of combined child and elderly population to the working population – is higher (65.4%) than the provincial average (60.4%). The percentage of seniors is significantly higher (14.5%) than the provincial average (12.8%), especially in the North. The seniors population is expected to grow by 31% by 2016.** The proportion of children aged 0 to 19 years is slightly higher (25.1%) than the provincial average (24.8%).

Lifestyle factors in the South West LHIN

- The South West has a higher proportion of people who are obese (18.1%) than the provincial average (15.1%). Obesity is a significant risk factor in many chronic diseases.†
- People in the South West are slightly more physically active or moderately active (52.3%) than the provincial average (51.3%).†
- The percentage of daily smokers is the same as the provincial average (20.7%).†
- 61.9% of the South West LHIN population rated their health as excellent or very good, compared with 60.8% of the provincial population.†
- 72.6% of the South West LHIN population rated their mental health as excellent or very good, compared with 72.8% of the provincial population.†
- The area has a greater proportion of people with an activity limitation (31.4%) than the provincial average (29.4%).†

Morbidity and mortality in the South West LHIN

- The South West has a greater proportion of people living with arthritis and rheumatism (18.8%), high blood pressure (17.2%), and diabetes (5.2%) than the provincial average (17.2%, 15.2% and 4.8%, respectively).†
- Life expectancy in the South West (81.7 years for females and 76.7 for males) is slightly lower than the provincial average (82.1 years for females and 77.5 for males).‡

This information has many implications for health care in our area and provides a strong knowledge base on which to develop and implement our integration priorities. We will continue to monitor demographic and health-related data on an ongoing basis, adapt our strategies and tactics accordingly, and endeavour to learn more about the people we serve.

Data source: 2001 Census, Statistics Canada except where indicated by:
* Population and Dwelling counts, 2006 Census, Statistics Canada;
** Population Projections by Gender, Age and LHIN of Residence, 2006-2016, Health System Intelligence Project;
† Canadian Community Health Survey, 2005;
‡ Ontario Vital Statistics, Mortality Database

A new vision for health care in Ontario

Left to right: Minister of Health and Long-Term Care George Smitherman, Assistant Deputy Minister Hugh MacLeod and Pat Campbell, President and CEO of Grey Bruce Health Services, at a forum for health care leaders held in London in May 2006.

Activities and accomplishments

In 2006-2007 the South West LHIN made significant progress toward the provincial vision, "A health care system that helps people stay healthy, delivers good care to them when they get sick, and will be there for their children and grandchildren." The following 'stories' describe some of our most significant activities and accomplishments in the past year.

Creating and implementing the South West *Integrated Health Service Plan*

This past year represents a significant milestone for the LHIN as it advanced its role in the planning and integration of health services in the South West. A primary focus of our activities was the development of the *Integrated Health Service Plan* outlining integration priorities for the next three years.

The starting point for our discussions was a set of six broad integration goals:

- To develop local health care services for local people
- To establish a single system that offers equity in service, ease of movement and informed and responsible consumer choice
- To leverage existing strengths
- To enhance the academic health care culture
- To establish a coordinated and collaborative approach to health human resources
- To promote linkages with regional and provincial partnerships and networks

With these goals in mind and after preliminary community engagement, a draft *Integrated Health Service Plan* was produced in July 2006. Next we undertook an extensive community engagement process involving thousands of providers and consumers between July and October 2006. Participants were provided with the draft priorities and invited to express their thoughts and ideas. Their input was incorporated and the final plan was submitted to the Minister in October.

The South West LHIN integration priorities are:

- Strengthening and improving primary health care
- Preventing and managing chronic illness
- Building linkages across the continuum: all seniors and adults with complex needs
- Accessing the right services, in the right place, at the right time, by the right provider

In addition, two enabling priorities – e-Health and health human resources – were identified.

Working together for end-of-life care

The End-of-Life Care Network provides physical, emotional and spiritual care and support to individuals and their families during the final stages of life. Pictured here: Kathy Williamson (far right) and her husband Jim Williamson (centre) are supported by June Ross and Teri Strachan, VON, and Pat Cartwright, South West Community Care Access Centre

The *Integrated Health Service Plan* was shared in a variety of ways with people who attended our forums, recognizing they would be important contributors to the work ahead.

With the plan complete, the focus turned to implementation. Priority Action Teams were identified for each of the ten action plans developed as part of the *Integrated Health Service Plan*. A request went out for volunteers to serve on the teams, and more than 400 people expressed an interest in being part of this transformative process. The LHIN formed nine of the ten Priority Action Teams in 2006-2007 and a new Health Human Resources Advisory Group to work alongside the existing Strategic Advisory Group and e-Health Steering Committee.

All team members were invited to participate in the *Integrated Health Service Plan* implementation launch event held in Stratford in February 2007.

Critical care

While the *Integrated Health Service Plan* process moved forward, progress was also being made on integration through an innovative provincial initiative in critical care. Dr. Michael Sharpe, an intensivist at London Health Sciences Centre and a professor of Anaesthesia and Perioperative Medicine at The University of Western Ontario, was appointed the South West LHIN Critical Care Lead, one of 14 Critical Care LHIN leaders appointed across the province to provide direction to and support for the implementation of Ontario's Critical Care Strategy.

Working closely with hospital CEOs, clinical leaders and LHIN leadership, Dr. Sharpe developed a strategic direction for critical care management across the LHIN, which led to several improvements.

- The first ever Adult Critical Care Service Inventory was completed in the South West and continues to be refined and updated. Work has begun on a similar inventory for paediatric critical care that will continue through 2007-2008.

- Using a provincially developed and provincially funded model, London Health Sciences Centre introduced a Critical Care Response Team, a multidisciplinary team providing specialized care and intervention for hospital in-patients who show signs of deterioration.
- In February 2007 London's hospitals became a lead site for the Critical Care Information System implementation. Critical care coaching teams were also deployed in several hospitals across the region to help identify performance improvement opportunities and provide a greater emphasis on efficacy and process enhancement.

Hips and knees services

Joint replacement surgery is one of the most successful surgical interventions in use today. With an aging population, the demand for these procedures is growing rapidly. The Province of Ontario has focused on hip and knee surgery as a key component of its wait times strategy. In May 2006, more than 20 people from across the care spectrum came together to develop a plan to deliver timely, coordinated and high quality hip and knee replacement care to the people of the South West. Beginning with a "current state" snapshot, a SWOT (strengths, weaknesses, opportunities and threats) analysis and a literature review, the group developed several recommendations, including:

- Ongoing education around joint health promotion and primary prevention
- A common set of information and expectations for primary care and referral to surgery
- Standard processes for pre-surgical screening and management
- Common in-hospital and community care pathways

"One of the benefits of this process is that we will be able to present patients with consistent information about hip and knee services," says Steve Elson, Director, Integrated Strategic Alliances and Networks with London's hospitals. "Whether it's a family physician, an orthopaedic surgeon, the CCAC or another care provider, people will know what to expect." The work of this group provided the base for the Hips and Knees Priority Action Team.

Diabetes

With chronic disease prevention and management as one of the South West LHIN's four integration priorities, diabetes was selected for a special "quick start" initiative. Diabetes is a growing problem, with 2.25 million Canadians affected and 60,000 new cases every year. The care guidelines for diabetes are well established, yet a recent study revealed that less than half of patients don't receive the follow-up tests they require to maintain health and avoid serious complications.

A Success Story

Getting a kick out of health care in Huron county

There will be a major disaster in Huron County this summer, and some people can hardly wait.

Actually, it's a mock disaster and it's part of Medquest, a camp designed to expose local high school students to the career opportunities in health care. As part of their experiential learning, they are patients in the exercise, which involves EMS personnel, fire fighters and other emergency responders in their community.

Medquest, in turn, is part of HealthKick Huron, an innovative long-term approach to health professional recruitment and retention. Other elements of the program include work experiences for rural youth at local health care facilities, skills development and upgrading for rural nurses, and rural-based learning experiences for future health professionals.

The results are impressive. Nine family physicians were recruited to Huron County in the first year, more than 400 students participated in various HealthKick activities, 25 people completed a Registered Practical Nursing program delivered by Georgian College, and three medical students completed a six-week elective in the region.

"Our program is unique in its approach to addressing the shortage of health care professionals in our region, but it's a very adaptable and flexible model that could work in other places," says Project Manager Laura Overholt. "Our story shows that a small community can do something innovative and really make a difference."

The South West LHIN, in partnership with the South West CCAC and three Family Health Teams, are working together to launch a new project which will begin shortly. The project will focus on the role of case management in patient care and will help to ensure that patients with diabetes receive their follow-up tests such as A1C checks, vision and foot exams. Patients will also be referred to appropriate resources in the community. This project, based on a similar one undertaken by the Canadian Home Care Association, has the potential to become the model for other chronic diseases within the South West.

e-Health

Founded on the vision, *"To enable measurably better information, better care, better health and less travel for all,"* the South West LHIN's e-Health Steering Committee brings together representatives from hospitals and emergency services, long-term care homes, community health centres, family physicians, community support services and other health service providers to help define the future of the electronic health system in the South West.

In 2006-2007, the Committee moved forward on its goal to have 80% of the area's health service providers connected to the province's ONE Network and ONE Mail System within a year, allowing them to share patient information quickly, confidently and securely. "This is a perfect illustration of how technology can support improved patient care," says Diane Beattie, South West LHIN e-Health Lead and Chief Information Officer at London's teaching hospitals.

In the coming year, the e-Health Steering Committee will continue to guide the development and implementation of the South West e-Health strategy. A key focus of their activities moving forward will be to enable electronic

Keeping healthy in our communities

The Southwestern Ontario Stroke Strategy promotes best practice rehabilitation across the region. Pictured here: stroke survivor Natalie Destun (left) and her physiotherapist, Rob Fazakerley (right)

health solutions that support the implementation of the *Integrated Health Service Plan*.

Linking performance and funding

Wait times

The South West LHIN is accountable for several performance measures, including wait times in key areas identified by the Province. During 2006-2007, health service providers, in partnership with the LHIN and the Ministry of Health and Long-Term Care, worked to reduce wait times, with some significant improvements.

Cancer

- The Cancer System Quality Index 2007 demonstrated significant progress in many areas of cancer services in the South West. Wait times for radiation treatment and chemotherapy declined, while cervical cancer screening rates increased. In addition, patient satisfaction with emotional support, physical comfort, coordination and continuity of care improved.

Cataract surgery

- Although there was a short-term increase in wait times for cataract surgery, the general trend was downward in the South West. In fact, wait times are at the lowest level since reporting started in the fall of 2005.

Joint replacement

- Wait times for total joint replacements continued to trend positively, although they have not yet reached the provincial access targets.
- The South West Hips and Knees Quality, Utilization and Access Steering Committee developed a series of recommendations to improve integration, ensure consistency and reduce wait times. The Hip and Knee Priority Action Team is building on this work.

Diagnostic imaging

- Wait times for diagnostic imaging continued to trend downward.
- Wait times for CT remained below the provincial average.

Cardiac care

- Wait times for cardiac care continued to trend downward in the South West.
- The readmission rate for acute myocardial infarctions (heart attacks) has been in steady decline since last year.

Long-term care

For clients and families, long-term care services are sometimes seen as a signal of lessening independence. In fact, the decision to obtain a service from the range of long-term care services available offers the possibility of continuing to live independently with support.

The South West LHIN is responsible for funding hospitals, the South West Community Care Access Centre (CCAC), long-term care homes and community support services, all key players in the process of finding services for those who require additional support in order to live independently in their home or in a residential setting. As our population ages, this will become an increasingly important function.

The placement time to long-term care homes continued to rise in 2006-2007, but remained consistent with the provincial average. Clearly, the availability of long-term care beds is an important factor in placement time. The LHIN is encouraged by the fact that more than 600 new and redeveloped long-term care beds have been announced for the City of London.

Other measures of health performance

Based on patient and client surveys, results for "perception of quality of care" measures have improved for the South West, relative to results obtained in 2005-2006.

Alternate Level of Care (ALC) days are the number of inpatient days that a physician indicated a patient was occupying an acute care hospital bed but whose condition had changed to a degree that he or she no longer required acute care. The percentage of Alternate Level of Care days continued to increase but remains below the provincial average.

Transfer of responsibility

On April 1, 2007, the South West LHIN and the 13 other LHINs in Ontario assumed responsibility for funding hospitals, long-term care homes, Community Care Access Centres (CCACs), community support service agencies, mental health and addictions agencies, divested psychiatric hospitals, and community health centres in their area. In all, more than 200 service agreements were assigned to the South West LHIN by the Ministry.

"Ultimately this means funding decisions will no longer be made centrally at Queen's Park," says Michael

Barrett, Senior Director, Performance, Contract and Allocation at the South West LHIN. "Instead those key decisions will be made by the South West LHIN Board of Directors acting on the health care needs and priorities identified by our communities."

A Success Story

Modeling collaboration in Grey-Bruce

It's a simple concept that has proved very powerful.

"We all sit down at the same table, talk through the challenges, and develop a common workflow, tools and ways of measuring success," says Carol Merton, describing the joint CCAC-Hospital Integrated Navigation Network, an initiative in Grey-Bruce. "Everyone is working from the same page, rather than in silos."

The framework was developed at a time when the hospital was dealing with extreme pressure on beds, yet systemic barriers made it difficult to find solutions. The hospital's CEO and the CCAC's Executive Director came together to create the Collaborative Projects Steering Committee, chaired jointly by the CCAC and the hospital. The Committee establishes priorities for joint projects, assigns resources, helps overcome barriers, and tracks progress.

Working together through the Committee, CCAC and hospital staff developed new approaches to long-term care placement from hospital, including role descriptions, patient information packages, and performance management tools. As a result, Alternate Level of Care days dropped from 18% to 12%. A similar approach applied to total knee replacements reduced length of stay from 4.5 to 3.7 days.

There are now 18 projects being managed by the Committee, including one to connect patients who are scheduled for breast surgery with CCAC services. The idea originated with frontline staff. Merton says they are now more likely to make suggestions, knowing there is a way to move them forward. "There was no additional cost," says Merton of the new approach, "because we used existing resources. The Committee makes decision-making faster and helps promote seamless care delivery. Everyone works together, our patients and clients benefit, and we all share the success."

In preparation for the April 1 transition, members of the South West LHIN staff worked closely with staff at the Ministry of Health and Long-Term Care to ensure that LHIN staff members were equipped with the information and knowledge required for their new responsibilities. This process continued into the first months of 2007-2008.

As part of the transfer of responsibility, all existing service and accountability agreements will continue until each new agreement is negotiated between the LHIN and health service provider. The negotiation of service and accountability agreements will be phased in over a three-year period, with the South West LHIN negotiating new service accountability agreements with hospitals in 2007-2008, community organizations in 2008-2009, and the South West CCAC in 2009-2010.

All of these agreements will include performance indicators, measures of financial efficiency, and service delivery and quality of care expectations. The goal, says Barrett, is to ensure that, "health care providers are delivering high quality services within an appropriate cost structure."

Performance management

It has been said that you can't improve what you don't measure. Performance measurement and reporting set the stage for quality improvement, which is fundamental to the goal of greater accountability and sustainability in Ontario's health system.

During 2006-2007 the South West LHIN began developing a LHIN-wide Performance Management framework that will ensure a consistent approach to defining agreed-upon outcomes and measures. Ultimately, the framework will help us to improve system performance and achieve integration. Recognizing that the framework can only be developed in partnership with health service providers, we began engaging providers in the development process at the end of the 2006-2007 year. This important work will continue in 2007-2008.

With the Ministry of Health and Long-Term Care moving to a stewardship role for the health care system, and LHINs assuming the responsibilities associated with managing the system, the LHINs and the Ministry have entered into an accountability agreement that articulates their mutual obligations and responsibilities.

The accountability agreement is intended to ensure that the South West LHIN is fully accountable to the taxpayers of Ontario for the resources entrusted to it. The agreement contains several schedules which describe the responsibilities associated with financial management and processes, local health system performance, community engagement, and communications.

Engaging our communities

During 2006-2007, more than 3,500 consumers and providers engaged in lively conversations about the future of the health care system in the South West. Beginning with a forum for 400 providers in May 2006, community engagement events were held across the area, in a variety of venues from small town church halls and community centres to a big city convention centre. Ideas and perspectives were also gathered through surveys and telephone polls. This process is described in the South West LHIN's 2006-07 Community Engagement Report, *Building our future together*.

The input was captured in the LHIN's first *Integrated Health Service Plan* and continues to inform the implementation process. Among recent opportunities for community engagement:

- Consumers were included in the Priority Action Teams to provide input from their unique perspective
- The Strategic Advisory Group and Area Provider Tables continue to keep us in touch with important community perspectives
- Public feedback is invited through the LHIN's newsletter and website

Engaging with unique populations

The South West LHIN recognizes that some groups within the area face unique barriers to participation in community engagement and ultimately, in accessing health services. The barriers may include language, culture, stigma and disability. Throughout our community engagement process, we reached out to many of these groups, ensuring that their voices were heard. Special meetings were scheduled with Aboriginal leaders and providers, mental health consumers, immigrants, the Deaf community and the Francophone community.

The Aboriginal population of the South West comprises 1.3% of the population and spans both rural and urban communities, with the highest percentages in the City of London and the north portion of Saugeen. We recognize that Aboriginal communities face significant health issues, including a higher prevalence of many chronic diseases, significant barriers to primary care, and limited access to services for seniors. We also recognize that the solutions to these challenges must be developed in respectful partnership with the communities. During the community engagement process preceding the development of our *Integrated Health Service Plan*, we held seven meetings with Aboriginal leaders and a forum with Aboriginal providers from across the South West. These relationships will continue to develop.

Meetings with health service providers and other community agencies

The key to achieving integration is close partnership with health service providers and other organizations across the South West. During 2006-2007 the South West LHIN began the process of building bridges to these organizations.

The LHIN continues to connect with Area Provider Tables, groups of health organizations in the same geographic area that meet regularly to discuss common issues. The Grey Bruce Integrated Health Coalition (North), the South Service Provider Council (South) and the Huron Perth Providers Council (Central) continue to provide insight into local needs and challenges.

The Strategic Advisory Group is a group of consumers and health professionals formed to help guide the development of the *Integrated Health Service Plan*. The Group continues to play a key role, supporting the implementation of the *Plan* and advising the senior leadership team.

In addition to LHIN health service providers, there are a number of other organizations in the South West that have an impact on the health of our people. In late January and early February the LHIN held meetings in Owen Sound, Mitchell and Dorchester to connect with these organizations and ensure that they are aware of the LHIN's strategic priorities.

Working in partnership for health

St. Joseph's Parkwood Hospital Physical Maintenance Program in London helps seniors maintain physical function and mobility for independent living.

Success stories in our LHIN

Integration is not a new concept: health providers have recognized for many years that collaboration and partnership are the way forward. The South West is fortunate to have several innovative interdisciplinary, cross-sector groups and projects that are already well along the integration curve. During 2006-2007, the LHIN connected with these groups and will continue to work with them in partnership. Here are some examples.

The Southwestern Ontario Geriatric Assessment Network

Established six years ago, SWOGAN brings together teams of health professionals with specialized training in the care of frail seniors across the region. St. Joseph's Health Care, London, a teaching hospital in London, Ontario, is the lead agency, with a team that includes a neurophysiologist, geriatric psychiatrists, advanced practice nurses, geriatricians and others. "The quality of service we can deliver in any one county is exponentially increased by the value of the other teams," says former Program Coordinator Catherine Glover. "If we achieve a breakthrough in Oxford County, for example, everyone knows about it and can replicate it."

The South West End-of-Life Care Network

The Network includes representatives from community agencies, hospitals, long-term care homes and others involved in palliative or hospice care across our area. It is currently supporting the development of three new residential hospices, the introduction of Symptom Management Kits, and the Expected Death in the Home protocol to avoid unnecessary hospitalization at the end of life. The Network also has a "mini-site" of information resources on www.thehealthline.ca, a popular health portal, and recently produced a video that takes an intimate look at one family's experience of caring for a woman dying at home. A discussion guide supports the video, which is shown at provider and consumer forums.

Regional Cancer Services Alliance South West

The Alliance brings together hospitals, the South West CCAC, public health units and other providers across the South West to improve access to and quality of cancer care in the catchment area of the London Regional Cancer Program. In August 2006, the Alliance announced its strategic priorities, which include increasing the rate of breast cancer screening,

maximizing the delivery of chemotherapy in community clinics, improving access to radiation therapy, and supporting the dissemination and use of clinical guidelines for cancer surgery. "This regional initiative supports and provides the opportunity for all patients to receive state-of-the-art care based on best practices and standards in all areas," says Nancy Maltby-Webster, Chief Operating Officer, Middlesex Hospital Alliance. "This continuum of care is one Ontarians have been requesting and now the strategy is in place and moving forward."

Primary care

Although the LHIN is not directly responsible for primary care, we recognize the key role that family doctors and other primary care providers play in the health care continuum. We also recognize that many people in our region don't have easy access to primary care.

Family Health Teams and Community Health Centres are two models of primary care that have the potential to provide exceptional care to more patients. There are 16 Family Health Teams and two Community Health Centres in the South West with three under development. Dr. Jason Bandey, a family physician in Stratford, is one of many who have embraced the FHT approach. "This is a new and exciting way to practice," he says. "When you're doing everything yourself as a family physician, it's refreshing to have people who are bright, motivated, full of good ideas and eager to help you out."

The South West LHIN also played a role in developing the Thames Valley Family Health Team (FHT). The Thames Valley FHT is a unique model in a number of ways. It is a network involving 70 physicians practicing in 11 sites, and also encompasses a Collaborative Maternity Centre, a Care of Complex Elderly Support Model, and a shared Mental Health Model, to support family doctors in dealing with these complex and time-consuming issues. As part of the network, the London InterCommunity Health Centre and the VON/Salvation Army Centre of Hope will provide expertise in caring for homeless people.

A Success Story

Southwestern Ontario Stroke Strategy

How do you get stroke rehabilitation on the agenda in Southwestern Ontario? By holding a day-long meeting to present the evidence and then challenge participants to do something about it.

The Southwestern Ontario Stroke Strategy has been working quietly across the region and across the care continuum for more than five years. Its activities run the gamut from primary prevention, chronic disease management, and primary care to acute care and long-term care, and include care, research, education, advocacy and policy activities.

The Stroke Rehabilitation Action Planning Day was designed to shine the spotlight on this important aspect of stroke care. "We wanted people to be aware of the evidence, best practices, and gaps in our region, and to understand what the gaps mean in terms of patient outcomes and health system costs," says Strategy Coordinator Chris O'Callaghan. "We were very pleased with the response and have worked hard to keep the momentum going." At a recent meeting, a group of rehabilitation leaders agreed in principle to implement best practices for stroke rehabilitation across the region.

"In a sense we were trying to function like a LHIN before LHINs existed," she says. "Now that we have the support of the LHIN, it helps enormously with our work."

Governance

The South West LHIN Board plays a key role in ensuring that our health system reflects local needs and priorities. During 2006-2007, the Board reached its full complement, learned a great deal about the South West and its health resources, and began an active outreach to health service provider boards.

Among the Board's key achievements:

- The Board reached its full complement in June 2006 with the appointment of the final three members. One director resigned during the year. The selection process for a new member began in early 2007.
- Regular monthly meetings were held in various locations across the South West. From November 2006, all meetings were open to the public.
- Two Board committees were established: the Audit Committee and the Nominations Committee. The Nominations Committee was convened in late 2006 to recruit a new Board member.
- Members of the Board participated in a governance training session in collaboration with neighbouring LHINs. In November, several members of the Board participated in the provincial LHIN Board and CEO orientation session and the LHIN/Rotman Governance Program. Each month, the Board members participated in education sessions led by local health service providers.
- Board members were very active in attending community meetings and events, participating in the community engagement process, helping to communicate the *Integrated Health Service Plan*, and building bridges to individuals and organizations throughout the South West.
- Each Board member became a member on one or more of the Priority Action Teams and began working actively with the teams.
- The Board joined with the 13 other LHINs in completing a board evaluation survey. Results showed a general satisfaction with the LHIN development process to date.
- A Conflict of Interest Policy was approved in October 2006.
- In March 2007, the LHIN hosted a gathering of hospital Board Chairs to begin the development of direct linkages between the LHIN Board and health service provider boards. This process will expand significantly during 2007-2008.

Building our future together

In the South West LHIN, 2006-2007 was a year of many stories – the stories of committed people coming together to create a vision for the future of our health care system, and to make that vision a reality. By sharing our stories, we have begun the process of getting to know one another and realizing the potential of this powerful new network. It's been a busy year, full of excitement and ripe with promise.

In 2007-2008, we will create compelling new stories by moving forward with confidence to implement the priorities of our *Integrated Health Service Plan*. We will continue to build partnerships with providers, consumers and communities. We will grow an even stronger organization, committed to serving the people of the South West and creating an excellent, accessible and sustainable health system for today and for future generations.

A Success Story

Thames Valley Family Practice Research Unit is one-of-a-kind

Primary care is at the heart of every effective health system. The South West LHIN is fortunate to be home to the renowned Thames Valley Family Practice Research Unit, Ontario's only health system-linked research facility focused solely on primary care. The Unit's diverse research interests include: family-physician communication, prevention and health promotion in primary care, home-based care and case management, and caring for populations at special risk, such as the chronically ill, elderly and victims of abuse.

The Unit is playing a key role in Delivering Primary Health Care Information (DELPHI), a project to support the use of electronic health records in family physicians' offices, and use the resulting data to understand, and ultimately, improve the quality of care that patients receive. "Among other things, data from DELPHI helps us to appreciate the problems people visit their family physician for, and understand how unorganized symptoms can coalesce into diagnosable and treatable problems," says Saleh Ahmed, Project Coordinator. "It also provides insight into the workload of family physicians and the multi-disciplinary aspects of primary health care teams. Ultimately this project will give us a more comprehensive picture of primary health care and allow us to make evidence-based decisions." Among key lessons from the project to date: the implementation of electronic health records is a challenging task for busy primary care providers, and those who set aside time for training and receive continuous support tend to be the most successful.

Board of Directors

Norm Gamble
Chair

Term of office:
June 1, 2005 to
May 31, 2008

Janet McEwen
Vice-Chair

Term of office:
June 1, 2005 to
May 31, 2008

Kerry Blagrave
Secretary

Term of office:
June 1, 2005 to
May 31, 2008

Bob Habkirk

Appointed:
January 5, 2006
Resigned:
November 15, 2006

Anne Lake

Term of office:
January 5, 2006 to
February 4, 2007
Reappointed:
February 5, 2007 to
February 5, 2010

John Van Bastelaar

Term of office:
January 5, 2006 to
January 4, 2008

Dr. Murray Bryant

Term of office:
May 17, 2006 to
May 16, 2008

Barrie Evans

Term of office:
May 17, 2006 to
June 16, 2007
Reappointed:
June 17, 2007 to
June 17, 2010

Ferne Woolcott

Term of office:
May 17, 2006 to
June 16, 2007
Reappointed:
June 17, 2007 to
June 17, 2010

Board member biographies are available on the South West LHIN website at www.southwestlhin.on.ca.

All Board members of the South West LHIN met with a Conflict of Interest Commissioner in 2006/07 and completed their declarations. The Conflict of Interest Commissioner provided advice in accordance with the LHIN Conflict of Interest Policy.

Sincerely,
Hon. Sydney L. Robins, Q.C., Conflict of Interest Commissioner
Hon. Lloyd W. Houlden, Q.C., Conflict of Interest Commissioner

Financial Statements of the South West LHIN

March 31, 2007

Deloitte.

Deloitte & Touche LLP
5140 Yonge Street, Suite 1700
Toronto ON M2N 6L7 Canada
Tel: (416) 601-6150
Fax: (416) 601-6151
www.deloitte.ca

Auditors' Report

To the Members of the Board of Directors of the South West Local Health Integration Network

We have audited the statement of financial position of the South West Local Health Integration Network (the "LHIN") as at March 31, 2007 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the South West Local Health Integration Network as at March 31, 2007 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
Toronto, Ontario
May 1, 2007

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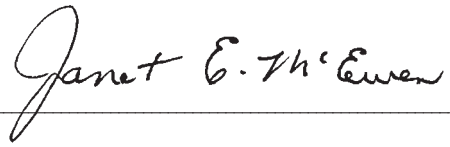
Financial Statements of the South West LHIN – Statement of Financial Position

March 31, 2007

	2007	2006
		(Notes 3, 14)
FINANCIAL ASSETS		
Cash	**$ 655,441**	$ 28,880
LIABILITIES		
Accounts payable and accrued liabilities (Note 4)	**483,690**	-
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**107,989**	29,274
Due to the LHIN Shared Services Office (Note 5)	**63,762**	-
Deferred capital contributions (Note 6)	**652,097**	788,337
	1,307,538	817,611
NET DEBT	**(652,097)**	(788,731)
NON-FINANCIAL ASSETS		
Prepaid expenses	-	394
Capital assets (Note 7)	**652,097**	788,337
ACCUMULATED SURPLUS	**$ -**	$ -

APPROVED BY THE BOARD

Director



Director

Financial Statements of the South West LHIN – Statement of Financial Activities

Year ended March 31, 2007

	2007		2006
	Budget (unaudited) (Note 8)	**Actual**	Actual (Notes 3, 14)
REVENUE			
MOHLTC funding	**$ 3,387,315**	**$ 3,288,751**	$ 248,439
e-Health funding (Note 10)	**132,000**	**132,000**	-
Amortization of deferred capital contributions (Note 6)	**-**	**207,804**	201,856
	3,519,315	**3,628,555**	450,295
EXPENSES			
General and administrative (Note 9)	**3,387,315**	**3,464,124**	421,021
e-Health (Note 10)	**132,000**	**132,000**	-
	3,519,315	**3,596,124**	421,021
ANNUAL SURPLUS BEFORE FUNDING REPAYABLE TO THE MOHLTC	**-**	**32,431**	29,274
FUNDING REPAYABLE TO THE MOHLTC	**-**	**(32,431)**	(29,274)
ANNUAL SURPLUS	**-**	**-**	-
OPENING ACCUMULATED SURPLUS	**-**	**-**	-
CLOSING ACCUMULATED SURPLUS	**$ -**	**$ -**	$ -

Financial Statements of the South West LHIN – Statement of Changes in Net Debt

Year ended March 31, 2007

	2007	2006
		(Notes 3, 14)
ANNUAL SURPLUS	**$ -**	**$ -**
ACQUISITION OF TANGIBLE CAPITAL ASSETS	**(71,564)**	(990,193)
AMORTIZATION OF TANGIBLE CAPITAL ASSETS	**207,804**	201,856
CHANGE IN OTHER NON-FINANCIAL ASSETS	**394**	(394)
DECREASE (INCREASE) IN NET DEBT	**136,634**	(788,731)
OPENING NET DEBT	**(788,731)**	-
CLOSING NET DEBT	**$ (652,097)**	**$ (788,731)**

Financial Statements of the South West LHIN – Statement of Cash Flows

Year ended March 31, 2007

	2007	2006
		(Notes 3, 14)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
OPERATING		
Annual surplus	**$ -**	$ -
Less items not affecting cash		
Amortization of capital assets	**207,804**	201,856
Amortization of deferred capital contributions (Note 6)	**(207,804)**	(201,856)
	-	-
USES		
Increase in prepaid expenses	-	(394)
SOURCES		
Decrease in prepaid expenses	**394**	-
Increase in accounts payable and accrued liabilities	**483,690**	-
Increase in due to MOHLTC	**78,715**	29,274
Increase in due to LHIN Shared Services Office	**63,762**	-
	626,561	29,274
CAPITAL TRANSACTIONS		
Acquisition of capital assets	**(71,564)**	(990,193)
FINANCING TRANSACTIONS		
Increase in deferred capital contributions (Note 6)	**71,564**	990,193
NET INCREASE IN CASH	**626,561**	28,880
CASH, BEGINNING OF YEAR	**28,880**	-
CASH, END OF YEAR	**$ 655,441**	$ 28,880

1. DESCRIPTION OF BUSINESS

Formation and status

The South West Local Health Integration Network was incorporated by Letters Patent on July 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the South West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC").

The LHIN has also entered into an annual Accountability Agreement for fiscal 2006/07 with the Ministry of Health and Long-Term Care which describes the responsibilities of the LHIN and the performance standards that are required to be maintained and achieved in order to obtain funding from the Province.

As of April 1, 2007, funding payments to providers will flow through the LHIN's financial statements. These transfer payments will be reflected as revenue and expenses in the LHIN's financial statements for the year ended March 31, 2008 and thereafter.

LHIN operations

The objects of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south.

2. SIGNIFICANT ACCOUNTING POLICIES

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Deferred contributions

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized over the useful life of the asset reflective of the provision of its services. The revenue is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred. Tangible capital assets are stated at cost less accumulated amortization.

Tangible capital assets are amortized over their estimated useful lives as follows:

- Computer equipment — 3 years straight-line method
- Leasehold improvements — Life of lease straight-line method
- Office equipment, furniture and fixtures — 5 years straight-line method
- Web development — 3 years straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. ADOPTION OF PUBLIC SECTOR ACCOUNTING RECOMMENDATIONS

At the direction of the MOHLTC, commencing in 2007, the LHIN has adopted generally accepted accounting principles, applying government accounting standards issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The comparative figures included in these financial statements have been restated to conform with the accounting standards adopted for the current year.

As a result of the change, during the year the LHIN obtained the fair market value for the donated tangible capital assets received in the prior fiscal period and chose to reflect this more meaningful valuation in the financial statements. This change has been applied retroactively and the prior period has been restated resulting in an increase in deferred capital contributions, and capital assets of $788,337 and net debt of $788,731 on the Statement of Financial Position. On the Statement of Financial Activities amortization of deferred capital contributions increased by $201,856 as did general and administrative expenses. On the Statement of Changes in Net Debt acquisition of tangible capital assets increased by $990,193, amortization of tangible capital assets increased $201,856 and closing net debt increased by $788,731.

4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities totaling $255,556 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 9 related to the prior period.

5. RELATED PARTY TRANSACTIONS

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

6. DEFERRED CAPITAL CONTRIBUTIONS

	2007	2006
Balance, beginning of year	**$ 788,337**	$ -
Capital contributions received during the year	**71,564**	990,193
Amortization for the year	**(207,804)**	(201,856)
Balance, end of year	**$ 652,097**	$ 788,337

7. CAPITAL ASSETS

			2007	2006
	Cost	**Accumulated Amortization**	**Net Book Value**	Net Book Value
Office equipment, furniture and fixtures	**$ 18,245**	**$ 7,298**	**$ 10,947**	$ 14,596
Computer equipment	**53,459**	**19,088**	**34,371**	19,087
Leasehold improvements	**973,053**	**383,274**	**589,779**	754,654
Web development	**17,000**	**-**	**17,000**	-
	$ 1,061,757	**$ 409,660**	**$ 652,097**	$ 788,337

8. BUDGET FIGURES

The total operating budget of $3,387,315 has been approved by the MOHLTC. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles.

9. GENERAL AND ADMINISTRATIVE EXPENSES

For the period ended March 31, 2006, certain operating expenses, other than those disclosed on the Statement of Financial Activities, were approved and paid for on behalf of the LHIN by the MOHLTC. These amounts were not included with the LHIN's financial activities and are disclosed below for information purposes. These expenses are as follows:

Salaries and benefits	$ 150,110
Accommodation/occupancy	1,078,421
Common services	42,126
Information technology	95,919
Other expenditures	286,251
	$ 1,652,827

For the first three months of fiscal 2007, all financial information was processed by the MOHLTC on behalf of the LHIN. Unlike 2006, these amounts are considered expenses of the LHIN directly and are included as part of the financial activities of the LHIN and included in the Statement of Financial Activities.

As part of this transaction, amounts totaling $77,085 of prior period expenses were not accrued. For the year ended March 31, 2007, these amounts were included in the Statement of Financial Activities of the LHIN.

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2007	2006
Salaries and benefits	**$ 1,237,843**	$ 214,431
Occupancy	**175,674**	943
Amortization	**207,804**	201,856
Shared services	**291,393**	-
Public relations	**318,118**	-
Consulting services	**825,083**	-
Supplies	**50,233**	1,627
Board member expenses	**172,861**	-
Mail, courier and telecommunications	**49,897**	364
Other	**135,218**	1,800
	$ 3,464,124	$ 421,021

10. e-HEALTH

During fiscal 2007, the South West LHIN received funding in the amount of $132,000 from the MOHLTC. These funds were used toward initiatives in support of its strategic e-Health Plan as defined in its Integrated Health Services Plan.

11. PENSION AGREEMENTS

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 18 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2007 was $73,871 (2006 - $16,428) for current service costs and is included as an expense in the Statement of Financial Activities.

12. GUARANTEES

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s.28 of the *Financial Administration Act*.

13. COMMITMENTS

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next four years are as follows:

2008	$ 132,476
2009	131,966
2010	128,956
2011	51,883
	$ 445,281

14. COMPARATIVE FIGURES

The prior period figures are from the date of incorporation, July 9, 2005 to March 31, 2006.
During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting. Presentation changes are a result of the change in presentation format to comply with PSAB.

NOTE: The aggregate remuneration for members of the Board of Directors for Fiscal 2006/07 was $127,923.01

South West
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Sud-Ouest

Contact Information

Telephone:

519 672 0445
Toll Free: 1 866 294 5446
Facsimile: 519 672 6562

Address:

201 Queens Avenue, Suite 700
London, ON N6A 1J1

Website:

www.southwestlhin.on.ca
www.lhins.on.ca

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Ontario