Hamilton Niagara Haldimand Brant
LOCAL HEALTH INTEGRATION NETWORK

RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Hamilton Niagara Haldimand Brant

Quality care in community hands. Planning for the future.

2006/07 Annual Report

Ontario

Introducing the Local Health Integration Network

The *Local Health Services Integration Act, 2006* was passed in March 2006. It provides the framework for an integrated health system to improve the health of Ontarians. Outcomes include better access to high quality health services, coordinated health care and effective and efficient management of the health system at the local level by Local Health Integration Networks (LHINs). LHINs are responsible for planning, integrating and funding health services, including community support services, community mental health and addictions agencies, community health centres, community care access centres, long-term care homes and hospitals within their geographic boundaries.

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The HNHB LHIN Board of Directors

Our Board and Staff are developing relationships and building health system intelligence that will guide our work. To do so, we need to continue to learn from you. Residents and stakeholders continue to share their expectations of their LHIN. They tell us: focus on people's experience in the health system, be fair and sensitive and bold, and lead by example. Through you, we are continually reminded that health is more than health care and that health improvement solutions will benefit from collaborations among health and related services.

Juanita G. Gledhill, Chair

Appointed: June 1, 2005 • Term: 3 years

I would like to thank the members of our community for the frank conversations about what our community needs for a truly local health system. We look forward to continuing to work with you as we collectively begin to address those needs.

Jack Brewer, Vice Chair

Appointed: June 1, 2005 • Term: 3 years

I am impressed with the attitude of health care workers from hospital administrators to community volunteers who have willingly embraced change with enthusiasm and creativity.

Stephen Birch, Member

Appointed: May 17, 2006 • Term: 2 years

The work of the LHIN continues to focus on the protection, promotion and restoration of the health of its communities as the basis for planning the configuration of health care services in the region.

Carolyn King, Member

Appointed: January 5, 2006 • Term: 13 months

Re-appointed: February 5, 2007 • Term: 3 years

Our Board is striving to create a new, stronger foundation for the delivery of health care in our LHIN. I feel fortunate to be a part of a process to improve the future for all of our people.

Bill McLean, Member

Appointed: May 17, 2006 • Term: 2 years

The LHIN Board and the health service provider Boards have been working diligently and co-operatively to ensure that the citizens of our LHIN get excellent, quality health care that is sustainable for the future.

Bill Millar, Member

Appointed: March 7, 2007 • Term: 2 years

As a new Board member, I am impressed with the accomplishments of our LHIN since its inception a relatively short time ago. The Board and LHIN staff are highly committed to the LHIN mandate and determined to meet its challenges successfully.

Janice Mills, Member

Appointed: May 17, 2006 • Term: 13 months

Re-appointed: June 17, 2007 • Term: 3 years

It was important to hear from our communities in preparation for our Integrated Health Service Plan (IHSP). It has enabled the LHIN to set priorities based on their needs.

Kim Stasiak, Member

Appointed: June 1, 2005 • Term: 3 years

Message from the Board Chair

The *Local Health System Integration Act, 2006* (LHSIA) is about the devolution of planning, coordinating and funding of health services for quality care in community hands. The future that citizens, stakeholders and providers have long asked for — local decision making for health improvement — is now.

We, the LHIN, and all of us, the collective LHIN, are evolving new roles, responsibilities and accountabilities. This year, our Board committed to building local governance. We had three goals: get to know our communities, learn our role as local decision makers in a new model of transparency, accountability and collaboration, and achieve our accountability agreement with the Ministry of Health and Long-Term Care (MOHLTC). We extend a sincere thanks to all who have taken the time to meet with us over the past year to give us insight into local communities within our LHIN.

Ethical and responsible decision making for health improvement requires the involvement of citizens, stakeholders and providers. Our Board met with people who live and work in our communities in 14 open houses and we participated in more than 400 sessions with networks, providers, associations and interested community members.

Board members continue to demonstrate commitment to becoming knowledgeable about the health system and the culture that LHINs will create. We join community conversations to become familiar with the hopes and concerns of the public and the role of various health service providers.

Our LHIN continues to value open discussion of health issues in our community. In November 2006, monthly Board meetings became open to the public and the media. Our commitment to hold our meetings in communities across our LHIN will ideally lead local citizens to come and observe decision making about their local health care system.

The Board met all of its commitments in its first full year to the MOHLTC. We are very proud of the commitment, in turn, of community leadership for implementing strategies for the priorities that were identified for the future LHIN in February 2005. Strategies are making a difference for accessible, quality services in the areas of occupational health and safety, child and youth mental health, independent living in the community, coordinated services for seniors, concurrent disorders, and palliative care. As well, a LHIN-wide plan for integrated information and communication technology (ICT) describes priorities for an improved health system.

Finally, I thank my colleagues on the Board and our CEO, Pat Mandy, and her team for their time, dedication and hard work. Their commitment to local decision making for a more integrated local health system that keeps people healthy, gets them good care when they are ill and will be there for our children and grandchildren is evident.

It remains an honour and a privilege to serve the citizens of Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk as Chair of our LHIN Board.

Juanita G. Gledhill, *Board Chair*

Message from the CEO

The close of the 2006/07 fiscal year marks the dawn of a new era in health service in the province of Ontario and in the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN).

Much has happened in the evolution of our LHIN over the past year. It has been a year of building and transition. I am particularly proud that we have been able to build an organization staffed with highly committed and skilled individuals who bring a diverse knowledge base and skill set to serve the residents of our community.

Our LHIN is blessed with people and communities who are willing to participate and collaborate. I would particularly like to celebrate a few key accomplishments that were achieved over the past 12 months:

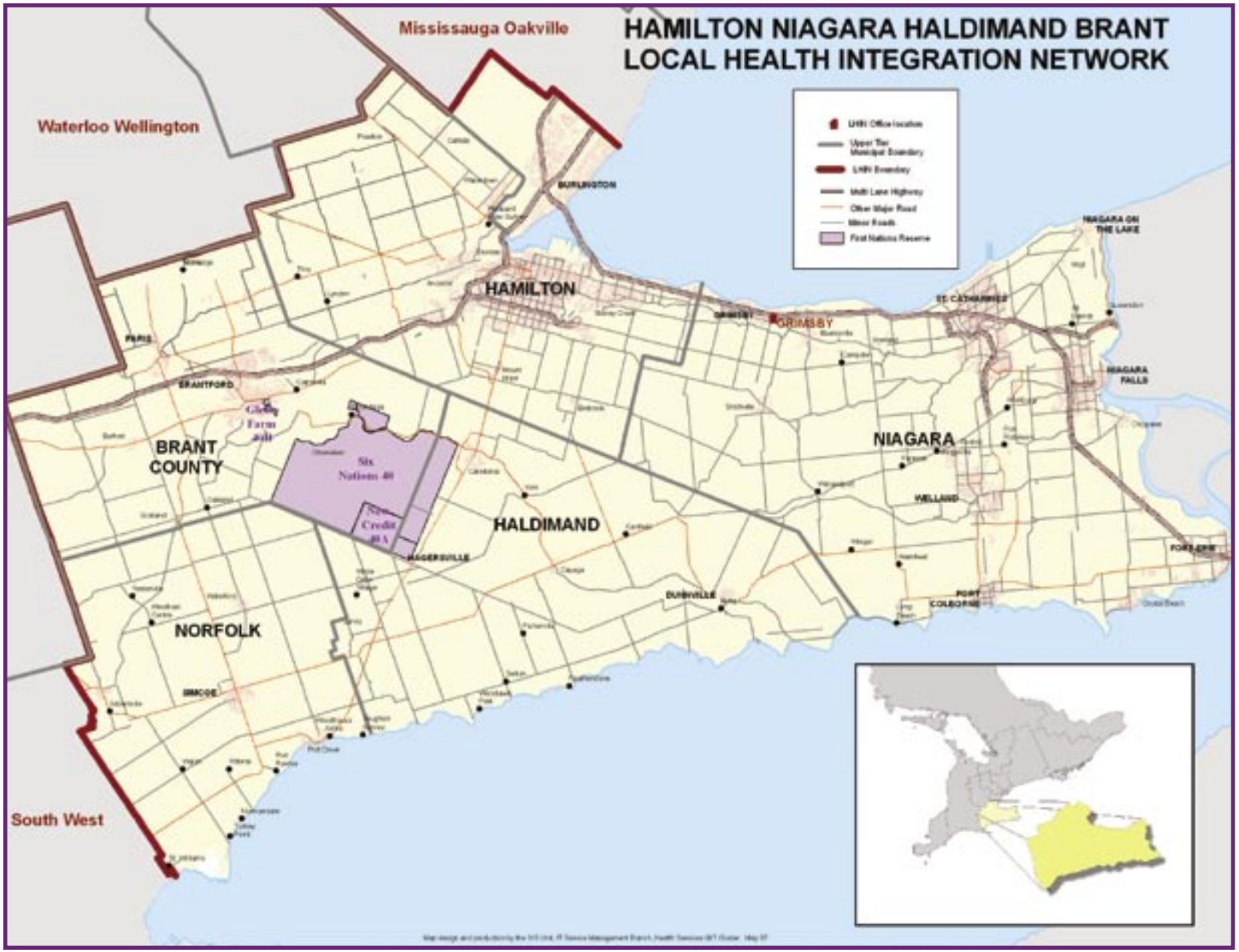
- The voice of our community has been heard. Last summer, more than 800 residents, stakeholders and providers attended 14 open houses to learn about our LHIN, its responsibilities and most importantly — to identify their concerns about their local health system.
- The Integration Health Service Plan (IHSP), Phase 1, inspired from stakeholder input and with the creative work of many people was delivered in October. From our initial series of open houses last summer to ongoing consultations and board linkage activities, community input is evident in the strategies and actions that were identified to improve the local health system.
- The roles and responsibilities of local governance are being reshaped as providers move to a true health "system" that celebrates collaboration.
- Health service providers are collaborating to improve access to procedures and diagnostics identified in the government's Wait Time Strategy. Residents of our LHIN are already experiencing a reduction in wait times for these procedures.
- The *Local Health System Integration Act, 2006* (LHSIA) was passed in March 2006 and defines the accountability of LHINs.
- On March 27, 2007 our three-year accountability agreement with the MOHLTC was signed and delivered.

The above information presents a limited selection of our achievements. Throughout this report you will find many more success stories. This growing legacy gives reinforcement to the mandate and tools by which we will continue to build relationships and advance positive change for our local health system that honours our core purpose to engage, enable and empower people for health.

Finally, I would like to acknowledge the leadership, advocacy and guidance of our Board of Directors who have truly energized and inspired the entire organization.

Pat Mandy, *Chief Executive Officer*

Please visit the Hamilton Niagara Haldimand Brant LHIN website at www.hnhblhin.on.ca or contact any of the staff identified in this annual report to find out more about how we can work together to improve the integration, quality and outcomes of health services in our community.


HAMILTON NIAGARA HALDIMAND BRANT
LOCAL HEALTH INTEGRATION NETWORK
Mississauga Oakville
Waterloo Wellington
South West
HAMILTON
BRANT COUNTY
HALDIMAND
NORFOLK
NIAGARA
BURLINGTON
GRIMSBY
ST CATHARINES
NIAGARA ON THE LAKE
NIAGARA FALLS
WELLAND
PORT COLBORNE
DUNNVILLE
HAGERSVILLE
BRANTFORD
SIMCOE
PARIS
Six Nations 40
New Credit 40A
LHIN Office location
Upper Tier Municipal Boundary
LHIN Boundary
Multi Lane Highway
Other Major Road
Minor Roads
First Nations Reserve

Introducing the Hamilton Niagara Haldimand Brant LHIN

Set amidst the natural beauty of Niagara Falls, the industrial heartland of the Golden Horseshoe and the agricultural landscape of our western communities, the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) stretches from Fort Erie to Turkey Point and Paris to Lowville covering approximately 7,000 square kilometers. It encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk, each having a rich history of local identification and sense of community.

The population estimate for the HNHB LHIN from the 2006 Census is approximately 1.4 million people. The HNHB LHIN is second only to the Toronto Central LHIN in population.

The LHIN is fortunate to have a rich cultural mix, in both urban and rural settings. Niagara, Haldimand and Norfolk boast strong agricultural sectors, with the greatest percentage of rural settlement in Haldimand and Norfolk.

Our LHIN...

Serving the communities of:

- Hamilton
- Niagara
- Haldimand
- Brant
- Norfolk
- Burlington

Both Hamilton and Niagara are designated communities for French language services with more than 5,000 people in each area identifying French as their mother tongue. Consistent with its history as a welcoming community, Hamilton remains one of the main ports of entry for new immigrants into Canada. Approximately 25% of the city's population are immigrants. Niagara, with its close proximity to the United States border, receives many refugees. Although not included in official population estimates, seasonal migrant workers are important contributors to the local economies of Niagara, Haldimand and Norfolk areas, including agriculture and tourism.

There are two reserves in the HNHB LHIN: Six Nations of the Grand River Territory and Mississaugas of the New Credit First Nation. Approximately half of the First Nations population residing in the LHIN area live on-reserve. As of August 2006, the total registered First Nations population living on or off-reserve in the LHIN was 24,263, or 1.7% of the total LHIN population.

The Year in Review

"A journey of a thousand miles begins with a single step."

—Confucius

In 2006/07, health care reform in Ontario gathered momentum with the proclamation of the *Local Health System Integration Act, 2006* (LHSIA) in March 2006. LHSIA formally assigned to LHINs the mandate to plan, integrate and fund local health services – including community support services, community mental health and addictions, community care access centres, community health centres, long-term care homes and hospitals – for specified geographic areas. The MOHLTC, will continue to set strategic directions and provincial standards for high-quality, accessible health care.

Evolution of the HNHB LHIN

Building Our Organization

Staffing

The staffing of our organization grew from a complement of five at the beginning of the year to 20 by year's end. We are pleased to have recruited talented individuals with a variety of skills and experience garnered from a variety of settings including: the regional offices of the Ministry, health service providers, community agencies and sectors outside of health. Our LHIN team was ready and able to take on the transfer of responsibility for health service providers from the MOHLTC.

MOHLTC/LHIN Accountability Agreement (MLAA)

All LHINs and the MOHLTC have together developed a three year MLAA (2007-08, 2008-09, 2009-10). This Accountability Agreement defines the expected outcomes and reporting requirements for a range of LHIN and MOHLTC responsibilities. At the same time, LHINs have worked with the MOHLTC to identify indicators that will be used to measure improved performance in the areas of financial management, health system outcomes, information management, corporate functions, and, community engagement, planning and integration. HNHB LHIN staff participated on all the associated work groups that offered advice on measurement tools.

Connecting with our Community

In our first year, we focused on building relationships with our local community. We initiated and participated in many open houses, meetings and forums where residents could voice their opinions and concerns. From the open houses held in the summer of 2006 to open Board meetings to feedback pages on a website, our LHIN actively solicited information on people's experience with the health system and their ideas to improve it.

Our Board members and senior staff met with approximately 800 people in 14 open houses through the summer of 2006. Residents and stakeholders shared their expectations of their LHIN: focus on people's experience in the health system, be fair, sensitive and bold, and lead by example. We continue to be reminded that health is more than health care and that health improvement solutions will benefit from collaborations among a broad range of health and related services.

> "Integrate funding so that the client is served according to their needs, not by which silo has the most money"
>
> *—Hamilton resident, 2006*

e-Health

e-Health enabled transformation of health care is a journey that requires aligning e-Health activities, leveraging current resources, securing new resources and building the capacity within our provider organizations to absorb new business processes and workflow changes. e-Health enables providers and patients to use information and communication technologies, including Internet

technologies, to plan, arrange, deliver, manage and account for care and achieve wellness in ways that protect individual privacy and sustain the viability of the health system.

On October 10, 2006, the e-Health Steering Committee released its Board-approved Strategic Plan. The Plan is the culmination of the efforts that started with the priority planning process in November 2004 where the development of an e-Health strategy was identified as one of our key priorities. The development of our e-Health Strategy was actively supported by our provider partners who demonstrated not only tremendous readiness for e-Health initiatives but are already leading and participating in a number of such initiatives. Consistent with the provincial e-Health Strategy this e-Health Strategic Plan calls for a long-term (seven to ten years) phased implementation approach. This document presents near-term priorities (one to three years) that will enable us to build a strong foundation for e-Health.

Environmental Scan

LHIN planning and decision making will be informed by a number of data and information sources. The HNHB LHIN initiated an environmental scan of health service and health needs in the local health system. The scan has been built on the findings of a prior HNHB LHIN Community Profile (August 2006), outcomes of community dialogue over the past year, existing data, and policy and funding directions at the national, provincial and local levels. A roundtable of community leaders was convened in March 2007 to validate the findings and propose potential priority health improvement directions for the HNHB LHIN. The environmental scan will be used to refresh the HNHB LHIN's Integrated Health Service Plan.

Chronic Disease Prevention and Management

In February 2007, the HNHB LHIN hosted a roundtable session to discuss opportunities for improved chronic disease prevention and management (CDPM) in our LHIN. CDPM was identified as an emerging priority in our IHSP. Approximately 60 participants learned about the ministry's CDPM Framework for improved health outcomes, met and conversed with the Minister of Health Promotion, Jim Watson, and identified local action opportunities for the LHIN. The Minister highlighted the government's high level of commitment to health promotion and disease prevention for healthy people, a healthy Ontario and a sustainable health system. Both the Minister and Jennifer Mossop, MPP for Stoney Creek, were congratulatory to the participants for their active engagement in CDPM collaboration. A small group was convened to review the session outcomes and work with the HNHB LHIN to identify next steps on this emerging priority.

Ministry of Health and Long-Term Care Strategic Plan

All LHINs collaborated with the MOHLTC when it launched community consultation sessions this year to seek input on its 10 year strategic plan. Our LHIN session was held in Stoney Creek in February 2007. The MOHLTC used the experience of our pilot session to inform the organization of sessions in other LHINs. The information gathered through these sessions provided a window on the issues and opportunities expressed by local residents and providers for health improvement. It was clear that our community endorsed three aspirations for the health system in ten years:

- a system that provides people with choices, information and a role in decision making;

- a system that works well and achieves value for money;
- a system that nurtures good health and well-being through life.

> "The opportunity to shape the future is ours to lose."
>
> *—Juanita G. Gledhill, HNHB LHIN Board Chair*

Working with Our Health Care Providers

"If you want to build a boat, do not instruct the men to saw wood, stitch the sails, prepare the tools and organize the work, but make them long for setting sail and travel to distant lands."
—Antoine de Saint-Exupéry

Integrated Health Service Plan (IHSP)

Our LHIN launched its first IHSP — Quality Care in Community Hands, Building an Integrated Health Service Plan Phase 1 — in November 2006. It is the first of a three year planning cycle that will over time, identify opportunities for health improvement across the continuum of health and health care. Phase 1 of the plan identifies strategies for HNHB LHIN health priorities identified in November 2004 and reported to MOHLTC in February 2005. Champions for change across all communities worked with their networks and communities to develop and implement strategies for health system improvement.

The pace at which change progresses and anticipated outcomes are achieved depends on the readiness and capacity of the leadership for each integration priority to move the solutions forward. Success requires leveraging information and expertise in the community, mobilizing stakeholders, maintaining momentum and staying focused on goals. Our LHIN is working in partnership with local champions for change to move forward implementation of the integration priorities.

Networks

There are more than 70 networks in our LHIN that focus on improved care and support for people using health services. This community of networks has tremendous potential to shape the future health system in the HNHB LHIN. These collaboratives involve two or more independent organizations working together to achieve common objectives. The HNHB LHIN, in dialogue with the leadership and members of the networks has developed an approach for the consideration of networks and their ways of work in strategies to improve the health system. The success of networks will be the extent to which they influence their respective organizations' processes to achieve health outcomes.

Wait Time Strategy

Our LHIN continues to operationalize the government's plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, and diagnostic imaging (MRI and CT exams). Locally, in partnership with providers from both the hospital and community sectors, a steering committee and five work groups were created to identify and eliminate barriers to lower wait times for residents of our community. These groups, comprised of health executives and managers, nurses, decision support, finance and allied health professionals, are working together to reduce wait times and improve patient access.

Where possible, these groups are aligned with existing networks, e.g. the Surgical Oncology Network for cancer wait times and the Regional Joint Replacement Access Model Operations Committee for total joint replacement.

Wait Time Strategy Summary
(measured in days)

Strategy	Feb 06/Mar 06	Feb 07/Mar 07	Days Change Better/(Worse)
Cardiac Procedures			
Angioplasty	23	16	7
Angiography	29	14	15
Bypass Surgery	36	42	(6)
Cancer Surgery	65	64	1
Cataract Surgery	248	188	60
Hip and Knee Replacements			
Hip Replacement	403	242	161
Knee Replacement	472	323	149
Diagnostic Imaging			
MRI	110	101	9
CT Scans	68	50	18

"We are delighted that all hospitals and the CCAC continue to work together and with the LHIN for improved access and health outcomes across the LHIN."

—Juanita G. Gledhill, HNHB LHIN Board Chair

Critical Care

Dr. Peter Kraus, Hamilton Health Sciences, was appointed by the Minister of Health and Long-Term Care as critical care leader for our LHIN. His role is to help implement the province's plan to improve access to critical care services. In his lead role, he is a member of a provincial group that is providing advice to the government on critical care issues. Within our LHIN, he will be working with critical care leaders in hospitals to develop and implement plans to maximize the use and efficiency of critical care resources.

Coaching Teams

Health service providers in our LHIN have been very successful in using the coaching model to identify and implement process improvements relating to surgical procedures and are looking forward to the same success in other areas. Coaching Teams not only benefit the hospitals that are reviewed but also enhance the knowledge and experience of the members of the Coaching Teams.

For example, the following topics were offered to support our LHIN's Critical Care Units with performance and quality improvement:

- End-Of-Life Decision-Making in Critical Care
- Intensivist-Led ICU Management Models

- Patient Flow and Inter-Unit Coordination
- System Integration and Communication
- Improving Work Life and HHR Issues
- Data and Information Management

Building Local Governance

The Ontario Health System is embracing a model of shared accountability and responsibility among health service providers and related stakeholders for health system improvement. To learn more about the opportunities for adopting shared accountability, our LHIN hosted a series of meetings with approximately 400 Board members and Executive leadership of health service providers in Fall 2006. The sessions provided an opportunity for participants to explore new ways of work, mutual expectations, and the responsibility we all have to fully participate in the health reform agenda.

Celebrating Innovations in Health Care Expo 2006

Our LHIN was well represented at the 2006 Expo that showcased innovative solutions and projects supporting health care system renewal in Ontario. The event provided an opportunity to share and learn about achievements and unique approaches in communities across the province related to the government's transformation strategies around primary care, wait times, critical care, information management, LHINs and other health care areas. The inaugural expo presented a unique occasion for collectively acknowledging the system's successes around the delivery of patient-focused and integrated health care services.

> "A showcase for the remarkable creativity, intelligence and drive that distinguishes Ontario's health care system."
>
> *— George Smitherman, Minister of Health and Long-Term Care*

Implementing Effective Governance

Board Members

2006/07 saw a few changes to our Board of Directors.

Leaving the Board – Having served as a Board Member of the HNHB LHIN from March 1, 2006, Vince Bucci resigned November 2006 following his election to municipal council in the city of Brantford. We wish Vince well in his new role.

Joining the Board – In March 2007, Bill Millar joined our LHIN's Board of Directors. Bill brings a wealth of experience from approximately 35 years working in public education in Ontario, most recently as Associate Director of Education for the District School Board of Niagara in 1999. Following retirement, Bill spent 2½ years as a consultant to the Education Quality Accountability Office, coordinating the development and application of an indicators program for Ontario's elementary and secondary schools.

The Board Moves to Open Meetings

Our LHIN values open discussion of health issues in our community. In November 2006, monthly Board meetings became open to the public and the media. Meetings

continue to be located across our LHIN which promotes better access to meetings close to home or work. Meeting notices were posted in local and community newspapers in addition to posting on our LHIN's website.

Conflict of Interest Policy (COI)

The Conflict of Interest (COI) Policy identifies appropriate ways of work for Board and Committee members. The HNHB LHIN Board passed a resolution adopting the COI Policy, Part I on June 7, 2006, and Part II on October 23, 2006. On March 28, 2007, Board members met with Commissioner Robbins, the Conflict of Interest Commissioner for Ontario. One Board member, Vince Bucci, on advice from the Commission, resigned from the Board of Directors due to his election to the Municipal Council in Brantford in November 2006.

Board Development/Orientation

The Board members have spent considerable time working to develop Board relationships, values, ways of work and a decision making process. Additionally, Board education days were held regularly, approximately one day a month, on a variety of topics related to LHIN implementation and understanding of the health care system. Board members continue to demonstrate commitment to understanding and becoming knowledgeable about the health system and the new health service culture that LHINs will create. Board members also attended community engagement activities to become familiar with public aspirations and concerns regarding health care, and the roles of various Health Service Providers.

The Rotman School of Business at the University of Toronto, in partnership with the LHINs and the MOHLTC, developed and held governance education and training for all LHIN board members in the areas of roles, relationships, accountability, and decision making.

Audit Committee

In October 2006, compliant with the requirements of the *Local Health System Integration Act, 2006* (LHSIA), the Board of Directors established an Audit Committee. The Audit Committee assists the Board in fulfilling its fiduciary responsibilities to provide oversight with respect to:

- the integrity of the LHIN's financial statements and other financial instruments;
- the LHIN's system of internal controls;
- the engagement and performance of the independent auditors;
- the performance of the internal controllership function;
- compliance with legal requirements and LHIN policies regarding ethical conduct.

The Committee provides a focal point for communication among our LHIN's Board representatives, the Senior Management, its Controller and the external auditors.

Nominating Committee

The Board of Directors reconvened the Nominating Committee, tasked with identifying individuals to fill vacant positions on the Board. The Committee was comprised of five (5) members:

- Board Chair;
- one (1) additional member of the Board;
- three (3) members of the community.

In December 2006, our LHIN posted ads for the vacant community nominated Board Position on the Public Appointment Secretariat website, in community newspapers across the HNHB LHIN and on the Hamilton

Niagara Haldimand Brant LHIN website. A total of 50 applications were received.

The Nominating Committee interviewed candidates in February. Acting upon recommendations from the Committee Chair, the Board of Directors submitted candidate recommendations to the Minister of Health and Long-Term Care in March 2007.

We are pleased to report that Douglas Archibald, a resident of Port Dover, will join our Board of Directors in May 2007.

Relationship between the Board and Senior Management

Our LHIN Senior Leadership Team includes the CEO, Senior Director – Performance, Contract and Allocation and the Senior Director – Planning, Integration and Community Engagement.

Senior Leadership Team members attend the regular Board meetings and present monthly verbal and written reports to the Board on the activities in their respective portfolios. Led by the CEO, the Senior Leadership Team guides day-to-day operations of the organization.

The Board provides ongoing direction to the CEO through:

- regular meetings;
- Board committees;
- policy direction;
- performance appraisal.

Financial Statements of Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2007

Auditors' Report

To the Members of the Board of Directors of the

Hamilton Niagara Haldimand Brant Local Health Integration Network

We have audited the statement of financial position of Hamilton Niagara Haldimand Brant 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 Hamilton Niagara Haldimand Brant 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 L.L.P.

Chartered Accountants

Licensed Public Accountants

Toronto, Ontario

April 26, 2007

Statement of Financial Position

March 31, 2007

	2007	2006 (Notes 3, 14)
Financial Assets		
Cash	**$ 677,583**	$ 30,351
Accounts receivable	**3,138**	-
	680,721	30,351
Liabilities		
Accounts payable and accured liabilities (Note 4)	**603,806**	-
Due to the Ministry of Health and Long-Term Care ("MOHLTC")	**-**	30,351
Due to the LHIN Shared Services Office (Note 5)	**79,507**	-
Deferred capital contributions (Note 6)	**618,425**	679,515
	1,301,738	709,866
Net Debt	**(621,017)**	(679,515)
NON-FINANCIAL ASSETS		
Prepaid expenses	**2,592**	-
Capital assets (Note 7)	**618,425**	679,515
Accumulated Surplus	**$ -**	$ -

APPROVED BY THE BOARD

Juanita G. Gledhill, Board Chair

Jack Brewer, Vice Chair

Statement of Financial Activities

Year ended March 31, 2007	2007 Budget (unaudited) (Note 8)	2007 Actual	2006 Actual (Notes 3, 14)
Revenue			
MOHLTC funding	**$ 3,625,620**	**$ 3,625,620**	$ 260,968
E-Health funding (Note 10)	**33,000**	**33,000**	-
Amortization of deferred capital contributions (Note 6)	**-**	**206,651**	169,878
	3,658,620	**3,865,271**	430,846
Expenses			
General and administrative (Note 9)	**3,625,620**	**3,832,271**	400,495
E-Health funding (Note 10)	**33,000**	**33,000**	-
	3,658,620	**3,865,271**	400,495
Annual Surplus before funding repayable to the MOHLTC	-	-	30,351
Funding repayable to the MOHLTC	-	-	(30,351)
Annual Surplus	-	-	-
Opening Accumulated Surplus	-	-	-
Closing Accumulated Surplus	**$ -**	**$ -**	$ -

Statement of Changes in Net Debt

Year ended March 31, 2007

	2007	2006 (Notes 3, 14)
Annual Surplus	**$ -**	$ -
Acquisition of Tangible Capital Assets	**(145,561)**	(849,393)
Amortization of Tangible Capital Assets	**206,651**	169,878
Change in Other Non-Financial Assets	**(2,592)**	-
Decrease (Increase) in Net Debt	**58,498**	(679,515)
Opening Net Debt	**(679,515)**	-
Closing Net Debt	**$ (621,017)**	$ (679,515)

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	**$ -**	$ -
Add Items not affecting cash - Amortization of capital assets	**206,651**	169,878
Less items not affecting cash - Amortization of deferred capital contributions (Note 6)	**(206,651)**	(169,878)
	-	-
Uses		
Increase in accounts receivable	**(3,138)**	-
Increase in prepaid expenses	**(2,592)**	-
Decrease in due to the MOHLTC	**(30,351)**	-
	(36,081)	-
Sources		
Increase in accounts payable and accrued liabilities	**603,806**	-
Increase in due to the MOHLTC	-	30,351
Increase in due to the LHIN Shared Services Office	**79,507**	-
	683,313	30,351
	647,232	30,351

Year ended March 31, 2007

	2007	2006 (Notes 3, 14)
Net Inflow (Outflow) of cash related to the following activities continued...		
Capital Transactions		
Acquisition of capital assets	**(145,561)**	(849,394)
Financing Transactions		
Increase in deferred capital contributions (Note 6)	**145,561**	849,394
Net Increase in Cash	**647,232**	30,351
Cash, Beginning of Year	**30,351**	-
Cash, End of Year	**$ 677,583**	$ 30,351

Notes to the Financial Statements

1. DESCRIPTION OF BUSINESS

Formation and status

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 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 Hamilton Niagara Haldimand Brant 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 the fiscal year 2007 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 includes the communities of Brant, Burlington, Haldimand, Hamilton, Niagara and most of the County of Norfolk.

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. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. 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. This amortization 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 the 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
Infrastructure/web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

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 accounting standards adopted for the current year.

As a result of this 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, net debt and capital assets of $679,515 on the statement of financial position. On the statement of financial activities amortization of deferred capital contributions increased by $169,878 as did general and administrative expenses. On the statement of changes in net debt acquisition of tangible capital assets increased by $849,393 amortization of tangible capital assets increased by $169,878 and closing net debt increased by $679,515.

4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities totaling $242,194 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. In this total, $4,990 was included as a prior period expense that related to fiscal 2007.

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 LHINs at the year end, are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all the LHINs.

6. DEFERRED CAPITAL CONTRIBUTIONS

	2007	2006
Balance, beginning of year	**$ 679,515**	$ -
Capital contributions received during the year	**145,561**	849,394
Amortization for the year	**(206,651)**	(169,879)
Balance, end of year	**$ 618,425**	$ 679,515

7. CAPITAL ASSETS

	2007			2006
	Cost	**Accumulated Amortization**	**Net Book Value**	Net Book Value
Office equipment, furniture and fixtures	**$ 266,939**	**$ 90,957**	**$ 175,982**	$ 150,278
Computer equipment	**57,450**	**19,150**	**38,300**	**-**
Leasehold improvements	**670,566**	**266,423**	**404,143**	529,237
	$ 994,955	**$ 376,530**	**$ 618,425**	$ 679,515

8. BUDGET FIGURES

The total operating budget of $3,797,750 has been approved by the MOHLTC. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. In March 2007, MOHLTC approved the carry over of unspent funds to implement the LHIN Wide Area Network Project. The Hamilton Niagara Haldimand Brant LHIN contributed $26,569 toward the cost of this project for 2007/08.

	2007
Approved operating budget	**$ 3,797,750**
Tangible capital assets	**(145,561)**
Revenue deferred to LSSO	**(26,569)**
Reclassifed operating budget	**3,625,620**
Approved project budget	**33,000**
Reclassified budget	**$ 3,658,620**

Reclassified budget	**$ 3,658,620**
Tangible capital assets	**145,561**
Reconciliation to Q4 report	**$ 3,804,181**

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	$ 96,582
Accommodation/occupancy	1,185,292
Common services	42,126
Information technology	102,221
Other expenditures	268,251
	$ 1,694,472

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 transition, amounts totaling $11,017 of prior period expenses were not accrued and these amounts were included in the March 31, 2007 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	**$ 1,421,781**	$ 227,647
Director's per diems	**148,926**	-
Travel	**79,986**	-
Consulting services	**677,334**	-
Banking services	**673**	-
Community forums & communication	**305,944**	-
Supplies, equipment, maintenance, other	**425,068**	2,970
Accommodation	**267,850**	-
Shared services	**290,201**	-
Conflict of interest (COI)	**7,857**	-
	3,625,620	230,617
E-health funding	**33,000**	-
Amortization	**206,651**	169,878
	$ 3,865,271	$ 400,495

Reconciliation to MOHLTC approved budget:

General and administrative expenses	**$ 3,865,271**
Less: amortization	**(206,651)**
Plus purchase of tangible capital assets	**145,561**
	$ 3,804,181

Note: Included in total travel expenses of $79,986, reported in Note 9 to the Financial Statements, is $23,571 of travel expenses incurred by the Board of Directors.

10. E-HEALTH

During fiscal 2007, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $33,000 (2006 - $200,000 was included in the total expenses of $1,694,472 disclosed in Note 9 as they were approved and paid for on behalf of the LHIN by 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 19 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 $68,532 (2006 - $7,338) 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.

13. COMMITMENTS

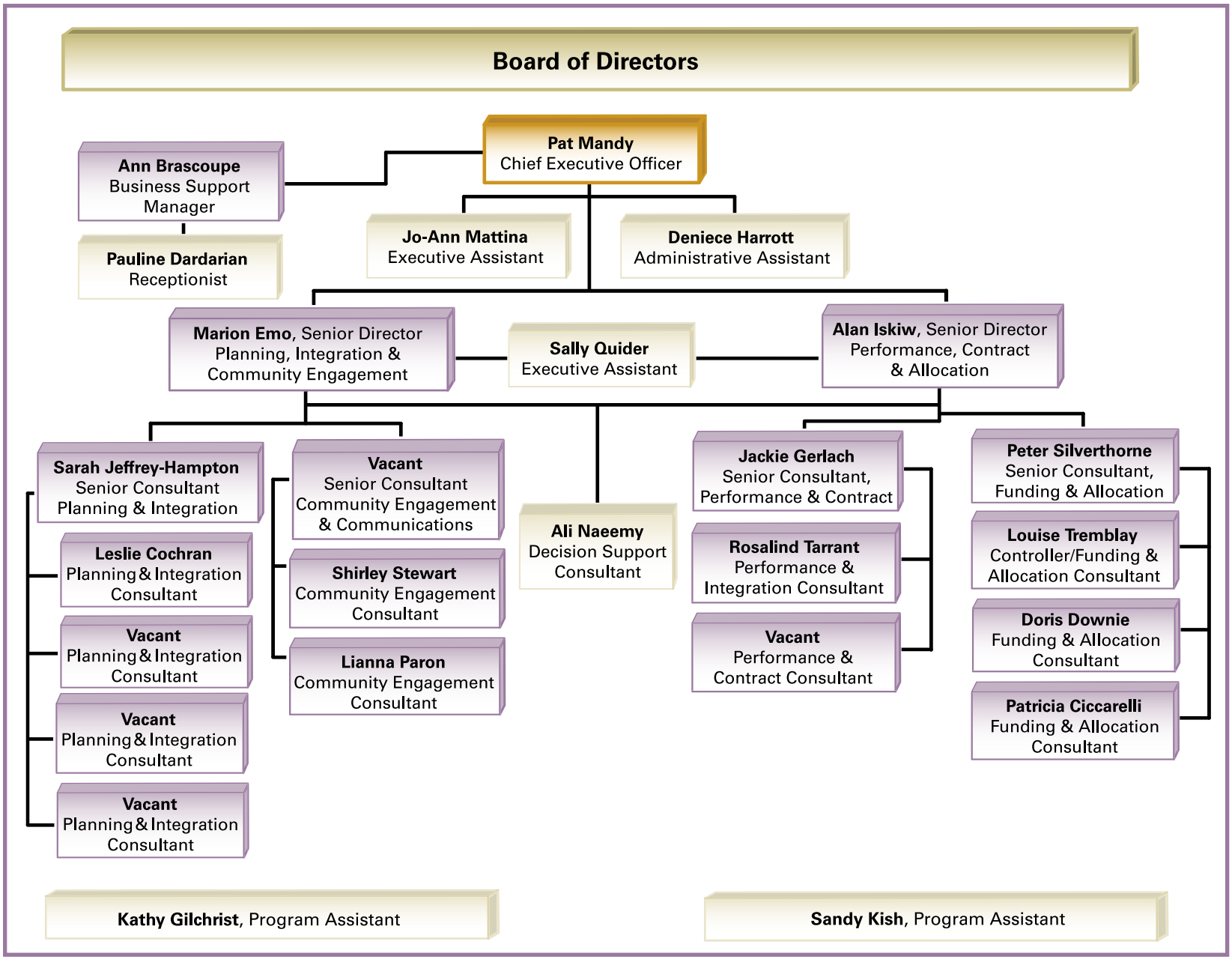
The LHIN has commitments under various operating leases. Minimum lease payments due in each of the next five years and thereafter are as follows:

2008	$ 157,044
2009	157,044
2010	157,044
2011	61,133
2012 and thereafter	13,178
	$ 545,443

14. COMPARATIVE FIGURES

The prior period figures are from the date of incorporation, June 2, 2005 to March 31, 2006. The comparative figures have been reclassified to conform to the current year's presentation. 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.

HNHB LHIN Organization Chart



As of June 1st 2007

Board Members

Juanita G. Gledhill
Chair

Jack Brewer
Vice-Chair

Douglas Archibald*
Board Member

Stephen Birch
Board Member

Vince Bucci, Sr.**
Board Member

Carolyn King
Board Member

William (Bill) McLean
Board Member

William (Bill) Millar
Board Member

Janice Mills
Board Member

Kim Stasiak
Board Member

Senior Staff Members

Pat Mandy
Chief Executive Officer

Alan Iskiw
Senior Director,
Performance, Contract and Allocation

Marion Emo
Senior Director,
Planning, Integration and Community Engagement

*appointed in 2007/08 fiscal year

**served from March 1, 2006 to November 2006

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2007.

Juanita G. Gledhill,
Chair, Board of Directors

Jack Brewer
Vice-Chair, Board of Directors

Hamilton Niagara Haldimand Brant
LOCAL HEALTH INTEGRATION NETWORK

RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Hamilton Niagara Haldimand Brant

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