



Public Health
Santé publique
SUDBURY & DISTRICTS

July 26, 2019

VIA ELECTRONIC MAIL

Ms. Helen Angus
Deputy Minister of Health and
Deputy Minister of Long-Term Care

Dr. David Williams
Chief Medical Officer of Health
Ministry of Health

Dear Colleagues:

Re: Transforming Public Health for the People of Northeastern Ontario

I write on behalf of the five Medical Officers of Health for Northeastern Ontario. As leaders of the public health units for Algoma, North Bay Parry Sound, Porcupine, Sudbury & Districts, and Timiskaming, we began some years ago to explore how greater collaboration among our organizations might improve our collective efficiency and effectiveness in meeting the unique public health needs of the people of the North East.

The announcements on April 11, 2019, of the government's consideration of a new province-wide model for public health served to accelerate and refocus our efforts. This led us to consider a range of structural, organizational, and governance options in support of a more integrated approach and resulted in the submission that is forwarded to you today for the Ministry's consideration.

We appreciate that there are decisions to come as to how the Ministry intends to receive input from stakeholders on a modernized approach to public health. We are confident that protecting and promoting the health of our population remains at the forefront for the Ministry as much as it does for us, and we are hopeful that our submission points to a feasible path forward for a Northeastern public health entity, should this remain the direction following the Ministry's consultations.

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Letter

Re: Transforming Public Health for the People of Northeastern Ontario

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The attached submission was prepared for your consideration, while you continue with determining the way forward for public health modernization. We would point out the key features of our work as follows:

- We have adopted a driving principle of think corporately and deliver locally. Translated, this means that we have considered how to create a single consistent set of systems for administrative purposes supporting, measuring, and managing a delivery structure that continues to identify and meet the public health needs of local communities.
- We have not lost sight of the concerns of our constituent municipalities, especially around cost management. To this end, we have proposed a representational governance structure that both respects that, and begins to embed best practices in good governance, embracing not only local representation, but also the complex set of skills, experience, and competencies that we know public health governance needs to succeed in the rapidly transforming health system in Ontario.

We have accomplished a great deal. We have reached agreement among a group of committed colleagues; obtained the support of our respective Boards to undertake this work; shared our work to date with our current Board Chairs; and have undertaken considerable detailed planning and analysis of both delivery and administrative systems, focussing on potential efficiencies within a new model. And, there is much yet to be done.

With the experience of the North East thus far, we submit that to do any transformation work well while ensuring the important work of public health continues uninterrupted, careful consideration must be given to sufficient transition time, funding and resources to support the required transition work, and flexibility as needed to incorporate potential regional variations.

We are now at the stage where we seek the opportunity to meet with Ministry senior leadership, to consider and refine our work to date. We would like to provide further context, review the recommendations, and clarify any points as needed. Public health is too important to get wrong and we remain dedicated to working with you to ensure a strong, effective, nimble, and locally connected public health system for the province of Ontario.

Letter

Re: Transforming Public Health for the People of Northeastern Ontario

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Thank you and we would sincerely appreciate an opportunity to engage. We would be pleased to organize this through my office at 705.522.9200 ext. 291.

Sincerely,

A handwritten signature in black ink, appearing to be 'Penny Sutcliffe', written in a cursive style.

Dr. Penny Sutcliffe
Medical Officer of Health and Chief Executive Officer
Public Health Sudbury & Districts

Encl.

cc: Ms. Elizabeth (Liz) Walker, Director, Accountability and Liaison Branch, Ministry of Health
Ms. Colleen Kiel, Acting Director, Strategy and Planning Branch, Ministry of Health
Dr. Jim Chirico, Medical Officer of Health and Chief Executive Officer, North Bay Parry Sound District Health Unit
Dr. Lianne Catton, Medical Officer of Health and Chief Executive Officer, Porcupine Health Unit
Dr. Marlene Spruyt, Medical Officer of Health and Chief Executive Officer, Algoma Public Health
Dr. Glenn Corneil, Acting Medical Officer of Health and Chief Executive Officer, Timiskaming Health Unit

TRANSFORMING PUBLIC HEALTH
FOR THE PEOPLE OF NORTHEASTERN ONTARIO

A SUBMISSION TO THE GOVERNMENT OF ONTARIO

HELEN ANGUS, DEPUTY MINISTER OF HEALTH

AND

DR. DAVID WILLIAMS, CHIEF MEDICAL OFFICER OF HEALTH

Introduction

This submission is the result of many months of work by the undersigned Medical Officers of Health (MOH), who are the Chief Executive Officers (CEO) of their respective Boards of Health. This work was undertaken on their own initiative for the five Northeastern Boards of Health. It has been developed in response to the current Government's announced intention to streamline the complex system of providing public health programs and services aimed at both protecting and promoting the health of the people of Ontario. This document provides our best advice regarding governance and leadership in the North East should the changes to the public health system proceed as announced.

Context

Over the past several years, there has been considerable attention paid to the current complexity of the public health system. As recently as 2017, the report entitled *Public Health within an Integrated Health System; Report of the Minister's Expert Panel on Public Health* raised a number of ideas and recommendations for transforming that system, addressing such challenging issues as system delivery boundaries and leadership and governance models that might better accomplish the best fit of public health within a larger, transformed health system.

Ontario's current government has introduced fundamental change in the way health care is to be funded, structured and delivered, and in its conceptualization has embodied some of the ideas raised earlier regarding public health.

The five Northeastern health units, serving the areas of Algoma, North Bay/Parry Sound, Porcupine, Sudbury/Manitoulin, and Timiskaming began in 2017 to explore how they could collaborate more closely to achieve improved efficiencies with potential "functional mergers". With the April 2019 announcement of public health regionalization, the five MOHs for these health units were in a unique position to quickly refocus this work to consider how a new, single autonomous regional public health 'entity' might be created should the announced changes proceed. The goal would be to continue to meet the important public health standards in Ontario with all of the requisite standardization, capacity, and equity in the delivery of programs and services across the larger region, while at the same time realizing efficiencies and meeting the cost savings goals of government.¹

This report is the result of that work since 2017.

¹ The Ministry has identified a goal of provincial cost savings of \$200 million system-wide by 2021/22. The impact on regional public health budgets will depend on the ultimate determination of the level of municipal funding to offset announced changes to the provincial/municipal apportionment of funding.

It addresses the combined challenges raised above, proposes models for reorganizing service delivery, leadership, and governance, and sets out an orderly process of transitioning from the current five Public Health Unit (PHU) model, to a single Northeastern Regional Public Health Entity (NE-RPHE). If these changes proceed there would be much work still to be completed, however, we believe that the recommendations herein form a solid foundation upon which to build a more detailed model for public health in the North East.

The model proposed will need careful scrutiny:

- by the Ministry, in the context of its overall health care transformational design;
- by the many (108) local governments in the North East who are expected to continue to share with Ontario the cost of public health programming;
- by those communities in the North East who have a passionate interest in the way services are provided to their communities; and
- with special attention to Indigenous peoples, both First Nation communities and Indigenous peoples living in urban environments, as well as the significant Francophone population in the North.

The Geography and Population of the North East

Ontario's North is appreciably different than the South, even the more rural parts of southern Ontario. With the combination of large distances, unique histories, challenging travel especially in winter, and widely dispersed populations, the delivery of programs and services and even the matter of representation of communities in governance is difficult. Significant Indigenous and Francophone populations are defining factors as well.

We understand that the Ministry is seeking consistency across the ten regional public health entities to be created to serve the entire Province. We outline our proposals for some level of such consistency but stress the substantively different circumstances that characterize the North.

The current North East public health infrastructure is composed of five distinct areas (health units), each with its own MOH who is the CEO, and autonomous board governance. For ease of reference, a map outlining the segmentation of Northeastern Ontario for public health purposes is attached as **Appendix A**. Shown on that map are the main public health service delivery 'assets' currently in place.

Program and Service Delivery

First, we considered how best to visualize *program and service delivery* in a new, single regional public health entity. We settled on a simple concept that has driven our thinking: **Think corporately; deliver locally**. Embedded in that notion is a concept that considers how to achieve efficiencies in our work; creating a *single consistent set of systems for administrative purposes* supporting, measuring and managing a delivery structure that continues to *identify and meet the public health needs of local communities*.

We concluded that there is a sound business case for mapping that local service delivery into four, rather than five, distinct *sub-regions* in the North East. Note that this work assumes the existing geographic boundaries of the five current North East boards of health. It does not incorporate the District of Muskoka or parts of Renfrew County as proposed by Ministry officials.

Those *four sub-regional service areas* are centred on the urban centres of Sault Ste. Marie, North Bay, Timmins, and Sudbury.

While we have given considerable thought to the geographies serviced by each sub-region, we do recognize that much work remains to be done in determining the most logical functional structure. This

would take into account community delivery assets, and be determined over time, as the new structure is implemented.

We have identified several fixed ‘assets’ within the current five health units where efficiencies in the physical location of Public Health staff and offices could be achieved by reorganization of those assets. Work continues at the detailed service level as to how to realize and quantify those efficiencies, while continuing to meet the Ontario Public Health Standards (OPHS) and address local needs.

Leadership and Management

Following our agreed-to fundamental principles of maintaining the appropriate level of protection and promotion of the health of the people of the North East, and our **think corporately and deliver locally** approach, we have very carefully considered how both the leadership and management of a NE-RPHE and a sub-regional delivery model might be structured.

Our conclusions:

1. There is solid support for the need to have singular corporate management of the regional level in the form of a Regional Medical Officer of Health who is the Chief Executive Officer of the organization (RMOH). There must be unified accountability to the Board for policy direction and resource management for such a new model to succeed. We fully support the work to date of the Council of Ontario Medical Officers of Health (COMOH) in this respect and make what we believe to be the obvious observation that such a position must be held by a qualified public health physician **with a range of well-defined managerial and leadership competencies**.
2. The RMOH will be accountable to the Board and to the Chief Medical Officer of Health (CMOH) for public health strategy and compliance with the OPHS under the *Health Protection and Promotion Act* (HPPA).
3. At the regional level, we see the need for a carefully constructed set of systems, procedures, and processes that will be followed by all parts of the new organization. Key to success will be administrative and programmatic systems, accountabilities, and measures that will drive both effectiveness and efficiency in service delivery.
4. We envisage senior level executives, reporting directly to the RMOH, who will take responsibility for building and managing those corporate-wide systems. This is a key element of the **think corporately and deliver locally** approach.
5. We envisage savings to accrue to the NE-RPHE as systems are integrated, with singular leadership of key corporate service elements (such as accounting and finance, procurement, information technology, and human resource management), foundational standard elements (such as program planning and evaluation, effective public health practice, population health assessment, and health equity) and programmatic elements (such as overarching policy and programming in both health protection and health promotion).
6. We also turned our attention to the matter of how best to structure the “deliver locally” aspect of our proposed design. Implicit in our thinking has been the need to ensure that capacity is maintained to not only identify, anticipate, and respond to local public health issues, whether they be urgent or strategic in nature, but also be *seen to be* responsive at the local level. We know that our communities and municipalities will demand that in any new model.
7. We understand the key role that qualified physicians with public health training play in the public health domain, and the expectation that our stakeholders have and will continue to have that a qualified MOH will be “there for them.” This is aligned with the thinking of COMOH in this respect. We understand that there is an important role in building and maintaining excellent community stakeholder relationships by such physicians. The challenge in this very large geographical area is one of determining how best to meet those expectations.
8. We have also adopted a principle of recognizing and supporting the key roles played in public health by other health professionals who are now, and will continue to be, essential in the delivery of local public health programming. Nurses and public health inspectors, for example, must and

will play a role in local delivery. We believe that those professionals should also play *leadership roles* at the regional and sub-regional level.

9. At present, across the five current PHUs, there are seven physicians who are designated as MOHs or Associate MOHs (Note that one MOH position is currently in an acting capacity.) The COMOH model of seeing all public health physicians as “MOHs” aligns with our thinking. It is our carefully considered opinion that in the regional model and with the expected constraints, a smaller number of public health physicians can effectively meet the standards required.
10. With all of that in mind, our conceptualization of the leadership structure is as follows:
 - One physician to be the Regional Medical Officer of Health (RMOH), and in that role to be the Chief Executive Officer.
 - Four physicians to be designated as sub-regional MOHs. The goal will be to ensure that each of the four sub-regions has access to a designated MOH, where the circumstances require access to that level of expertise. One of those four MOHs would be designated as the Deputy Regional MOH (DRMOH) so as to ensure appropriate chain of authority at all times, acting in the place of the RMOH.
 - We continue to work on the challenge of building appropriate accountabilities and cross-discipline leadership in this model. We assert that the RMOH must be the ultimate decision-maker and we have identified two possible models for leadership at the sub-regional level. The preferred model is for the MOH assigned to that sub-region to take on the leadership role. It is also recognized that team leadership skills in some sub-regions might better be found in another health discipline. In this approach, the sub-regional MOH would not have this line authority. We note that COMOH supports MOHs playing various roles (e.g. local organizational leadership, medical leadership, program expertise consultation, etc.) according to local needs and this is aligned with our model.
 - Regardless, strong team leadership should be the most important factor in building and transitioning to a new and quite different set of accountabilities.
 - Finally, there is of course the matter of finding the best fit for the many valued professionals, including physicians, who now make up the public health assets across the North East.

We attach as **Appendix B**, a set of functional diagrams outlining how we see the structure of the regional/sub-Regional design for the new NE-RPHE. We note that these are a work in progress and depict the key reporting relationships, representing our thinking to date on how the regional and sub-regional functions can best be supported by these relationships.

Representation and Governance

One of the most challenging aspects of the restructuring is the matter of representation of the wide territory, numerous communities and municipalities, and diverse populations that make up the North East. We have endeavoured to strike a fair and reasonable formula for the creation of a single governing body of the regional public health entity, at least on a transitional basis.

In the current model according to the applicable Regulations under the HPPA, there are a total of 74 seats on the five Boards of Health; 51 of which are appointed by municipal councils. Of these, 38 municipal representatives are elected; the remaining 13 are non-elected ‘citizen’ representatives.

Perhaps the most striking thing to realize is that even under the *current* composition requirements, there are considerably fewer municipal representatives on the five existing Boards than there are municipalities (108).

Contemplating the composition of *one board that would represent 108 municipalities* makes clear the first challenge in constituting a regional Board.

We understand that, with the diverse population in Ontario's North, there are special considerations to be taken into account in developing representational models. Across the five current Boards there are no individuals on those Boards who are there *as identified representatives of diverse communities*, including First Nations/Indigenous populations, and the substantial Francophone population. There are indeed Indigenous and Francophone representatives, but they were not chosen specifically to represent those parts of their respective communities, to the best of our knowledge.

Another complexity to be considered. We will explore below the means by which such representation could be assured in the proposed new structure.

At present, the Province has a mandate under the current HPPA Regulations to appoint several representatives to each Board. There have been challenges to date for the Provincial Appointments Secretariat to populate those seats, resulting in numerous vacancies.

It should be acknowledged that there is another challenging issue facing municipal councillors who are appointed to PHU Boards, much as is the case with other bodies in the North, such as District Social Services Administration Boards. That issue is one of *fiduciary responsibility* to the PHU Board, and reconciling that duty to the fiduciary responsibility owed to the municipality where each holds elected office. This issue is particularly challenging in circumstances where those Boards have the statutory authority to set levies which the municipalities are obliged to pay.

Finally, and perhaps constructively, is the current best practice of creating governance boards on the basis of a carefully balanced set of skills, knowledge, familiarity with community, and experience – commonly referred to as a balanced matrix of *competencies*. Our premise, given all of the challenges outlined here, is to propose a *transitional model* for the first Board of the NE-RPHE that *bridges* those challenges, and **works toward skills-based boards in the public health sector**.

In fact, we urge adoption of a policy that would seek careful consideration of diversity and skills/competencies, as well as geographic representation, by both the municipal entities and the Province of Ontario, as they consider appointments to the proposed Board. Further, we urge that those appointing entities be encouraged to consult their existing PHUs and MOHs as to the most needed categories of Directors required.

Our proposal for composition, keeping in mind diversity, skills and competencies, and geographic locale:

- One representative municipal councillor, an elected official currently holding office in a larger, urban municipality, for each of the newly defined four sub-regional areas, centred on Sault Ste. Marie, North Bay, Timmins and Sudbury.
4 members
- Two additional municipal councillors, currently holding elected office in the many smaller municipalities throughout the North East, to ensure that the perspectives of smaller municipalities are reflected.
2 members.
- One non-elected representative of the community within each of those four sub-regional areas, chosen carefully by municipalities to bring to the Board table *a set of defined competencies and experience that contribute to a well-balanced Board*.
4 members

In the body of those municipal appointees, constituting the majority of the new Board, careful attention to representing all of the North East. Further, given the historical existence of an autonomous Board of Health in the Timiskaming District, at least one of the members of the initial Board as outlined above shall be a representative of the Timiskaming District.

- Three representatives appointed by the Province of Ontario, following the procedures of the Provincial Appointments Secretariat with approval by the Lieutenant Governor in Council, *with careful attention to*:
 - *the set of defined competencies and experience,*
 - *representation of the Francophone population of the North East:*
3 members
- One representative each for two defined populations in the North East, specifically chosen to represent:
 - A First Nations person, living in a First Nation community
 - An Indigenous person (First Nations, Metis, Inuit), living in an urban community
2 members

We note that representatives of diverse communities identified specifically in our proposal may be supplemented by other persons appointed by municipal or provincial bodies.

A total of 15 members.

Transition

We recognize that there may well be significant challenges in implementing the proposed composition of the first Regional Board; hence, the qualifier that this be considered a *transitional* process.

Considerations for how to choose such representatives include:

- A request of the current five Boards of Health, collectively, to collaborate on their advice to the appointing municipalities regarding the selection of current Councillors and community members who have demonstrated considerable interest in the public health issues and challenges in the North East, and who are supportive of and interested in the 'start-up' challenge of this new venture
- An interim Regulation under the Act that enables the Minister of Health to appoint or confirm the appointment of such Directors, whether municipally or provincially selected, to the transitional Board
- Building consensus amongst the appointing parties, including the Ministry of Health, as to the desired competencies for the composition of the inaugural Board. A draft outline of such competencies is attached to this proposal as **Appendix C**

Enabling transition

The Ministry in its announced plans for migration to a system with ten, rather than 35, PHUs across the province, has indicated a preference for consistent governance approaches. While this is a worthy goal, there are substantive differences across the north/south and urban/rural divides.

We believe that the desired consistency across Ontario should focus on some core principles of good governance:

- Skills-based boards, to the extent possible, while respecting the freedom of municipalities to appoint representatives of their choosing;
- Recognition of the need for representation that reflects geo-political difference, with special attention to the needs of Indigenous and other diverse populations;
- A careful balance of urban and rural representation so as to ensure that the perspective of all parts of the new Region are at the table;
- Appropriate mechanisms for the selection and appointment of representatives, where there are multiple and/or different political structures at the municipal level who are charged with making appointments of Directors;

- Attention to the above-noted challenge of appropriate fiduciary responsibility.

We fully expect that the HPPA and its Regulations will continue to include explicit direction to PHUs regarding core standards for public health. Those, and the associated mandate to the CMOH, should not change.

There will be a need, however, for substantial changes to the Act and Regulations to create the framework for the proposed streamlined new approach. We urge careful and diligent consultation with affected stakeholders in crafting a new regulatory regime to enable the system changes required.

All of which is respectfully submitted.

Algoma Public Health

Marlene Spruyt, BSc, MD, CCFP, FCFP, MSc-PH

North Bay Parry Sound District Health Unit

James Chirico, BSc, MD, FRCPC, MPH

Porcupine Health Unit

Lianne Catton, MD, CCFP-EM, MPH

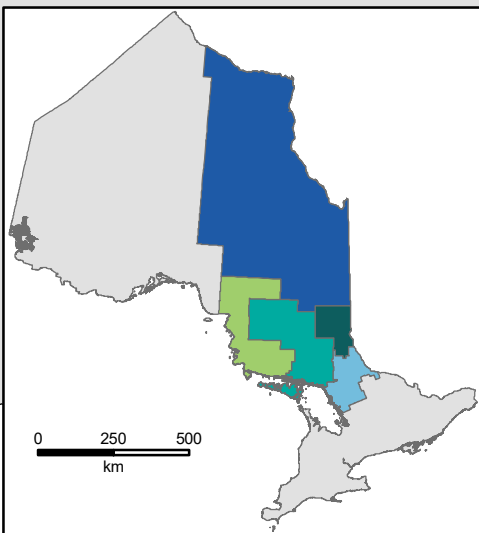
Public Health Sudbury and Districts

Penny Sutcliffe, MD, MHSc, FRCPC

Timiskaming Health Unit

Glenn G. Corneil, MD, CCFP, FCFP

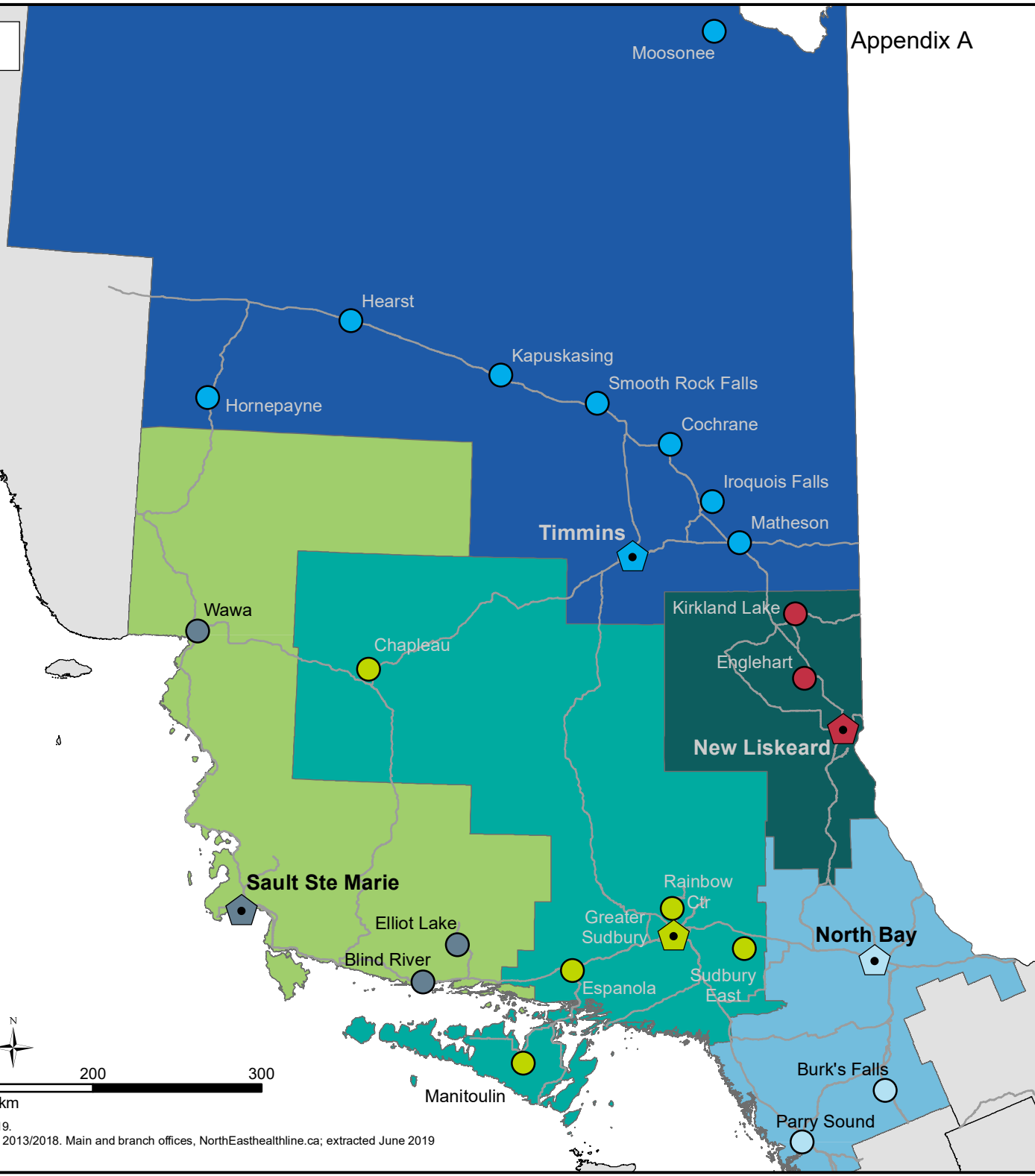
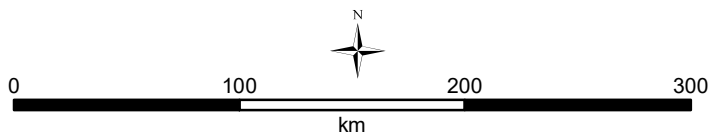
July 2019



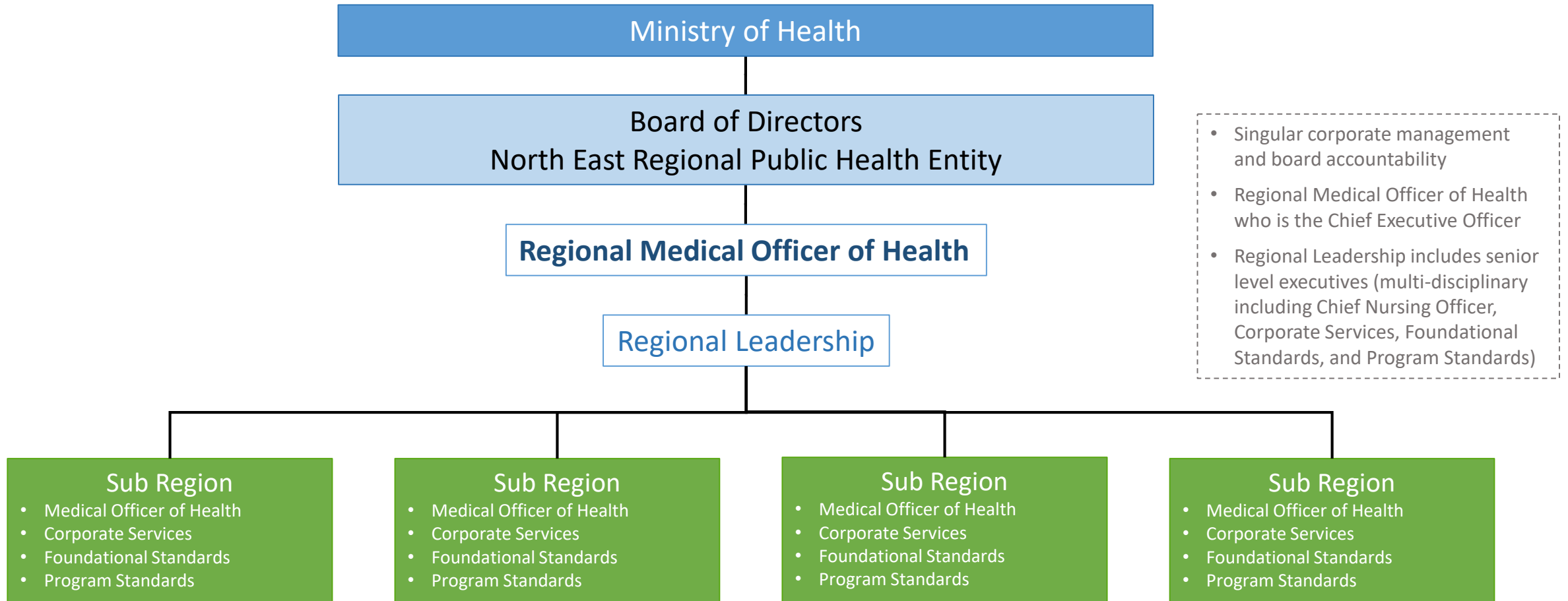
NE Public Health

- North Bay Parry Sound District Health Unit
- Porcupine Health Unit
- Public Health Sudbury & Districts
- Algoma Public Health
- Timiskaming Health Unit

- Main office
- Branch/District/Satellite office



FUNCTIONAL CHART OVERVIEW

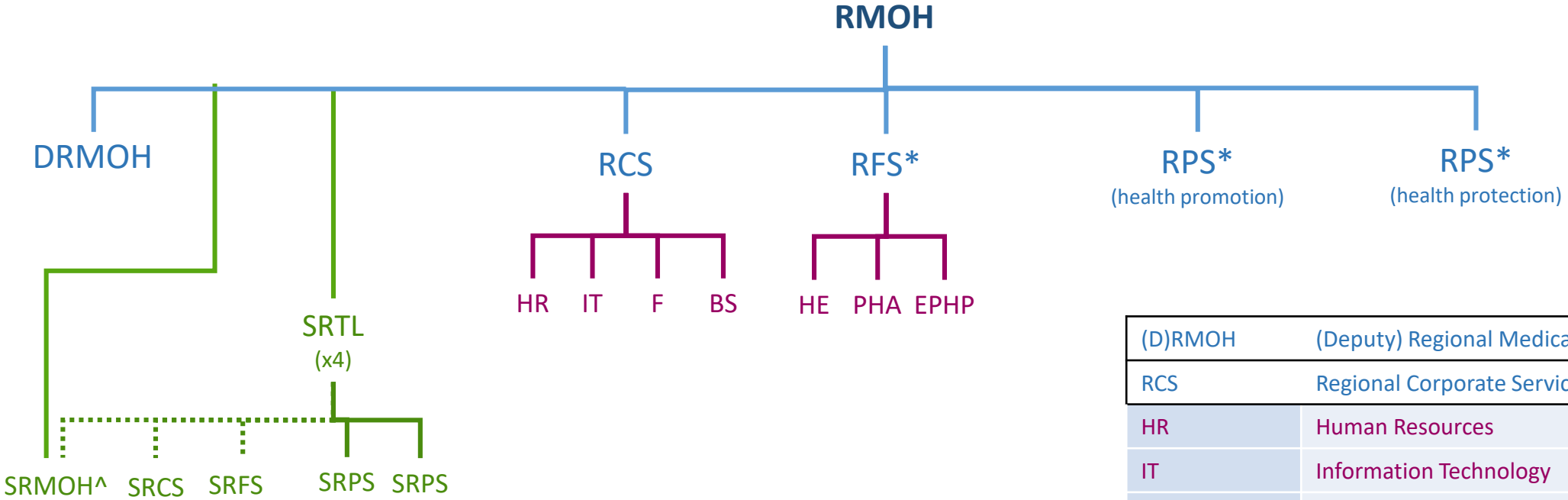


- Singular corporate management and board accountability
- Regional Medical Officer of Health who is the Chief Executive Officer
- Regional Leadership includes senior level executives (multi-disciplinary including Chief Nursing Officer, Corporate Services, Foundational Standards, and Program Standards)

- Sub region leader is Medical Officer of Health (preferred) but could be from another health discipline
- Each sub region has a designated Medical Officer of Health
- Corporate Services and Foundational Standards teams – solid line to regional leadership as many functions are regional but require sub regional implementation
- Program teams – dotted line to regional leadership as many functions are sub regional but require regional coordination

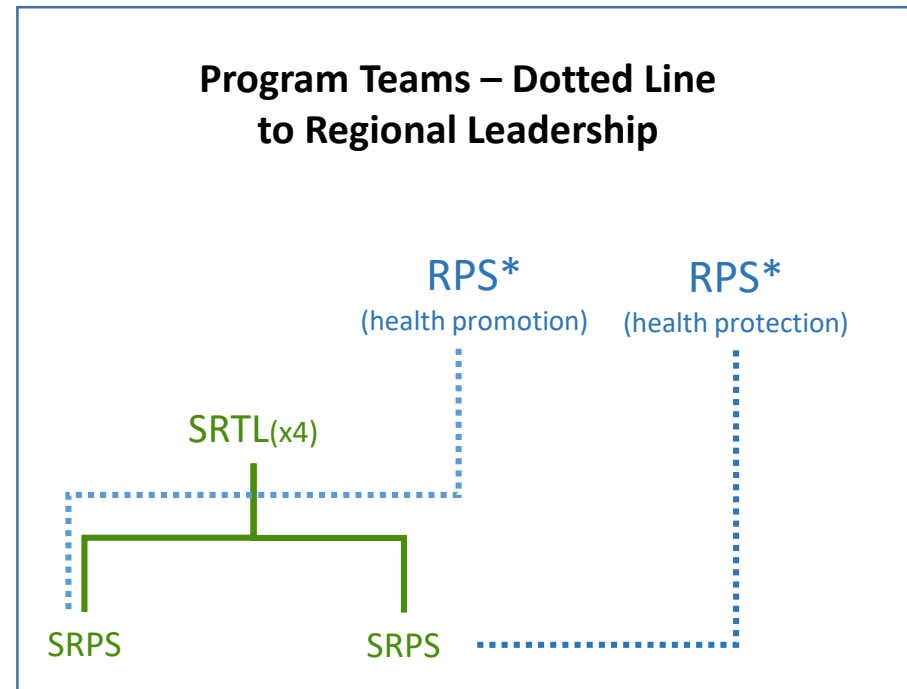
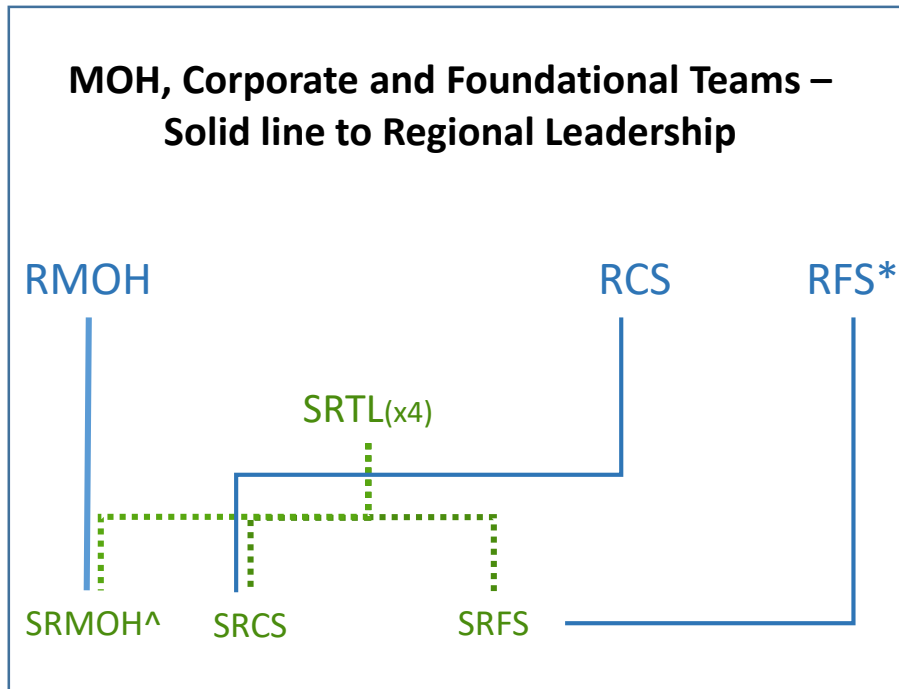
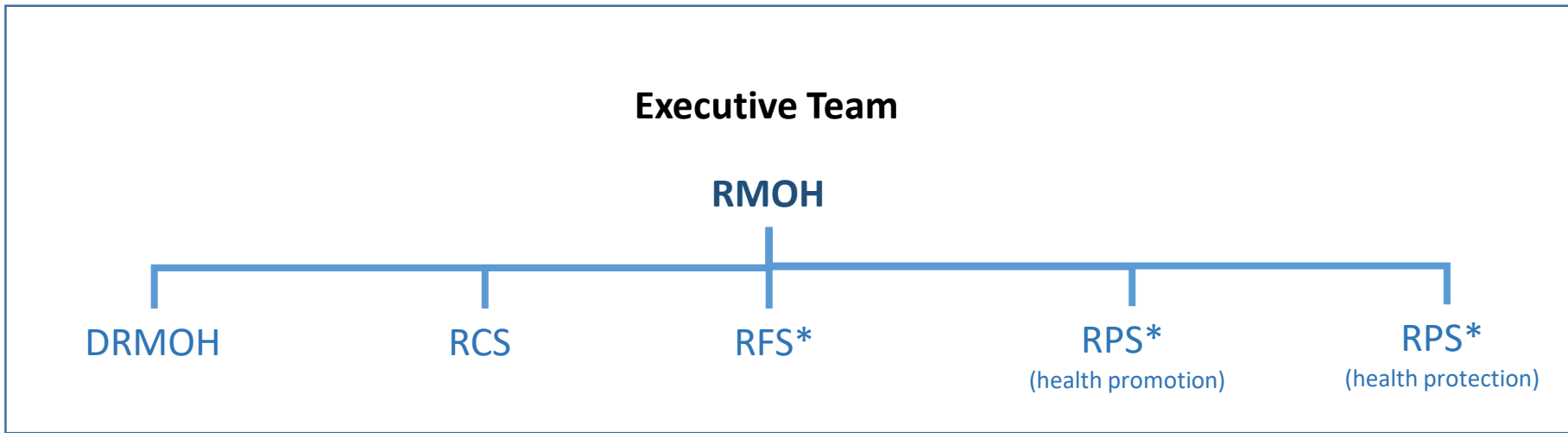
FUNCTIONAL CHART DETAILED VIEW

Board of Directors NEPHE



(D)RMOH	(Deputy) Regional Medical Officer of Health
RCS	Regional Corporate Services
HR	Human Resources
IT	Information Technology
F	Finance
BS	Building Services
RFS	Regional Foundational Standards
HE	Health Equity
PHA	Population Health Assessment
EPHP	Effective Public Health Practice
RPS	Regional Program Standards
*	One of these positions is also the Chief Nursing Officer

SRTL~	Sub-Regional Team Leader~ (preferred option is the SRMOH, one of whom is the deputy regional MOH)
SRCS	Sub-Regional Corporate Services
SRFS	Sub-Regional Foundational Standards
SRPS	Sub-Regional Program Standards (health promotion)
SRPS	Sub-Regional Program Standards (health protection)
SRMOH	Sub-Regional Medical Officer of Health



*One of these positions is the Chief Nursing Officer
 ^One of these positions is the DRMOH

NORTHEASTERN REGIONAL PUBLIC HEALTH UNIT
BOARD GOVERNANCE

DIRECTORS PROFILE MATRIX		
		BOARD SIZE: 15
SKILL / EXPERIENCE	DESCRIPTION	NUMBER OF DIRECTORS REQUIRING SKILL
General		
Analytical and Critical Thinking	Individual having the ability to think analytically and critically, to evaluate different options, proposals and arguments and make sound decisions.	All
Inter-personal Communications	Individual having the ability to effectively communicate their ideas, positions, and perspective to their peers, as well as understand the ideas, position, and perspective of their peers and facilitate resolutions of differences in the common interest.	All
Creative and Strategic Vision/Planning	Individual having the ability to envision and define future goals and objectives that provide improved benefits for the groups and individuals on whose behalf the organization acts. (For example, experience with strategic planning, performance measurement, business planning, etc.)	All
Experience service on boards of directors	<ul style="list-style-type: none"> • Strong understanding of and experience with the appropriate roles, group processes, protocols and policies that form the systems of Public Health Unit governance. • Demonstrated judgment and integrity in an oversight role. • Experience serving on a board or governance committee and/or senior level experience working with other strategic or policy boards. • Determination to act in one's own independent deliberative judgment with confidence and persistence in order to ask appropriate, relevant and necessary questions. 	All
Financial Literacy	Individual able to read and have a layman's understanding of financial statements, including budgets, income statements, balance sheets and cash flow projections.	All
Community Knowledge	Knowledge of the community (fabric; particular needs) and more broadly knowledge of the needs of the entire Regional area.	All
Commitment to Mandate	Demonstrates a strong understanding and commitment to the organization's mandate.	All

NORTHEASTERN REGIONAL PUBLIC HEALTH UNIT
BOARD GOVERNANCE

Specific		
Financial Expertise	<ul style="list-style-type: none"> • Senior executive experience (preferably with a designation) in financial accounting and reporting and corporate finance. • Comprehensive knowledge of internal financial controls, financial operational planning and management in an organization that includes expertise in auditing, evaluating and analyzing financial statements. 	1 or more
Communications / Public Relations Practices	Senior executive or consulting experience (preferably with a designation) with the planning, design, implementation and evaluation of strategic communications, and/or stakeholder relations initiatives.	1 or more
Risk Management	Senior executive or consulting in analyzing exposure to risk in the private, public or not-for-profit sector and successfully determining appropriate measures to manage such exposure.	1 or more
Legal Expertise	Individual having expertise in the law (preferably with a designation), particularly, as it relates to subjects of relevance to public health institutions.	1 or more
Health System Expertise	Individual having expertise in aspects of health, particularly as it relates to subjects of relevance to a public health organization, including research.	1 or more
Human Resources Expertise	Senior executive or consulting experience in human resources (preferably with a designation) particularly in the areas of compensation, labour relations, change management, organizational development and leadership.	1 or more
OTHER REPRESENTATION CONSIDERATIONS		
Other	As much as possible, given requirements above, the board will aspire to gender balance, cultural and linguistic diversity and a diversity of ages, with special attention to Indigenous representation from both urban communities and distinct First Nation Communities and the Francophone population.	