Trillium Health Partners
Better Together

Board of Directors
Policy Manual

September 29, 2023

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INTRODUCTION

Purpose:

This Board Policy Manual provides the foundation for implementing effective governance of the Corporation. The Board has adopted the "Pointer-Orlikoff" governance model, which includes three roles for the Board: policy-formulation, decision-making and oversight.

> *"Board policies perform two absolutely essential functions. First, they express Board expectations – of the organization as a whole, of itself, of management and the medical staff. Policies are the means by which Boards specify and convey what they want done (and what they want the organization to refrain from doing) in addition to the range of acceptable (and unacceptable) means for accomplishing specified goals. To lead rather than follow, policies must clarify and articulate Board expectations. Second, policy is the mechanism by which Boards direct and constrain as they delegate authority and tasks to management and the medical staff."*[1]

Scope and Organization of Policies:

Many boards establish policies related only to their own structures and processes (i.e. those matters that are contained in Part V of the Board Policy Manual). However, a critical element of the "Pointer-Orlikoff" governance model is for the Board to establish policies related to each of its defined areas of responsibility. Subsequently, Board policies are organized in accordance to the Board responsibilities as described in Policy V-A-2:

- Strategic Direction
- Excellent Management
- Program Quality and Effectiveness
- Financial and Organizational Viability
- Board Effectiveness
- External Relationships

These policies then provide the context for the Board to fulfill its two other roles: decision-making and oversight in relation to each of its six areas of responsibility.

Review of Policies:

The Corporation will amend these Board policies and develop new ones to respond to changing circumstances. A policy guiding the process to review these Board policies is included in this Board Policy Manual.

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1 Pointer and Orlikoff, Board Work: Governing Health Care Organizations, San Francisco: Jossey Bass, 1999.

Definitions:

In this Board Policy Manual:

"**Board**" means the board of directors of the Corporation;

"**Board Policy Manual**" means the written policies and procedures adopted by the Board concerning Board governance of the Corporation in accordance with Section 16.2 of the Corporate By-law, as amended from time to time;

"**Chair**" means the chair of the Board;

"**Chief Executive Officer**" means, in addition to 'administrator' as defined in the *Public Hospitals Act*, the President and Chief Executive Officer of the Corporation;

"**Chief Nursing Executive**" means the senior nurse employed by the Corporation, who reports directly to the Chief Executive Officer and is responsible for nursing services provided in the Hospital;

"**Chief of Staff**" means the Medical Staff member appointed by the Board, in accordance with the Professional Staff By-law, to serve as Chief of Staff in accordance with the regulations under the *Public Hospitals Act*;

"**Corporation**" means Trillium Health Partners;

"**Dental Staff**" means those Dentists and Oral and Maxillofacial Surgeons appointed by the Board to attend or perform dental services or oral and maxillofacial surgery, as applicable, for patients in the Hospital;

"**Dentist**" means a dental practitioner in good standing with the Royal College of Dental Surgeons of Ontario;

"**Director**" means a member of the Board;

"***Ex-officio***" means membership "by virtue of office" and includes all rights, responsibilities and power to vote unless otherwise specified;

"**Extended Class Nursing Staff**" means those Registered Nurses in the Extended Class who are:

(a) employed by the Corporation and who are authorized to diagnose, prescribe for or treat patients in the Hospital; and

(b) not employed by the Corporation and to whom the Board has granted privileges to diagnose, prescribe for or treat patients in the Hospital;

"**Hospital**" means the public hospital or hospitals operated by the Corporation;

"**LHIN**" means the Mississauga Halton Local Health Integration Network (also known as the "Home and Community Care Support Services" or "HCCS");

"**Medical Advisory Committee**" means the committee established by the Board pursuant to the Professional Staff By-law as required by the *Public Hospitals Act*;

"**Medical Staff**" means those Physicians who are appointed by the Board and who are granted privileges to practice medicine in the Hospital;

"**Members**" means members of the Corporation as described in Article 2 of the Corporate By-law;

"**Midwife**" means a midwife in good standing with the College of Midwives of Ontario;

"**Midwifery Staff**" means those Midwives who are appointed by the Board and granted privileges to practice midwifery in the Hospital;

"**Ministry**" means the Ministry of Health and Long-Term Care;

"**Oral and Maxillofacial Surgeons**" means those dentists in good standing who hold a specialty certificate from the Royal College of Dental Surgeons of Ontario authorizing practice in oral and maxillofacial surgery;

"**Physician**" means a medical practitioner in good standing with the College of Physicians and Surgeons of Ontario;

"**Professional Staff**" means the Medical Staff, Dental Staff, Midwifery Staff and members of the Extended Class Nursing Staff who are not employees of the Corporation;

"***Public Hospitals Act***" means the *Public Hospitals Act* (Ontario), and, where the context requires, includes the regulations made thereunder;

"**Registered Nurse in the Extended Class**" means a member in good standing with the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act, 1991*; and

"**Rules**" means the rules adopted by the Board in accordance with Section 16.2 of the Corporate By-law

Part I:

Strategic Direction

CATEGORY: **STRATEGIC DIRECTION**

POLICY #: **I-1**

SUBJECT: **STRATEGIC PLANNING**

Strategic planning is a systematic process for assessing a changing environment and creating a plan of action that will position the Corporation to be successful in the environment consistent with its vision, mission and core values. As per Policy V-A-2, the Board, in collaboration with the CEO, Chief of Staff and the senior management team, is responsible to establish the Corporation's strategic directions consistent with the planning cycle, the Strategic Plan and the Corporation's vision, mission and core values. The vision, mission and core values of the Corporation provide the foundation upon which the strategic directions are developed.

The strategic plan will incorporate specific, focused and measurable strategic directions to be pursued over the course of the plan, as well as longer term directional priorities.

The Board will:

- consider key stakeholders and health care needs and ensure appropriate engagement with the community, the LHIN and other health service providers when developing plans and setting priorities for the delivery of hospital-based health care as required under the *Local Health System Integration Act, 2006*;
- establish and periodically review and update the Corporation's vision, mission and core values;
- contribute to the development of and approve the Corporation's strategic plan, ensuring that it is aligned with community needs, Ministry policy and the LHIN integrated health services plan.
- conduct a review of the strategic plan, as part of a regular annual planning cycle, and assess the need to refine the strategic directions as the environment dictates;
- approve the measures and targets related to each strategic direction and direct management to report on a regular basis the progress that is being made consistent with the strategic directions and the overall plan;
- in approving the annual hospital operating plan, ensure that the operating plan enables the attainment of the strategic plan and directions over time; and
- monitor and measure corporate performance regularly consistent with the Board-approved strategic and operating plans and performance targets and performance metrics.

Strategic Planning Process

1. The CEO is responsible to the Board for establishing the strategic planning process, for Board approval. The Board will engage with the CEO and senior management team in developing the strategic plan and monitoring it on an on-going basis. The Governance

Committee will provide guidance to management and support the Board in preparation for the initial development and periodic monitoring of the corporate strategic plan.

2. Once the strategic plan has been developed, everything the Corporation currently does, undertakes as new, or stops doing, will be measured to assess whether or not it advances the achievement of the strategic plan.

3. The Corporation's annual operating plan will ensure the advancement of the strategic plan by addressing annual corporate goals and objectives. The annual corporate goals and objectives will be set by the CEO with Board approval.

4. Annually, the Board will review the corporate goals and objectives prepared by the CEO.

5. Annually, the Board will establish Board goals consistent with the vision, mission and core values and the strategic plan, and key issues that are a priority for the Board in the coming year.

6. At its annual retreat, the Board will review the strategic plan and the progress being made to advance its achievement. As necessary, the Board will direct the CEO and senior management team to augment/revise/update the strategic plan to ensure it continues to support the achievement of the Corporation's vision, mission and core values.

7. The CEO and senior management team will provide regular monitoring and progress reports to the Board according to the Board's work plan.

CATEGORY: **STRATEGIC DIRECTION**

POLICY #: **I-2**

SUBJECT: **COMMUNITY ENGAGEMENT**

Section 16(6) of the *Local Health System Integration Act, 2006* requires all health service providers to engage the communities served in planning and setting priorities.

The Board will ensure that processes are established as required for engagement with the LHINs, other health service providers and the community when developing plans and setting priorities. It is essential that the Corporation communicate regularly to the broader public about its operations and future directions. The process and scope for community engagement will vary depending on the issue and will be approved by the Board, upon the recommendation of the CEO as required.

It will be essential for the Corporation to maintain strong and positive relationships, which have been established by The Credit Valley Hospital and Trillium Health Centre with Regional Municipality of Peel, the City of Toronto and the City of Mississauga. Mechanisms for nurturing these relationships may include: the Chair and CEO to meet at least annually with regional and municipal councils to present and engage in dialogue on strategic directions, priorities and challenges.

Recognizing the breadth of the community, the Chair and the CEO will ensure that information on the Corporation's activities is widely communicated to the public through the media throughout the catchment area. The Board will be sensitive to the needs and diversity of the community.

Board mechanisms for community engagement may include but are not limited to:

- initiation of Community Advisory Committees/Panels;
- posting on the Corporation's website highlights of Board meetings;
- periodic articles in the local media on matters of interest to the community by the Corporation;
- annual meeting of the Chair and CEO with the regional and area municipal councils to present on the Corporation's strategic plan, priorities, and challenges; and
- program or issue specific processes for community engagement as may be approved by the Board, upon the recommendation of the CEO, from time to time.

Part II:

Excellent Management

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-1**

SUBJECT: **CEO SELECTION AND SUCCESSION PLANNING**

The Board will ensure that provision is made for continuity of leadership for the Corporation. The Board will have in place a documented process for succession should the CEO position become vacant due to sudden vacancy (e.g. death, resignation or termination) or planned vacancy (e.g. retirement). The succession plan will also specify the process for appointing an interim CEO, should the CEO require an extended leave of absence due to personal, health or other reasons. The CEO will report on the succession plan annually during the CEO evaluation process.

1. **Planned Vacancy** (e.g. retirement)

   The process to fill a planned vacancy will be as follows:

   i) The Board will establish a CEO Search Committee consisting of up to four elected Directors, including the Chair, the Chief of Staff and the President of the Professional Staff. Support for the CEO Search Committee will be provided by the Chief Human Resources Officer unless directed differently by the Chair.
   ii) The CEO Search Committee will be chaired by the Chair or his/her delegate.
   iii) The CEO Search Committee may, at its discretion, select a search firm to assist with the process.
   iv) The CEO Search Committee will interview a short list of candidates and recommend to the Board its candidate of choice.

2. **Sudden Vacancy** (e.g. death, resignation, termination, extended leave)

   The CEO will identify to the Governance and Human Resources Committee in writing at the beginning of each fiscal year which member(s) of the senior management team are recommended to fill the role of interim CEO, if a sudden vacancy occurs. The appointment of an interim CEO will be subject to Board approval.

   An offer will be subject to submission of a declaration that the candidate has no conflict of interest consistent with organizational policy, in a form as required by the Board, and satisfactory results of a criminal reference check as determined in the sole discretion of the Board.

   A legally binding employment agreement will be developed by an employment lawyer and will be executed by the Chair and the candidate accepting the position of CEO. This process may be supported by the Chief Human Resources Officer.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-2**

SUBJECT: **CEO DIRECTION**

The Board's sole official connection to the Corporation, its achievements and conduct will be through the CEO. The CEO is appointed by, reports to, and is accountable to the Board.

The Board provides direction to the CEO in accordance with Board policies. The Board delegates responsibility and authority to the CEO for the management and operation of the Corporation and requires accountability to the Board.

The CEO is required to follow directions of the Board as received through the Chair. When Directors or committee members make requests without Board authorization, the CEO can decline such requests when in the CEO's opinion a material amount of staff time or funds are required to carry out the requests. The CEO may refer the matter through the Chair to the next Board meeting for discussion.

The CEO shall perform the duties described in *Policy II-3 President and Chief Executive Officer Position Description - POL INT* as set out in the Board Policy Manual.

The CEO will report, and be responsible, to the Board for implementing the Corporation's strategic plan, operating and capital plan, and for the day-to-day operation of the facilities of the Corporation in a manner consistent with Board policies.

The CEO will not cause or, with the CEO's knowledge, allow any practice, activity, decision or organizational circumstance that is either unlawful, imprudent, or in violation of commonly accepted business and professional ethics.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-3**

SUBJECT: **PRESIDENT AND CHIEF EXECUTIVE OFFICER POSITION DESCRIPTION**

Position Description: President and Chief Executive Officer

Appointed by and reporting to the Board of Directors ("the Board") the President and CEO ("CEO") will have overall accountability and responsibility for the effective operation and administration of this complex academic hospital.

The CEO will support and lead the Executive/Senior Leadership Team to deliver exceptional experiences for patients, families, staff, professional staff, learners, and volunteers. S/he will be the most senior leader internally, and will be the primary 'face' of the hospital externally, always focused on excellence and quality of care for all who access services through THP.

As the leader of the organization, the CEO will provide exemplary leadership to position the organization as a leading institution in the healthcare sector. Key responsibilities include:

Strategic Leadership

- Advances the organization's strategic plan, through bold, innovative, and decisive leadership
- Proactively seeks and incorporates input from key internal and external partners and stakeholders to continually refine and advance priority objectives, and determine funding models and solutions that support delivery of quality, accessible and sustainable outcomes
- Supports the Board with medium and long-term goal and objective setting, with responsibility for implementation including advice on risks and opportunities, and course correction
- Sets and manages accountability for operational objectives in collaboration with the hospital's executive and senior teams, to deliver on the THP strategic plan commitment
- Advises and recommends changes to policies, strategies and objectives to the Board
- Works within the framework of the Strategic Plan to enable THP to be a leading hospital in the areas of education, innovation and research
- Cultivates strong, positive working relationships with the Board, union leaders, physicians, community partners/leaders, government decision-makers, and regional and provincial health care partners and peers

Operational Leadership

- Creates and sustains the necessary structures, processes and systems that will support and drive the best possible patient experience, through a quality-based approach
- Directs development and execution of enterprise operating plans, redevelopment plans, policies and procedures that enable effective and efficient operations
- Directs, oversees and holds senior leaders accountable for the effective alignment and management of organizational resources (financial, human, capital)
- Ensures sound infrastructure is in place to support the realization of THP's objectives, including talent, financial, facilities and redevelopment, technology, and data management and analysis
- Ensuring compliance with all applicable legislation, directives, and policies that govern hospital operations

Talent/People Leadership

- Ensures staff, professional staff, volunteers, and learners have a clear understanding of THP's vision, values and goals
- Builds strong leadership pipelines through effective talent management and succession planning strategies
- Champions and leads the organization to deliver on its promise to become an equitable, anti-racist and inclusive organization, through clear objectives, deliverables and outcomes
- Develops and builds an effective senior leadership team, to lead the organization in delivering on strategic and operational goals
- Models the organization's values of compassion, courage and excellence, and sets the tone for a positive, professional and inclusive environment to work, practice, learn and volunteer
- Fosters a healthy, safe, performance-driven, inclusive culture and operational environment that leverages diversity

Collaboration and Partnership

- Represents THP externally through government, agencies, and professional bodies, and participates on multi-level task forces/committees/associations at the regional, provincial, and national levels as appropriate
- Collaborates with and supports the THP Foundation on strategic fundraising and donor relationship management
- Serves as an ex-officio member of the THP Board of Directors, and the THP Foundation Board of Directors
- Supports long-term care development and delivery through effective partnership with Partners Community Health
- Demonstrates health system leadership through partnership and collaboration at the community, regional, and provincial level
- Develops and sustains effective and productive working relationships with municipal and provincial government/agencies
- Facilitates a mutually beneficial relationship with the University of Toronto, in support of teaching excellence, research capability, and strategic talent pipeline development

CEO Competencies

1. **Visionary & Transformational Leadership**
   - Develops and advances a compelling strategy for the organization that is grounded in the needs of the community served and the realities and constraints of healthcare and the organization
   - Continually champions transformational service delivery and boldly creates a "new kind of healthcare", inside and outside, the hospital
   - Sets clear goals and objectives for the Executive Team and organization in alignment with priorities
   - Creates compelling 'one THP' culture, grounded in inclusion and belonging, across the organization
   - Communicates effectively at all levels to help in advancing both in-year and multi-year plans

2. **Building & Leading Teams**
   - Promotes belief in and alignment of the organization's strategic vision and purpose
   - Delegates effectively; empowers the team to lead strategy and deliver results
   - Fosters strong team cohesion and effectiveness with a climate of openness, trust and solidarity. Critical conversations and objectives are present
   - Manages the key capabilities required to perform staff roles and assigns the right people to the right positions to deliver on objectives
   - Builds strong talent management process at all levels, and ensures succession plans are in place for key leadership roles; builds strong leadership pipeline to position the organization for success over time
   - Attracts, develops and retains top talent that reflects the diversity of the community the hospital serves at all levels
   - Champions organizational understanding and commitment to equity, inclusion and anti-racism, and ensures these principles are foundational to policy development and service delivery

3. **Relationship Management (Collaboration & Partnering)**
   - Proactively builds, maintains, and expands relationships with key internal and external stakeholders to support the organization's strategic goals (e.g., Board, physicians, union leaders, front line leaders, community partners, local & provincial government, Ontario Health, peer hospitals/networks)
   - Uses network to identify new opportunities and gather intelligence to support and advance the strategy or inform new strategic opportunities
   - Involves other stakeholders in problem-solving and decision-making to gain buy-in and alignment; creates a community-based team environment
   - Leverages stakeholders to help advance strategy
   - Builds a reservoir of good will; exchanges information, services, or time within network to benefit the organization and seeks to learn from others
   - Represents the organization effectively; Seen as a strong and trusted partner, leader, and brand ambassador in the community

4. **Delivering Results & Leading Through Complexity**
   - Strategically works across cross-functional teams and at multiple levels (frontline to executive) to influence decision-making and build desired culture inside and outside the hospital
   - Coaches and supports the team (and teams at all levels) to deliver on operating plans
   - Effectively navigates a complex work environment and balances competing demands and priorities
   - Calculates impact of initiatives or plans on hospital; continually calibrates risk
   - Breaks down complex issues to facilitate reaching an understanding
   - Demonstrates critical thinking and sound decision-making, even in the face of ambiguity
   - Displays drive, ambition, and passion to transform the organization, and the resilience to work through challenges and obstacles

5. **Authenticity & Integrity ('True North Leadership')**
   - Conducts self in an authentic, and genuine manner on a consistent basis, and with all stakeholders
   - Demonstrates integrity and commitment to doing the right thing for the hospital, its people, patients, and the broader community
   - Conveys views openly, honestly, and transparently and creates space for sharing of different ideas, perspectives, and lived experience
   - Exceptional social and emotional intelligence, and ability to engage at any level modelling respect, fairness, inclusion, and vulnerability
   - Conveys self-awareness of their own values, position, privilege, and lived experience
   - Is receptive to others' feedback and works actively to address feedback

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-4**

SUBJECT: **CEO PERFORMANCE MANAGEMENT AND EVALUATION**

The Board of Directors (the "Board") is responsible for the appointment and performance management of the Chief Executive Officer ("CEO"). To achieve this, the Board will review and evaluate CEO performance based on progress towards achieving-mutually agreed upon goals and objectives on an annual basis. These goals and objectives established must align with the agenda of the Government of Ontario, the strategy and priorities of Trillium Health Partners (the "Corporation"), and all legislative requirements.

CEO performance management process is the responsibility of the Board Chair, in collaboration with the CEO. The process is designed to align expectations with CEO and provide for regular review of progress. It also provides an opportunity for discussion of core competencies and personal development goals for the CEO. Through this process, the Board will assess CEO performance annually based on established goals and objectives and associated metrics. This assessment will be used directly to determine CEO reward for performance compensation, consistent with statutory requirements and the Corporation's ability to pay.

Performance goals and objectives are to be set in consultation with the Chief of Staff ("COS") as the COS shares these goals and objectives and the responsibility of achieving them. The Board Chair will also have a conversation with the COS regarding performance objectives and the process.

GUIDING PRINCIPLES:

i) Performance management supports, reinforces and integrates the achievement of the strategic and operational priorities. It clearly connects short-term activities and long-term priorities for the Corporation and results in individual performance goals for all leaders in the organization.

ii) The performance objectives will be clearly aligned with the Government of Ontario agenda, the strategy of the Corporation and all legislative requirements including the *Excellent Care for All Act*.

iii) Performance objectives will be established that are measurable, specific, realistic, time-bound and outcome based. Targets for selected performance measures will reflect the high level of performance expected and focus both on improving organizational performance, processes and on enhancing CEO performance. A measurement system will be used to track progress and report to the Board on that progress. The performance measures will:

a. be strategically aligned outcome measures that balance quality, access, sustainability and leadership performance;
b. include quality measures that assess the experience of patients, families and the people who work for and with the Corporation;
c. represent long-term efforts to achieve strategic goals; and
d. be an assessment of overall leadership performance.

iv) The COS will participate in the process of establishing CEO performance objectives and will adopt the same goals and objectives to ensure alignment.

v) CEO performance objectives will cascade as organizational objectives to all leaders in the organization in order to align performance and strategic goals at all levels.

PROCESS:

1. The Board Chair and the CEO will initiate the process of developing the annual performance goals and objectives in December.

2. The CEO, in consultation with the COS, will develop the annual performance goals and objectives with ongoing engagement of the Board Chair.

3. The CEO and the Board Chair will present drafted annual performance goals and objectives to the Quality and Program Effectiveness Committee in February for advice and feedback. The CEO and the Board Chair will recommend the annual performance goals and objectives to the Governance and Human Resources Committee, with the Chair of the Quality and Program Effectiveness Committee in attendance, for approval in March.

4. The annual performance goals and objectives will be recommended to the Board by the Governance and Human Resources Committee in March for approval.

5. Quarterly updates on progress will be provided to the Board through the Governance and Human Resources Committee.

6. The Board Chair will formally review the CEO's performance against established goals and objectives on an annual basis and will make a recommendation on an overall performance assessment to be considered by the Governance and Human Resources Committee in an *in camera* session after the conclusion of the fiscal year. A mid-year review will be conducted by the Board Chair to support this. The Board will consider and finalize the CEO's performance assessment based on the recommendation of the Governance and Human Resources Committee.

7. The Board Chair will communicate the results of the performance assessment to the CEO.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-5**

SUBJECT: **CEO COMPENSATION**

The Board is responsible for establishing an appropriate and competitive compensation package for the position of CEO in order to:

i) attract and retain a highly skilled CEO with the requisite competencies; and
ii) reward meritorious performance.

The compensation package paid to the CEO will be set out in a properly prepared Board-approved employment contract between the Corporation and the CEO.

In establishing the compensation package, consideration will be given to market rates paid for similar positions within the local geographic area and within the Province, particularly as applicable to public sector employment. The total compensation package for the CEO will include the sum of base salary, vacation[1] incentive compensation, benefits, and perquisites allowable according to Broader Public Sector directives and guidelines. In keeping with all applicable legislation CEO compensation will be linked to achieving performance improvement targets set out in the annual quality improvement plan.

Adjustments to the compensation package will be considered on a regular basis, giving consideration to cost of living changes, market rates, and changes in duties or requirements. Changes to the compensation package will only be made upon Board approval, and will generally be made at the time of the annual reviews. Determination and payout of incentive compensation will be made once all the applicable information is available. Upon the recommendation of the Board Chair and Chair of the Governance and Human Resources Committee, the Board will approve the incentive compensation calculation.

The Board Chair and Chair of the Governance and Human Resources Committee, will annually review the CEO compensation for possible annual adjustments, subject to the CEO meeting performance expectations as determined through the performance review process, and within the limits of the overall salary budget set by the Board.

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[1],In keeping with *all relevant legislation*.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-6**

SUBJECT: **CEO EXPENSE REIMBURSEMENT AND TRAVEL**

This policy outlines the process for the approval and reimbursement of Chief Executive Officer ("CEO") expenses.

Guiding Principles

Expenses

The process for the reimbursement of CEO expenses is consistent with the organization's *Business Expenses, Travel &Transportation, Meals and Other Allowable Expenses - P&P* which is applicable to other employees of Trillium Health Partners (the "Corporation").

Exceptions may be permitted at the discretion of the Chair of the Board of Directors ("Board Chair").

Out-of-Country Travel

All out of country travel which is paid for by the Corporation, is to be approved in writing by the Board Chair prior to any trip taking place.

Policy

Consistent with applicable legislation, the CEO will be reimbursed for reasonable expenses incurred, in compliance with the expense claim directives issued by the Management Board of Cabinet under the *Broader Public Sector Accountability Act, 2010* ("BPSAA"), while carrying out duties and traveling for the Corporation.

CEO expenses will be made public in keeping with the requirements under the BPSAA.

Procedure

The CEO will submit a signed THP expense claim form, together with supporting receipts or proof of payment, to the Board Relations Lead, for review and approval by the Senior Vice-President, Corporate Services & Chief Financial Officer ("CFO").

The Board Relations Lead will forward the claim to the Board Chair for final approval and the CEO's executive assistant will arrange for reimbursement.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-7**

SUBJECT: **OCCUPATIONAL HEALTH AND SAFETY - ACCOUNTABILITY FRAMEWORK**

The Corporation, the Board and CEO are committed to the health, safety and wellness of employees, and the prevention of occupational injuries and disease in support of a safe and healthy workplace. The Corporation acknowledges its responsibility to effectively manage and communicate its programs regarding health, safety and wellness and to maintain compliance with the *Occupational Health and Safety Act* and related regulations. Every employee, including those with privileges, contractors, students and volunteers are responsible for working in a safe and healthy manner and promoting a secure and hazard free environment.

In accordance with the Corporate By-law (Section 15.6), there will be an occupational health and safety program for the Corporation, which includes procedures for:

i) a safe and healthy work environment in the Corporation;
ii) the safe use of substances, equipment and medical devices in the Corporation;
iii) safe and healthy work practices in the Corporation;
iv) the prevention of accidents to persons on the premises of the Corporation; and the elimination of undue risks and the minimizing of hazards inherent in the Corporation environment; and
v) The CEO to designate an individual to be in charge of occupational health and safety in the Corporation. The designate will be responsible to the CEO for the implementation of the Occupational Health and Safety Program.

The CEO will report to the Board as necessary on matters concerning the Occupational Health and Safety Program.

The Board will receive annual reports from the CEO on the Corporation's Occupational Health and Safety Program to include information about the ability of the Corporation to meet occupational health and safety requirements, identification of risk issues, statistical data on incidents, and program outcomes. All members of the organization are expected to demonstrate their commitment towards a safe and healthy environment by acting in compliance with this Policy.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-8**

SUBJECT: **CHIEF OF STAFF SELECTION AND SUCCESSION PLANNING**

The Board will ensure that provision is made for continuity of leadership for the Corporation. The Board will have in place a documented process for succession should the Chief of Staff position become vacant due to sudden vacancy (e.g. death, resignation or termination) or planned vacancy (e.g. retirement). The succession plan will also specify the process for appointing an interim Chief of Staff, should the Chief of Staff require an extended leave of absence due to personal, health or other reasons.

The Board will select and appoint the Chief of Staff and will provide for Chief of Staff succession planning.

Based on best practice, the Chief of Staff is expected to identify and develop his/her successor through internal succession planning. The Chief of Staff will report on this matter annually during the Chief of Staff evaluation process.

1. Sudden Vacancy (e.g. death, resignation, termination, extended leave)

   The Chief of Staff shall, in consultation with the CEO, designate an alternate to act during the absence of the Chief of Staff. If the Chief of Staff is not able to designate an alternate due to death, termination or other circumstance, the CEO and Chair of the Board of Directors, in consultation with Medical Advisory Committee (MAC) will appoint an alternate for an interim period. The appointment of an interim Chief of Staff will be subject to Board approval.

2. Planned Vacancy (e.g. retirement)

   i) In accordance with the *Professional Staff By-law* (Section 9.2), the Board shall appoint a Physician on the Active Staff to be the Chief of Staff after considering the recommendations of a selection committee composed of members of the Board and the Medical Advisory Committee.

   ii) Membership of the Selection Committee shall include: the Chair who shall be chair; three members of the Medical Advisory Committee, one of whom will be the President of the Professional Staff or his/her delegate from the Professional Staff executive; the Chief Nursing Executive; the CEO; one other member of the active Professional Staff as the Chair deems advisable; and other Directors as the Chair deems advisable.

   iii) The Selection Committee may, at its discretion, select a search firm to assist with the process.

iv) The Selection Committee will interview a short list of candidates and recommend to the Board its candidate of choice.

v) Subject to annual confirmation by the Board, an appointment of the Chief of Staff shall be for a term of five years; however, the Chief of Staff shall hold office until a successor is appointed.

vi) In accordance with Section 9.3(c) of the *Professional Staff By-law*, the maximum number of years in this office shall be ten provided, however, that following a break in the continuous service of at least one-year, the same person may be reappointed.

vii) The Board at any time may revoke or suspend the appointment of the Chief of Staff.

If a new Chief of Staff has not been appointed before the departure of the current Chief of Staff, the current Chief of Staff may hold office until a successor is appointed or an interim appointment may be made at the discretion of the Board.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-9**

SUBJECT: **CHIEF OF STAFF DIRECTION**

The Board provides direction to the Chief of Staff (COS) in accordance with Board policies. The Board delegates responsibility and authority to the Chief of Staff for the general clinical organization of the Corporation and the supervision and practice of credentialed professional staff in the Corporation.

In accordance with the Professional Staff By-law (Section 9.3), the Chief of Staff shall:

a) be an *ex-officio* member of the Board and, as a director, fulfill fiduciary duties to the Corporation;
b) chair the Medical Advisory Committee;
c) be an *ex-officio* member of all Medical Advisory Committee sub-committees;
d) comply with the Professional Staff By-law, the Rules and Regulations and Policies (as defined in the Professional Staff By-law), and the Professional Staff Credentialing Policy and Professional Staff Credentialing Procedure;
e) be accountable to the Board for all the care provided by Professional Staff members to patients of the Hospital;
f) perform the duties described in Policy II-10 (Chief of Staff Position Description) as set out in the Board Policy Manual; and
g) perform such other duties as directed by the Board from time to time.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-10**

SUBJECT: **CHIEF OF STAFF POSITION DESCRIPTION**

The Chief of Staff (or COS) is responsible–and reports directly to the Hospital's Board of Directors (Board) in the COS's capacity as the Chair of the Medical Advisory Committee (MAC) (MAC Chair) and as otherwise prescribed under the Public Hospitals Act (PHA), the Hospital's By-Laws, and the Hospital's applicable policies and procedures. The COS, reporting through the Board Chair, provides leadership and guidance to the professional staff, in addition to supporting, overseeing and reporting on the delivery of high quality and safe care provided by professional staff to all patients. The COS is accountable for promoting effective communication among the professional staff, Hospital and Board of Directors and for ensuring that the organization of the professional staff is such that it functions effectively within the framework of the policies established by the Hospital and Board. The COS, in executing all aspects of the role, is supported by Medical Affairs, a Hospital function which reports to the CEO, and provides enabling support related to professional staff recruitment, credentialing, retention, engagement and ongoing development and performance processes.

The COS, in addition to being Board appointed as the Chair of the MAC, will have overall responsibility for:

- quality of care provided by members of THP professional staff (doctors, registered midwives and dentists)
- professional staff credentialing, accountability, engagement and performance*
- professional staff advancement of the Hospital's academic mandate**

* *Reporting to the Chair of the Board and the Board*

** *Reporting to the CEO, and in conjunction with the Education Office and Academic Affairs*

Specific Chief of Staff Responsibilities:

(a) report regularly in writing including the minutes of the MAC to the Board about the activities, recommendations and actions of the MAC and any other matters about which they should have knowledge;

(b) be an ex-officio member of all committees that report to the MAC and exercise leadership in the selection of appointments to and the functioning of the committees of the MAC;

(c) act on other committees as requested by the Board;

(d) be a member of the Hospital's senior leadership team to advance the strategic goals of the organization through input into priorities, policies and allocation of resources;

(e) maintain an active clinical role within the Hospital, in their field of expertise;

(f) ensure, with the Chief Executive Officer (CEO):

i. the advancement of the organization's strategic plan, including future planning and development, through courageous, innovative, and engaged leadership;
ii. the maintenance and continuous improvement of a healthy, safe, inclusive and respectful workplace that enables exceptional experiences for patients, families, staff, professional staff, learners and volunteers;
iii. the evolution of the Hospital's academic mandate by attracting and retaining top talent, including professional staff, to the Hospital and developing structures and systems that promote staff and professional staff integration and engagement within the academic mandate;

(g) ensure his/her duties are assumed by a Program Chief when absent from the hospital; and

(h) perform such other duties as assigned by the Board, CEO, and/or prescribed by law, By-Law or policy.

Medical Supervisory Duties of the Chief of Staff:

(a) with the MAC, be responsible to the Board for the organization of credentialed professional staff of the Hospital and for the supervision of the credentialed professional staff care given to all patients of the Hospital in accordance with the policies established by the corporation and provisions of the PHA and other relevant legislation;

(b) be appointed by the Board as the Chair of the MAC;

(c) advise the MAC and the Board with respect to the quality of credentialed professional staff diagnosis, care and treatment provided to the patients of the Hospital;

(d) consult and communicate with the CEO on matters that may impact professional staff credentialing or quality of care delivered by professional staff;

(e) assign, or delegate the assignment of, an appropriate member of the credentialed professional staff to discuss in detail with any member of the professional staff any potential credentialing matter which is of concern to the Chief of Staff and to report the discussion to the Chief of the appropriate Program;

(f) assign, or delegate the assignment of, an appropriate member of the credentialed professional staff:

i. to supervise the practice of the respective credentialed professional staff as appropriate, for any period of time;
ii. to receive a written report from the Chief of the appropriate Program;

(g) when necessary:

i. under urgent/emergent conditions, and whenever possible in consultation with and otherwise upon immediate notice to the CEO and the appropriate Program Chief, in accordance with the Professional Staff By-Law, restrict or suspend temporarily any or all privileges of any member of the credentialed professional staff until such time as a special meeting of the Medical Advisory Committee and/or its executive can be arranged in;
ii. assume, or assign to any other member of the credentialed professional staff, responsibility for the direct care and treatment of any patient in the Hospital under the authority of the *Public Hospitals Act*; and
iii. notify the Chief Executive Officer and, if possible the patient, with respect to such aforementioned assignment.

(h) support an effective process of professional staff self-government through the Professional Staff Association;

(i) in consultation with the CEO, report members of the professional staff to their respective Regulated Health Professions Colleges pursuant to the PHA and *Regulated Health Professions Act*;

(j) in partnership with the appropriate Patient Care Services executive(s), provide strategic advice regarding program management and/or issues which influence patient care; and

(k) perform such other duties as assigned by the Board, CEO, and/or prescribed by law, By-Law or policy.

Leadership of Program Chiefs and Medical Directors:

(a) in partnership with relevant Patient Care Services executive(s) and in alignment with Hospital leader performance and talent management frameworks:

i. build a strong leadership pipeline for Program Chiefs and Medical Directors through effective recruitment, talent management, leadership development and succession planning strategies, including, but not limited to, conducting regular reviews of Program Chief and Medical Director performance.

(b) delegate appropriate responsibility to the Program Chiefs, and

i. receive and review recommendations from Program Chiefs regarding new appointments, reappointments and changes in status including changes in privileges;

ii. ensure Program Chiefs complete annual reviews and make recommendations concerning appointments and reappointments and that all recommendations are forwarded to the credentials committee.

(c) perform such other duties as assigned by the Board, CEO, and/or prescribed by law, By-Law or policy.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-11**

SUBJECT: **CHIEF OF STAFF PERFORMANCE MANAGEMENT AND EVALUATION**

The Board provides direction to the Chief of Staff (COS) in accordance with Board policies. The Board delegates responsibility and authority to the Chief of Staff for the general clinical organization of the Corporation and the supervision and practice of credentialed professional staff in the Corporation.

Appointment of the Chief of Staff is a key appointment which is the direct responsibility of the Board. Performance evaluation of the Chief of Staff is the process of reviewing and evaluating his/her performance based on progress towards achieving mutually agreed objectives. A formal performance appraisal provides for regular review and assessment and an opportunity for the Board to discuss expectations with the Chief of Staff. It also allows the opportunity for discussion of core competencies and personal development goals.

Guiding Principles:

i) Performance management supports, reinforces and integrates the achievement of strategic and business plan results with individual performance goals.
ii) Performance objectives, measures and indicators will be established. Performance commitments and measures will be set at a level that reflects the high level of performance expected.
iii) Performance management focuses both on improving organizational performance, processes and structure and on enhancing the Chief of Staff's performance.

Process:

1. The Chief of Staff will develop annual performance objectives in consultation with the MAC, the CEO and Chair, for initial discussion with the Human Resources Committee, which will then recommend the performance objectives to the Board for approval each March/April.
2. The Chief of Staff performance review process will be the responsibility of the Chair and the Chair of the Human Resources Committee, in consultation with the Chief of Staff and the CEO. The review process will commence annually in the month of October (mid-year review) and March/April (year-end review).
3. All Directors will be requested to provide feedback annually in a standard format on the performance of the Chief of Staff. The Chair and Chair, Human Resources Committee will then compile the feedback and develop the performance review documentation.
4. The Chair and Chair, Human Resources Committee will provide a report to the Board in an *in camera* session, on the Chief of Staff's performance relative to both achievement of the goals and the assessment of core competencies.
5. The Chair will communicate the results of the evaluation to the Chief of Staff.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-12**

SUBJECT: **CHIEF OF STAFF COMPENSATION**

The Board provides direction to the Chief of Staff (COS) in accordance with Board policies. The Board delegates responsibility and authority to the Chief of Staff for the general clinical organization of the Corporation and the supervision and practice of credentialed professional staff in the Corporation.

The Board is responsible for establishing an appropriate and competitive compensation package for the position of Chief of Staff in order to:

i) attract and retain a highly skilled Chief of Staff with requisite competencies; and
ii) reward meritorious performance.

The compensation package paid to the Chief of Staff will be set out in a properly prepared Board-approved employment contract between the Corporation and the Chief of Staff.

In establishing the compensation package, consideration will be given to market rates paid for similar positions within the local geographic area and within the Province, particularly as applicable to public sector employment. The total compensation package[1], for the Chief of Staff will include the sum of base salary, vacation, incentive compensation, benefits, and perquisites. In keeping with all applicable legislation, Chief of Staff compensation will be linked to the achievement of agreed upon performance objectives including targets set out in the annual quality improvement plan.

Adjustments to the compensation package will be considered on a regular basis, giving consideration to cost of living changes, market rates, and changes in duties or requirements. Changes to the compensation package will only be made upon Board approval, and will generally be made at the time of the annual reviews. Determination and payout of incentive compensation will be made once all the applicable information is available. The Chair of the Governance and Human Resources Committee will approve the incentive compensation calculation.

The Board, through the Governance and Human Resources Committee, will annually review the Chief of Staff compensation for possible annual adjustments, subject to the Chief of Staff meeting performance expectations as determined through the performance review process, and within the limits of the overall salary budget set by the Board.

[1] In keeping with all relevant legislation

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-13**

SUBJECT: **REPORTING ON COMPLIANCE**

The Directors understand that their fiduciary duties include the duties imposed by statute.

The CEO shall ensure that processes and operating policies are in place to ensure compliance with legislation (federal/provincial/municipal), statutory filings and any associated risks; and will report to the Board on the status of statutory filings, compliance with legislation (federal/provincial/ municipal) and any associated risks.

The CEO will report to the Board on a quarterly basis on the Corporation's compliance with the following items:

- The Corporation has, as required by law, paid all:

  i) salary, wages and vacation pay owing to employees of the Corporation;
  ii) remittances for employee income tax deductions, Canada Pension Plan (CPP) and Employment Insurance (EI) premiums and contributions;
  iii) remittances for required deductions for payments to non-residents;
  iv) Workplace Safety and Insurance Board (WSIB) premiums;
  v) Employer Health Tax (EHT); and
  vi) Harmonized Sales Tax (HST).

The CEO will report to the Board on an annual basis on the Corporation's compliance with the following items:

- The Corporation is in compliance in all material respects with occupational health and safety legislation and all appropriate steps are being taken to maintain a safe working environment, including the following:

  i) a safety committee is in place;
  ii) safety committee meeting minutes are being maintained;
  iii) the safety committee's recommendations and the senior management team's responses are being recorded;
  iv) actions are taken, where appropriate;
  v) safety manuals are up-to-date;
  vi) hazardous materials are identified;
  vii) there is proper maintenance of signage;
  viii) ongoing training is being performed; and
  ix) a proper procedure is in place for monitoring compliance on an ongoing basis.

- Compliance with environmental legislation and regulations.

- Directors' and officers' liability insurance is in place and coverage is suitable and in accordance with risk, the indemnity amount is sufficient in light of risk, all premiums have been paid, and the policy is up-to-date.

- In keeping with the *Broader Public Sector Accountability Act, 2010*, the Corporation will prepare all required CEO attestations on the Corporation's compliance concerning:

  i) the completion and accuracy of reports required on the use of consultants;
  ii) compliance with the prohibition on engaging lobbyist services using public funds;
  iii) compliance with the expense claim directives consistent with the Broader Public Sector Directives; compliance with the perquisite directives issued by the Broader Public Sector Directives; and
  iv) compliance with the procurement directives issued by the Broader Public Sector Directives.

The Board will approve all such attestations. The Corporation will post all such Board-approved attestations on its website.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-14**

SUBJECT: **WHISTLEBLOWING**

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1. Purpose

The purpose of this Policy is to encourage and enable the reporting of alleged or potential wrongdoing and violations of Hospital policies related to ethical behaviour or business conduct, without fear of reprisal.

Alleged or potential wrongdoing related to ethical behaviour or business conduct may include:

- Questionable financial, accounting controls, audit practices or potential violations of law.
- Quality or malpractice of care, including abuse of patients.
- Environmental issues, including failure to comply with legislation or policies concerning dangerous goods or hazardous substances.
- Violations of behavior and conduct policies, conflicts of interest or other human resources policies and legislation.
- Breach of contract and negligence or failure to comply with legislation including criminal offences.

The Policy cannot directly address every situation in which Individuals may find themselves, but it provides a set of principles, rules and ethical standards to be used as a guide for the day-to-day conduct of business.

This Policy supports and follows from the reporting provisions in other policies of the Hospital:

- Employees, Professional Staff, volunteers and students/medical learners across all sites of the Hospital may also report violations of this Policy on a confidential basis through the external service provider, ClearView Connects. Please see Section 3.1(2).
- A matter involving the Chief of Staff, the Chief Executive Officer or a Board Director must be reported to the Board Chair.
- Board Directors must follow the Process for Resolution outlined in the Board's *Conflict of Interest Policy* in the event of an actual or perceived conflict of interest.

- The *Code of Conduct Policy* for all employees, Professional Staff, volunteers, students/medical learners, and the *Professional Staff Code of Conduct Policy and Procedure* require all Individuals to report violations of the codes of conduct to their manager/leader.
- The *Workplace Discrimination, Harassment and Violence Prevention Policy and Procedure* permits complaints of misconduct as well as the reporting of workplace violence events to Human Resources either directly or through a manager.

This Policy is in effect during working hours and at work-related functions, on or off the Hospital's premises.

1.1 Application

All Board directors, employees, persons with practicing privileges (physicians, dentists, midwives and RNs in the extended class), volunteers, students/learners, independent and external contract workers, and all individuals who represent the Hospital are bound by this Policy. For the purposes of this Policy, everyone included in the scope of this Policy will be referred to as "Individuals".

2. Policy and Guiding Principles

Implementation of this Policy will be guided by the following principles and policy statements:

- The Hospital complies with all relevant laws and regulations.
- All policies support and embody the Hospital's core values.
- The Hospital maintains high standards of business and ethical conduct and applies these standards to all matters of business.
- All complaints will be dealt with promptly, be fully reviewed and/or investigated as appropriate, in a fair and equitable manner, ensuring a respectful process is followed for those involved.
- There will be no reprisals against anyone reporting in good faith under this Policy.
- Confidentiality will be protected to the maximum extent possible.

2.1 Reporting Responsibility

Any Individual who is aware of or suspects a breach/violation of Hospital policies related to ethical behaviour or business conduct, including a violation of the behavior and standards of conduct or potential violations of law, or has concerns relating to business, financial, accounting or auditing practices, is responsible for reporting the concern as soon as possible.

2.2 No Reprisals

Individuals reporting in good faith under this Policy will not suffer harassment, retaliation or adverse employment consequences (for example, demotion, denial of promotion or compensation) even if after the investigation has been completed, the allegations are not substantiated.

Individuals who experience any form of retaliation before or after submitting a report should immediately inform their manager, a senior member of the Human Resources group or the General Counsel.

An Individual who retaliates against another Individual for reporting in good faith will be subject to discipline, which may include termination or removal.

Failure to report a violation may lead to disciplinary action.

2.3 Acting in Good Faith

In making a report, an Individual must be acting in good faith with reasonable grounds for believing there is alleged or potential wrongdoing, a breach of the standards of behavior or questionable financial or business practices. An Individual who makes an unsubstantiated report, which is knowingly false or made with malicious intent, will be subject to discipline, up to and including termination or removal.

2.4 Confidentiality

Anyone involved in a complaint process will keep reports confidential to the maximum extent possible, consistent with the Hospital's legal and ethical responsibilities, including the need to conduct an effective investigation. Please note that confidentiality may not mean anonymity.

The Hospital will accept reports under this Policy on an anonymous basis.

The Hospital will not tolerate any attempt by another Individual or group to identify an Individual who reports in good faith on a confidential or anonymous basis.

3. Policy

The Hospital recognizes the importance of providing Individuals with multiple channels through which to report issues of alleged or potential wrongdoing. The more channels offered to Individuals, the more comfortable they will feel in the reporting process.

Individuals may file a complaint with their immediate manager/leader, or with the General Counsel, please refer to the Internal Reporting Processes (Appendix C). If they are not comfortable reporting through Internal Reporting Processes, they have the option of filing an anonymous complaint through the Hospital's independent, external service provider, ClearView Connects. Please see Section 3.1(2).

3.1 How to File a Complaint

3.1.1 Any Individual who is aware of, or suspects a breach of the standards of behaviour or of alleged or potential wrongdoing under this Policy, will report the concern directly to the General Counsel. Alternatively, the

Individual may report the concern to his/her manager/leader who will forward the complaint to the General Counsel for review and/or investigation, please refer to the Internal Reporting Processes (Appendix C).

3.1.2 If the Individual wishes to remain anonymous, s/he may contact the Hospital's independent, third party service provider (at this time, ClearView Connects).

Hotline at 1.866.921.0105, or
www.clearviewconnects.com; or
P.O. Box 11017, Toronto, ON., M1E 1N0.

The external service provider creates an anonymous report that is referred to the General Counsel and Chief Executive Officer (see *Appendix B - ClearView Connects* for details). The process is completely confidential.

3.1.3 The General Counsel and CEO are accountable for ensuring the matter is investigated and appropriate action is taken. If the matter concerns a member of the professional or credentialed staff, the Chief of Staff will also be involved.

3.1.4 The person will be advised of the complaint against them and be given the opportunity to respond.

3.1.5 The actions that may be taken to address a violation will depend on the particular circumstances, and consequences may include, but are not limited to, discipline up to and including termination or withdrawal of privileges.

If an Individual has a complaint pertaining to the Chief Executive Officer, Chief of Staff, or a Board Director, the complaint will be sent to the Board Chair. The complaint will be investigated through the Priorities and Planning Committee (PPC) of the Board. External investigations are required for complaints involving the CEO and/or the Chief of Staff to avoid potential conflicts.

If an Individual has a complaint pertaining to the Board Chair, it will be sent to the PPC Chair for review and investigation.

4. Investigation of Complaints

4.1 Principles for Investigating Complaints

The Hospital will conduct investigations based on the following principles:

- The investigation will be carried out fairly and without bias.
- Those involved in the investigation will be independent of both the person who made the report and any persons under investigation. This means they should not either be reporting to, or supervising, any such persons.

- Disclosure of information will be limited to those who need to be involved in order to carry out the investigation.
- The person who is the subject of the report is entitled to know the substance of the allegation(s) and have an opportunity to respond.
- Investigations will be conducted in a timely manner.
- The Hospital expects Individuals to cooperate during any investigation.

4.2 Responsibility for Investigating Complaints

The General Counsel and CEO are accountable for ensuring that complaints are appropriately investigated, resolved and reported under this Policy. Managers/leaders must forward any Whistleblowing complaints they receive to the General Counsel. Complaints relating to the CEO, Chief of Staff or a Board Director will be forwarded to the Board Chair.

For Individuals below the CEO and Chief of Staff levels, the General Counsel and CEO will evaluate the nature of the complaint and determine the appropriate level of response. If the complaint relates to a Professional Staff member, the CEO, General Counsel and Chief of Staff will evaluate the nature of the complaint and determine the appropriate level of response.

The General Counsel and CEO may delegate responsibility for overseeing or investigating specific matters to external counsel or other staff, including the VP, Human Resources, Volunteer Resources and Organizational Effectiveness or the Chief of Staff. Complaints may be referred to the appropriate law enforcement or regulatory authorities as appropriate.

If the Board Chair receives a complaint about a Board Director, or the PPC Chair receives a complaint regarding the Board Chair, the investigation will be coordinated with the CEO.

If the CEO has an actual or perceived conflict, the complaint must be sent to the Board Chair and the investigation will be coordinated with the General Counsel.

If the General Counsel has an actual or perceived conflict, the complaint must be sent to the CEO. The CEO will evaluate the nature of the complaint and determine the appropriate level of response.

4.3 Whistleblowing Files

Complaint and investigation files must be kept separate from employee, physician, or learner files and stored in a secure location with access limited to those responsible for conducting the investigation. No record of a complaint will be kept in any employee/physician/learner file unless improper conduct is found that results in disciplinary action. In that case, the outcome of the investigation will be reflected in the file of the disciplined employee/physician/learner. Please refer to the *Professional Staff Code of Conduct* for details related to professional staff files.

5. Supports for Individuals

Anyone involved in an investigation, whether as a complainant, alleged offender or person interviewed, may wish to use the confidential counseling service that is available to all Individuals through the Hospital's Employee Assistance Program.

Guidanceresources
Toll Free Number: 1.855.410.7628
TDD: 1.877.373.4763
https://guidanceresources.com/groWeb/login/login.xhtml
Your company Web ID: EAP4THP

6. Reporting to the Board

6.1 Annual Reports to the Board

The Board will receive annual reports from the PPC Chair and the CEO on Whistleblowing. The report will provide an overview of the number of complaints received, the nature of the complaints, the number of complaints substantiated or resolved and a general description of how they were resolved. It will also identify any trends or risk issues to be addressed by the Hospital and/or Board. These reports will not contain information that could identify the individuals involved.

6.2 Specific Whistleblowing Complaints

The CEO will report to the Board, through the PPC, specific Whistleblowing incidents as required.

The following criteria are designed to provide guidance to the CEO as to whether the PPC should be advised of a specific Whistleblowing incident:

- Poses a reputational risk to the organization.
- It is likely to be made public.
- Outside authorities need to be advised.
- Law suit is likely.
- Significant breach of organizational values.
- At the CEO's discretion based on the severity or nature of the complaint.

The Board Chair will receive specific whistleblowing complaints regarding the Chief of Staff and/or the CEO directly.

APPENDIX A - FILING OF COMPLAINTS SUMMARY CHART

If the Complaint is About….	File Complaint With…	Investigates Complaint
Board Chair	Chair, Priorities and Planning Committee	Chair, Priorities and Planning Committee appoints an external investigator.
Board Director	Board Chair	Chair, Priorities and Planning Committee appoints an external investigator.
Chief Executive Officer or Chief of Staff	Board Chair	Chair, Priorities and Planning Committee appoints an external investigator.
Physicians and Credentialed Staff	Chief of Staff or to the General Counsel	Determined on a case-by-case basis by Chief of Staff, General Counsel and CEO. May delegate responsibility to others in organization or to an external investigator.
Medical Learners	Direct Supervisor, the Medical Education Office or to the General Counsel	Determined on a case-by-case basis by Chief of Staff, General Counsel and CEO, and as per the University's policies and processes.
All Other Individuals in Scope of this Policy	Direct Supervisor or Manager; or directly to the General Counsel	Determined on a case-by-case basis by General Counsel and CEO. May delegate responsibility to others in organization or to an external investigator.
General Counsel	CEO	CEO may delegate responsibility to others in organization or to an external investigator.

APPENDIX B - CLEARVIEW CONNECTS

The Hospital recognizes the importance of providing Individuals with multiple channels through which to report issues of alleged or potential wrongdoing. The more channels offered to Individuals, the more comfortable they will feel in the reporting process.

The following outlines the three reporting processes available to Individuals through ClearView Connects - an independent, external service provider. Individuals may make anonymous complaints through ClearView Connects, or may identify themselves.

1. Web Site Reports

When an Individual chooses to make a report through the ClearView Connects website, they log on to www.clearviewconnects.com from any internet-accessible computer, anywhere in the world. They enter the organization's name "Trillium Health Partners" and begin the reporting process. Once they enter the Hospital name, they are immediately taken into a fully encrypted portion of the ClearView Connects web application.

Throughout the web site reporting process, no personal information is specifically requested that could identify the reporter. Furthermore, instructions are provided warning the reporter not to divulge any personal information that would identify them if, in fact, they prefer not to be identified. As well, when reports are submitted using the web-based reporting process, the IP address is not recorded in the ClearView Connects system. This ensures anonymity for the reporter, and confidentiality of the information provided within the security of the ClearView Connects system.

At the conclusion of the reporting session, the ClearView Connects system generates a unique login and password for the reporter. The system encourages the Individual to write this information down and keep it in a safe place, as ClearView Connects DOES NOT keep track of these login and password pairings. This is critical to protect the security of the information in the system, as well as to protect and maintain the anonymity of the Individual submitting the report.

Once the report has been submitted, the system immediately generates automatic email notifications and sends these to the General Counsel and CEO at the Hospital who have access to review reports.

2. Telephone Reports

It is important to note that the process an Individual follows when submitting a report using the telephone hotline with live operator is exactly the same as if they were submitting the report using the web-based tool. When an Individual chooses to make a report using the ClearView Connects telephone hotline system, they call a special toll free number (1.866.347.7417). The Individual is given the option of speaking with a live ClearView Connects agent, or leaving a voice mail message with their report information.

Live Agent

The Individual advises the ClearView Connects agent that they wish to make a verbal report. ClearView Connects does not request personal information over the telephone from the Individual calling. Furthermore, instructions are provided warning the Individual not to divulge any personal information that would identify them, if in fact; they prefer not to be identified. It is ClearView Connects' policy not to subscribe to caller ID services.

The ClearView Connects agent enters the report from the Individual verbatim, directly into the ClearView Connects online reporting system. No separate handwritten notes are taken by the agent that could be read later by another person (the ClearView Connects call centre is a paperless environment). As information is being entered into the system, it is fully encrypted.

At the conclusion of the reporting session, the system generates a unique login and password for the reporter. The system encourages the Individual to write this information down and keep it in a safe place, as ClearView Connects DOES NOT keep track of these login and password pairings. This is critical to protect the security of the information in the system, as well as to protect and maintain the anonymity of the Individual submitting the report.

Once the report has been submitted, the system immediately generates automatic email notifications and sends these to the General Counsel and CEO at the Hospital who have access to review reports.

Voice Mail

The Individual's voice mail is transcribed verbatim by a ClearView Connects agent and is entered directly into the web-based reporting system. Unless specifically instructed by the Individual who leaves the voicemail message, no personally-identifiable information is included in the transcribed voicemail report. Please note that when an Individual submits a report using the voicemail option, there is no further follow up available with the Individual, since the voicemail system does not generate and assign a unique login and password for them. The system immediately generates automatic email notifications and sends these to the General Counsel and CEO at the Hospital who have access to review reports.

3. Mail Reports

When an Individual chooses to make a report by mail, they prepare their information in any format they wish. They should be careful to leave out any personal details if they do not wish to be identified. They may include any documents they feel substantiate the allegations contained in their report. They will mail the report to a confidential Post Office Box [P.O. Box 11017, Toronto, ON., M1E 1N0]. When ClearView Connects receives the report by mail, it will be input into the ClearView Connects system verbatim, along with any documents that have been attached (these will be scanned electronically and attached to the electronic report). The Individual's name will not be included anywhere in the report unless the Individual has specifically given authorization for their name to be used. Note that when an

Individual submits an anonymous report using the regular mail option, there is no further follow up available with the employee, since there is no way to communicate a unique log in and password. The system immediately generates automatic email notifications and sends these to the General Counsel and CEO at the Hospital who have access to review reports.

Interactive Dialogue Capability

When a report is received by the ClearView Connects system, automatic email notifications are immediately sent to the General Counsel and CEO who have access to review the reports. They log onto the system using a secure login and password provided by ClearView Connects (note – passwords are changed quarterly by ClearView). After reviewing the report, there is an opportunity for them to ask the Individual additional questions through the web system to validate information in the report or to gather additional information to assist in an investigation.

When the Individual logs back into the system – or calls the toll free hotline - to check the status of their report, they will see that additional information has been requested by the General Counsel and will have an opportunity to answer the question(s) if they choose.

APPENDIX C – INTERNAL REPORTING PROCESSES

The Hospital recognizes the importance of providing Individuals with multiple channels through which to report issues of alleged or potential wrongdoing. The more channels offered to Individuals, the more comfortable they will feel in the reporting process.

A. Collection of Information

The following outlines the internal reporting details required to initiate an investigation:

i) To the extent possible, be specific about names, departments, individuals, documents, policies, etc. In addition, try to remember locations, dates, times, and who was involved.
ii) Please see Section 4.2 of the Policy for complaints involving the General Counsel, the Chief of Staff, the CEO, a Board member or the Board Chair.
iii) Collect and attach a copy of any documents to support the concern being raised (to the extent the Individual opted to provide his/her identity).
iv) Include details of any previous instances in which this concern was reported, to whom it was reported, when and with what outcome.

Upon collection of the above information by the appropriate leader under the category *"File a Complaint With"* in Appendix A ("Hospital Agent"), the Individual's report shall be escalated in accordance with Sections 3, 4 and 6 of the Policy.

B. Mechanisms of Internal Report

The following outlines the three reporting mechanisms available to Individuals through internal reporting. When reporting a complaint through a manager/leader, General Counsel or CEO, an Individual has the option to remain anonymous to other bodies; or have their identity revealed in the investigation process.

1. In-Person

When an Individual chooses to make an in-person report, the Individual may contact the appropriate Hospital Agent. The Hospital Agent will request from the Individual the information outlined in Section A above.

2. Telephone Reports

When an Individual chooses to make a report using the telephone system, the Individual is given the option of speaking directly with the Hospital Agent, or leaving the Hospital Agent a voice mail message with their report information.

Live Agent

The Individual advises the Hospital Agent that they wish to make a verbal report. The Hospital Agent will request from the Individual the information outlined in Section A above. The Hospital Agent does not request personal information over the telephone from the Individual calling. Furthermore,

instructions are provided warning the Individual not to divulge any personal information that would identify them if, in fact, they prefer not to be identified. Please note the Hospital's telephone system subscribes to caller ID services, if it is the Individual's preference to be anonymous, the Individual should be mindful in utilizing a telephone system with blocked caller ID services.

Voice Mail

The Individual may leave a voicemail for the Hospital Agent describing the nature of the reported concern; including the details outlined in Section A above.

The Individual's voice mail is transcribed verbatim by the Hospital Agent. Unless specifically instructed by the Individual who leaves the voicemail message, no personally-identifiable information is included in the transcribed voicemail report.

3. Mail Reports

When an Individual chooses to make a report by mail, they prepare their information in any format they wish (please refer to Section A above for the information that would assist the Hospital Agent in conducting the investigation). They should be careful to leave out any personal details if they do not wish to be identified. They may include any documents they feel substantiate the allegations contained in their report. The Individual will mail the report marked "Private and Confidential" to the Hospital Agent identified in Appendix A. The Individual's name will not be included anywhere in the report unless the Individual has specifically given authorization for their name to be used.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **II-15**

SUBJECT: **COVID-19 IMMUNIZATION FOR THE BOARD OF DIRECTORS**

The purpose of this Policy is to set out the standards for COVID-19 immunization for all Directors of Trillium Health Partners' ("THP") Board of Directors ("Directors").

THP requires all Directors to be vaccinated with a Health Canada authorized COVID-19 vaccine.

Background

COVID-19 is an acute respiratory illness caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus. It is characterized by fever, cough, shortness of breath and a number of other symptoms. Asymptomatic infection is also possible. COVID-19 is primarily transmitted person-to-person through respiratory droplets. The risk of severity for the disease increases with age and is elevated in those with underlying medical conditions.

Trillium Health Partners continues to be one of the most impacted hospitals in Ontario. Peel Region has been a hotspot of COVID-19 inpatient activity throughout the entirety of the pandemic, with community and variant cases remaining high. A Health Canada authorized COVID-19 vaccine is the best defense in preventing the spread of COVID-19 and severe illness for all Individuals, patients and community members.

To ensure the safest possible environment to work and deliver care to our community, mandatory COVID-19 vaccinations are a necessary step for all THP employees, professional staff, learners, volunteers and, among the volunteers, Directors.

Policy

THP requires that all individuals (THP employees, professional staff, learners, volunteers, contractors, vendors) receive the COVID-19 vaccine. This policy explicitly extends this requirement for vaccination to include Directors, who are to confirm vaccination status by October 20, 2021. The Hospital will provide information to Directors about the risks and benefits of the vaccine, as appropriate. THP will offer the COVID-19 vaccine to all Directors free of charge.

As a condition of candidacy, all applicants for Director positions will be required to declare they are fully vaccinated in order to be considered for appointment, where fully vaccinated means having received the full series of a COVID-19 vaccine or combination of COVID-19 vaccines authorized by Health Canada (e.g., two doses of a two-dose

vaccine series, or one dose of a single-dose vaccine series; and having received the final dose of the COVID-19 vaccine at least 14-days prior).

This Policy is subject to modification pending further national or provincial vaccination advice or direction.

Program Procedure

All current Directors are required to declare their vaccination status by October 20, 2021 to the Chief Human Resources Officer ("CHRO") by indicating one of two options listed below:

1. I am fully vaccinated and have provided proof of full vaccination (vaccine receipt for each dose) to the CHRO; or

2. I am unable to be vaccinated for approved medical exemption or other accommodation reasons.

    a. I have submitted relevant documentation to the CHRO requesting a medical exemption or accommodation. An exemption/ accommodation request form will be provided to Directors by the CHRO once requested, and my request will be considered. If my request is not approved, I will be required to be fully vaccinated.

The CHRO will confirm compliance status for all current Directors by October 21, 2021 to the Chair of the Board of Directors and the Chief Executive Officer (CEO).

The CHRO is accountable to ensure the requirements of this policy are embedded into the standard process for recruitment of future Directors.

CATEGORY: **EXCELLENT MANAGEMENT**

POLICY #: **VI-1**

SUBJECT: **COMMUNICATIONS**

The Board will comply with its obligations on consultation and communications with its stakeholders.

The Corporation will respond in a timely manner to public inquiries, complaints and concerns on the activities and operations of the Corporation.

As per the Corporate By-law (Section 13.2), the Chair is responsible for Board communications and may delegate authority to one or more Directors, officers or employees of the Corporation to make statements to the news media or public about matters that the Chair determines appropriate for disclosure. The CEO is the spokesperson for the Corporation for all operational matters. The CEO and Chair will mutually determine their respective roles as may be required from time to time. No Director will be a spokesperson for the Board unless specifically delegated by the Chair. From time to time, the Chief of Staff may be expected to speak on medical and patient care issues.

The Board will ensure that the Corporation develops policies and processes as required to ensure effective ongoing communication and positive relationships between the Corporation and the community. Recognizing the breadth of the community, the Chair and the CEO will ensure that information respecting the Corporation's activities is widely communicated to the public through the media throughout the catchment area. Mechanisms for broader ongoing communication to the public may include:

- Regular Board updates;
- an annual report to the community on the activities of the Corporation;
- periodic media briefings on the activities of the Corporation;
- periodic articles in the local media on matters of interest to the communities served by the Corporation; and
- periodic open forums to provide an opportunity for broader community engagement.

<u>Correspondence to the Board</u>

The Board will receive all correspondence that, in the opinion of either the Chair or CEO or Chief of Staff, is appropriate to the role of the Board. The Board will be made aware of all correspondence to the Board in a Notice of Correspondence.

The Chair or the CEO or Chief of Staff may direct a letter to one of the Board committees for action before receipt of correspondence by the Board.

Part III:

Program Quality and Effectiveness

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-1**

SUBJECT: **QUALITY IMPROVEMENT AND SAFETY**

Based on the *Excellent Care For All Act, 2010*, the Board:

- recognizes that a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe;
- is committed to ensuring that the Corporation is responsive and accountable to the public, and focused on creating a positive patient experience and exceptional outcomes, and
- believes that quality is the goal of everyone involved in delivering health care in Ontario, and that ultimately, this health care organization should hold its executive team accountable for its achievement.

The Corporation is committed to meeting or exceeding established and evolving standards of quality and patient safety. The Corporation is committed to addressing quality issues and identifying and acting upon opportunities to continuously improve patient care and service delivery. The Board recognizes the importance of monitoring, evaluating and continuously improving the quality of patient care and services.

The Board recognizes the importance of the safe delivery of its services, as well as the importance of reducing or preventing the potential for injury or loss to its patients, visitors, employees, professional staff members, students and volunteers. Embedding a culture of patient safety throughout the corporation is an underlying principle in the success of quality improvement. Patient safety has been defined as a patient's "freedom from accidental injury" when interacting in a healthcare system. Care and management standards are integral to the achievement of this goal. Standards and quality planning will align with the Corporation's mission, vision, core values and corporate priorities, and will support the goals and objectives of the Corporation's strategic plan.

The Board is ultimately responsible for oversight and decision making related to quality and safety issues including:

i) reviewing and recommending policies and standards;
ii) overseeing compliance with quality and safety related issues, including accreditation; and
iii) reviewing and making recommendations following adverse events.

In keeping with the requirements under the *Excellent Care for All Act, 2010,* the Corporation will:

- carry out patient satisfaction surveys and employee satisfaction surveys;
- develop a patient declaration of values, and publicly post it;

- establish a patient relations process that reflects the content of its patient declaration of values, and publicly post it;
- develop an annual quality improvement plan publicly post it, and provide a copy of it to the Ontario Health Quality Council; and
- annually establish performance targets and performance metrics related to quality and patient and staff safety for monitoring by the Quality and Program Effectiveness Committee.

At least quarterly, the Quality and Program Effectiveness Committee will monitor the Corporation's quality of patient care, and patient and staff safety against the defined performance targets and performance metrics and report to the Board.

The Board will discuss issues related to quality of patient care and patient and staff safety on the agenda at every regularly scheduled Board meeting.

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-2**

SUBJECT: **RISK MANAGEMENT**

The Board must be knowledgeable about risks inherent in Hospital operations and ensure that appropriate risk analysis is performed as part of its decision-making. In particular, the Board:

i) oversees the CEO's risk management program;
ii) ensures that appropriate programs and processes are in place to protect against risk;
iii) expects the CEO to identify unusual risks to the Corporation and ensure that there are plans in place to prevent and manage such risks;
iv) expects the CEO to identify and assess the associated organizational risks when reviewing and approving resource allocation decisions;
v) anticipates financial needs and potential risks, and develops contingency plans; and
vi) works with the CEO to reduce organizational risks and promote ongoing quality improvement.

The Board is responsible for ensuring that appropriate risk management practices are in place, and for reviewing and approving the Corporation's variance and risk tolerance levels.

Each Board Standing Committee will review the risks related to its mandate. The Priorities and Planning Committee will review the enterprise risk management program at least on an annual basis and report thereon to the Board.

The CEO is accountable for: identifying the principal organizational risks of the Corporation; determining the Corporation's exposure to risk; and developing and implementing a risk management framework.

The Board will annually monitor and assess the Corporation's quantification of risks, including asset protection, and how those risks are addressed.

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-3**

SUBJECT: **IDEA ETHICAL DECISION-MAKING FRAMEWORK**

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1. PURPOSE AND APPLICATION

The purpose of this policy is to outline the IDEA: Ethical Decision Making Framework (hereafter the IDEA Framework) that is used to inform decision-making within the Corporation from the point of care to the boardroom.

2. BACKGROUND

Accreditation Canada Leadership Standards require that an organization develops or adopts an ethics framework to support ethical practice. An ethics framework provides a standardized approach to working through ethics issues and making decisions.

3. DEFINITIONS AND ACRONYMS

Ethics – Ethics is about making "right" or "good" choices and the reasons that we give for our choices and actions. Ethics involves deciding what we should do, explaining why we should do it, and describing how we should do it.

4. GUIDING PRINCIPLES

The framework incorporates the organization's mission, vision, and values, as well as additional values/principles that are agreed upon by relevant stakeholders.

5. POLICY

The IDEA Framework provides a step-by-step, fair process to help guide healthcare providers and administrators in working through ethical issues encountered in the delivery of healthcare. The IDEA Framework will be used to inform decision-making within the Corporation from the point of care to the boardroom.

6. PROCEDURE

The IDEA Framework (see Appendix A) incorporates the following four process steps and five conditions. A Guide for using the IDEA Framework including worksheets is available on the thpHUB.

The four process steps are:

I - Identify the facts.
Ask: What is the ethical issue?

D - Determine the relevant ethical principles.
Ask: Have perspectives of relevant individuals/groups been sought?

E - Explore the options.
Ask: What is the most ethically justifiable option?

A - Act.
Ask: Are we (am I) comfortable with this decision?

The five conditions are:

Empowerment: Strategies are in place to ensure input from relevant parties with less power and influence.

Publicity: The process, decisions, and rationales are transparent and accessible to stakeholders.

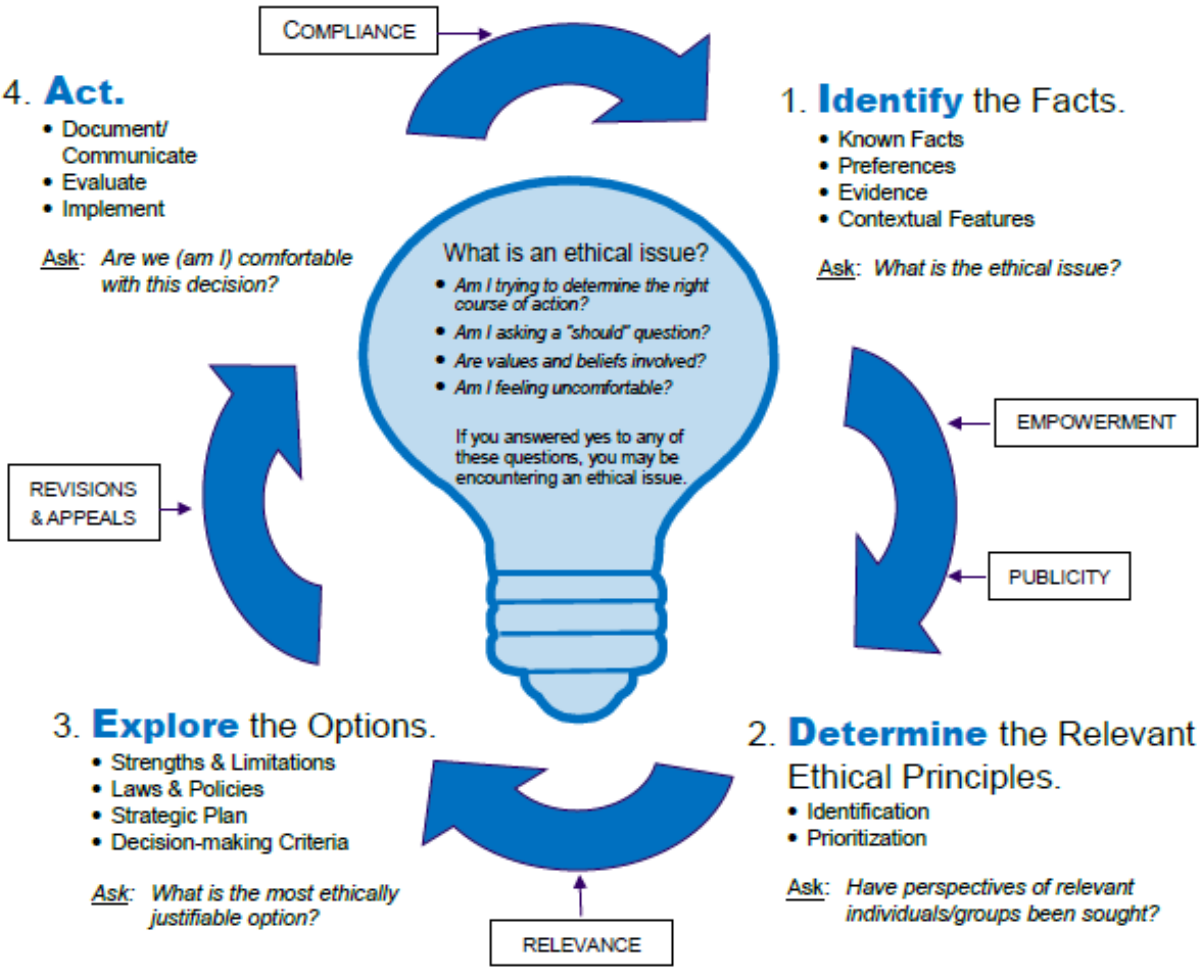
Relevance: Relevant parties agree on pertinent ethical values, principles, and criteria to guide decision-making.

Revisions and Appeals: A mechanism is in place to revisit and revise decisions in light of new facts and/or to address concerns about omissions or errors in the process.

Compliance (Enforcement): There is voluntary or public regulation of the process to ensure that the other four conditions are met.

Appendix A

IDEA[1]: Ethical Decision-Making Framework



[1] The IDEA: Ethical Decision-Making Framework builds upon the Toronto Central Community Care Access Centre Community Ethics Toolkit (2008), which was based on the work of Jonsen, Seigler, & Winslade (2002); the work of the Core Curriculum Working Group at the University of Toronto Joint Centre for Bioethics; and incorporates aspects of the accountability for reasonableness framework developed by Daniels and Sabin (2002) and adapted by Gibson, Martin, & Singer (2005).

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-4**

SUBJECT: **RESPECT FOR DIVERSITY**

The Corporation, as represented by the Directors, officers, Professional Staff members, Board committee members, employees, volunteers and students, values and respects the diversity of its patients and their families, the community and each other.

The Corporation is committed to being an organization which recognizes the dignity and worth of every person.

In addition to complying with applicable laws, the Corporation will:

- establish the principles, processes and responsibilities essential for creating and maintaining a respectful, inclusive and positive work environment consistent with applicable laws;
- promote a climate of understanding and mutual respect for the dignity and worth of every person;
- be respectful, courteous and tactful in all interactions;
- respect the customs and beliefs of individuals consistent with the mission of the Corporation;
- strive towards equity, fairness and inclusion, and uphold the organizational values of compassion, courage and excellence;
- be sensitive to potential barriers to accessibility;
- provide for equal rights and opportunities without discrimination;
- promote respectful relationships with health care partners and community stakeholders; and
- create an environment of shared expectations for how we treat one another through the THP Declaration of Respect.

THP Declaration of Respect

As patients, staff, medical professionals, volunteers, learners, family members and visitors we are Better Together. We commit to living our values of compassion, excellence and courage, creating a healthy, safety and respectful environment for healing.

Together, we developed our shared expectation of how we treat one another and commit as a community to:

- Respect other and treat them as they would want to be treated
- Listen and engage to build trust and mutual understanding
- Involve one another and work as a team
- Take accountability for our actions and the impact hey have on others
- Learn from our experience and continuously improve

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-5**

SUBJECT: **PRIVACY SECURITY AND CONFIDENTIALITY OF INFORMATION**

In accordance with the Corporate By-law (Article 13), every Director, officer, Professional Staff member, committee member, employee, volunteers and students and agent of the Corporation shall respect the confidentiality of matters:

i) brought before the Board;
ii) brought before any committee;
iii) dealt with in the course of the employee's employment or agent's activities; or
iv) dealt with in the course of the Professional Staff member's, volunteer's or student's activities in connection with the Corporation.

In compliance with the *Public Hospitals Act*, the Board recognizes the importance of respecting and ensuring the confidentiality of all patient and employee-related information.

Every Director, officer, Professional Staff member, Board committee member, employee, volunteer and student of the Corporation will respect the confidentiality of matters brought before the Board or before any Board committee, or dealt with in the course of the individual's employment or other activities in connection with the Corporation.

All Directors must adhere to the by-laws and policies and procedures on privacy, security and confidentiality of information including, without limitation, confidential information, release of patient information, facsimile of patient information, release of information to the media and personnel records.

The CEO is responsible for ensuring the protection of the personal information of patients and their families, Professional Staff members, employees, volunteers and students, and all corporate and business information.

The CEO will take reasonable steps to ensure that such organizational policies are implemented consistent with legal requirements and enable the Corporation to handle such information in a secure and confidential manner.

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-6**

SUBJECT: **ACCESS TO INFORMATION**

Consistent with the Board's commitment to good governance practices, timely access to information, appropriate protection of personal privacy, and appropriate protection of other information that is exempted or excluded from disclosure under the *Freedom of Information and Protection of Privacy Act*, the Board will make available to the public:

- the statement of Board and Director roles, responsibilities and accountabilities;
- a list of elected and *ex-officio* Directors and their attendance records;
- policies governing the Board and Board standing committees;
- a report on the Corporation's performance as part of its Annual Report;
- the Corporation's Quality Improvement Plan, in compliance with the *Excellent Care for All Act, 2010;*
- information about expense claims in compliance with any directives made under the *Broader Public Sector Accountability Act, 2010*; and
- upon request, information that is subject to disclosure under the *Freedom of Information and Protection of Privacy Act*; and
- minutes of Board of Director meetings.

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-7**

SUBJECT: **COMPLAINTS (PATIENT CARE AND OTHER)**

It is important to patients, their families, and the community at large that all complaints are dealt with in a timely, impartial and confidential manner. Consistent with the *Excellent Care for All Act* (ECFAA), it is the policy of the Board to support and monitor the Corporation's patient relations process to ensure facilitation, mediation and resolution of complaints.

The Board is accountable for ensuring that there is a complaints management process in place. Trends are reported to the Board through the Quality and Program Effectiveness Committee.

If a written or verbal complaint is received by a member of the Board, the member of the Board shall forward the complaint to the appropriate Patient Relations Officer.

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-8**

SUBJECT: **RESEARCH**

The Corporation is committed to:

- seeking solutions to health issues by fostering learning, discovery, and innovation;
- advancing scientific knowledge and its dissemination into practice;
- achieving excellence in basic and applied sciences for research;
- maintaining and developing research partnerships and collaborations; and
- providing a supportive environment, infrastructure, resources, and facilities to achieve each of the above.

The Corporation may permit its facilities and resources to be used for research-related activities in health and related fields. The Corporation, within the limits of its available resources, and having due regard for the intended purpose of patient care funding, may support research initiatives that meet the following criteria:

i) The research is consistent with the Corporation's vision, mission, core values, strategic plan and operating plan.
ii) The research conforms to corporate policies and guidelines on research, research ethics and research standards, professional conduct, and the protection of human participants (an individual whose data, biological materials, or responses to interventions, stimuli or questions by the researcher, are relevant to answering the research question(s)). involved in research.
iii) The deliverables of the research and the ownership of any new apparatus or procedures will be subject to the Corporation's intellectual property policy and/or the research agreements with research partners, collaborators and supporters.

Each proposed research study (human and non-human) shall be evaluated against current standards to ensure sound ethical and scientific merit and conduct. This will be enabled through standard review processes of the Corporation. The broad principles, rights and obligations that will govern the conduct of research, and the oversight, management and funding of research, will be determined through affiliation agreements, and research agreements with other academic and research partners, collaborators and supporters.

All research studies that involve human participants shall undergo review by the Research Ethics Board (REB) to ensure compliance with Good Clinical Practice

Guidelines, the Tri-Council Policy Statement 2 (TCPS 2), and best practices to protect personal health information and the safety and welfare of human research participants. This also applies to research involving human remains, cadavers, tissues, biological fluids, embryos and fetuses. Employees, privileged staff, professional staff, agents, contractors, students, and volunteers of the Corporation that are conducting research involving human participants within or under the auspices of the Corporation, are required to adhere to the TCPS.

Under the Research Policy, the Board of Directors is accountable for the following:

- To establish the Research Ethics Board (REB) within the Corporation;
- To require the REB to maintain an active Institutional Review Board (IRB) and Institutional Review Board Organization (IORG) registration with the Office of Human Research Protections (OHRP);
- To require the Corporation to maintain and retain an active Federal-Wide Assurance (FWA) with the OHRP;
- To require the REB to operate as an independent objective review board;
- To require the REB to make independent determinations regarding whether to approve or disapprove human participants research protocols based on whether or not human participants are adequately protected;
- To require the REB to have protocols in place, warranting an unbiased REB review, objective and free from conflict of interest to prevent compromising the objectivity of the review process;
- To require the Corporation to have a formal appeal mechanism in place to enable researchers to appeal a negative REB determination; and
- To develop the Intellectual property policy for the Corporation and review it on a regular basis.

The mandate of the REB is to approve, reject, propose modifications to, or terminate any proposed or ongoing research involving human participants that is conducted under the auspices of the Corporation. Specifically, the REB will review all human participants research conducted that meets any of the following criteria. The research:

- is conducted by any of the Corporation's employees, privileged staff, professional staff, agents, contractors, students, and volunteers in relation to their role within the Corporation; or
- is conducted at any of the Corporation's sites; or
- is conducted with any hospital resources; or
- is being performed as part of the Corporation's training program; or
- the name of the Corporation will be used as part of an individual's credentials for any type of publication, presentation or abstract.

The Corporation retains the authority to reject any REB approved research. A decision made by the REB to reject research may not be overridden by the Corporation.

The Corporation will have in place a policy for granting the use of an external REB for the ethical review of human participants research conducted within or under the auspices of the Corporation, and similarly for permitting the use of the Corporation's REB for the ethical review of human participants research conducted within or under the auspices of an external organization. This policy will establish a standard process to determine when an external REB will be used in place of the Corporation's REB, and when the Corporation's REB will be used by external organizations. All authorization for delegation of REB review and oversight must be granted by the Board or Board's delegate.

As a Toronto Academic Health Science Network Associate Member, THP is required to comply with the requirements under the afflation agreement. Under this agreement, THP has a commitment to ensure its research policies: (i) support the highest standards of ethical conduct in every aspect of research; (ii) align with and/or (iii) complement those of the University of Toronto.

CATEGORY: **PROGRAM QUALITY AND EFFECTIVENESS**

POLICY #: **III-9**

SUBJECT: **RESEARCH ETHICS BOARD APPEALS**

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1. PURPOSE AND APPLICATION

Purpose: This policy sets out the components of and requirements and procedure for appealing a Research Ethics Board (REB) decision.

Application: All employees, privileged staff, volunteers, students/learners, independent and external contract workers, and all individuals who engage in research conducted within or under the auspices of the organization are bound by this Policy. For the purposes of this Policy, everyone included in the scope of this Policy will be referred to as 'Individuals'.

2. BACKGROUND

As required by the Tri-Council Policy Statement 2 (TCPS2) and Board Policy III-8 Research, where a researcher:

1. does not receive ethics approval by the REB, or

2. receives approval conditional on revisions that they find compromise the feasibility or integrity of the proposed research,

the researcher will be entitled to reconsideration by the REB. If the REB reconsideration efforts are not successful and the REB has refused ethics approval of the research, the researcher may appeal the REB decision through an established appeal mechanism.

The appeal process is not a substitute for the REB and researcher working closely together to ensure high-quality ethical research, nor is it a forum to merely seek a second opinion.

The researcher and REB should make every effort to resolve disagreements they may have through deliberation, consultation and advice.

This policy sets out the components and requirements of the REB appeal mechanism at Trillium Health Partners.

3. POLICY

3.1 Reconsideration by the REB

3.1.1 Before a request for appeal can be considered by the REB Appeal Board, the researcher must first attempt to resolve the matter through a formal reconsideration request to the REB.

3.1.2 Researchers have the right to request, and the REB has an obligation to provide, prompt reconsideration of decisions affecting a research project.

3.1.3 In order to facilitate reconsideration by the REB the researcher must:

(i) justify the grounds on which they request reconsideration by the REB, and

(ii) indicate any alleged breaches to the established research ethics review process, or any elements of the REB decision that are not supported by the TCPS2.

3.1.4 The REB shall review a reconsideration request at their next convened full board meeting, and shall communicate their decision in writing within 2 weeks of reaching that decision.

3.1.5 If a disagreement between the researcher and the REB cannot be resolved through the reconsideration process, the researcher shall have the option of appealing the REB decision(s) through the established appeal mechanism.

3.2 Appeal of REB Decision

3.2.1 All requests for appeal of the REB's decision must meet the following Eligibility Criteria for Appeal:

(i) The researcher and the REB must have fully exhausted the reconsideration process as described above and the researcher should document the demonstrated effort to resolve the matter through the REB's existing reconsideration processes (consultations, ad hoc meetings, ongoing correspondence and communication).

(ii) The REB must have issued a final decision before the researcher initiates an appeal.

(iii) The researcher must justify the grounds on which they are requesting an appeal.

(iv) The researcher must indicate any breaches of the research ethics review process or any elements of the REB decision that are not supported by the TCPS2 (i.e. jurisdictional and or procedural breaches).

(v) The researcher must submit written documentation that confirms criteria (i) through (iv) have been met to the Research Office within 60 days of completion of the reconsideration process with the REB.

3.2.2 The Appeal Board

The Appeal Board shall function impartially, provide a fair hearing to those involved, and provide reasoned and appropriately documented opinions and decisions. Both the researcher and a representative of the REB shall be granted the opportunity to address the Appeal Board, but neither shall be present when the Appeal Board deliberates and makes a decision. Appeal Board decisions on behalf of the organization shall be final, and will be communicated in writing (in print or by electronic means) to researchers and to the REB whose decision was appealed.

3.2.3 Appeal Board Constitution

Appeal Board membership shall reflect the range of expertise, membership and knowledge similar to that of the organization's REB and will be formed on an ad hoc basis. The organization will establish and maintain a listing of potential candidates for consideration in establishing the Ad Hoc Appeal Board. Potential candidates will be assessed by the Research Office in relation to their ability to partake in the appeal process for the appeal submitted, and selected based on this assessment. The assessment and selection process will take into consideration individuals:

- potential, perceived or actual conflict of interest in the matter, and
- expertise that can be applied in review of the necessary documentation.

Following the membership assessment process the Research Office will provide the Board of Directors with a listing of potential candidates that:

- are free from potential, perceived or actual conflict of interest in the matter, and
- collectively reflect the minimum REB membership criteria.

The Board of Directors will establish the Ad Hoc Appeal Board from the listing of eligible potential candidates provided by the Research Office.

3.2.4. Appeal Board Authority

The Appeal Board shall function impartially, provide a fair hearing to those involved, and provide reasoned and appropriately documented opinions and decisions.

The Appeal Board will review the material submitted by the researcher and REB in relation to the matter being appealed. The Appeal Board will decide, in its sole and absolute discretion, whether the matter is eligible to be reviewed and resolved through the appeals mechanism.

If the request for appeal is deemed eligible by the Appeal Board, the Appeal Board will convene to discuss, deliberate and vote on the matter.

The Appeal Board shall have the authority to review negative decisions made by the REB. In so doing, it may approve, reject or request modifications to the research proposal. Its decision on behalf of the organization shall be final.

If the request for appeal is denied by the Appeal Board, the Appeal Board must communicate their findings to both the researcher and REB and its decision on behalf of the organization shall be final.

4. PROCEDURE

4.1 Within 60 days following the completion of the REB Reconsideration process, the researcher must inform the Research Office of their request to appeal the REB decision and submit the following documentation:

(i) Documentation demonstrating the efforts to resolve the matter through the REB's existing reconsideration processes (consultations, ad hoc meetings, ongoing correspondence and communication);
(ii) A copy of the REB's final decision letter; and
(iii) A document justifying the grounds on which the appeal is being requested indicating any breaches of the research ethics review process or any elements of the REB decision that are not supported by the TCPS2.

4.2 The Research Office will notify the REB of the request for appeal and request information from the REB in relation to the decision(s) being appealed.

4.3 The REB will provide the Research Office with copies of all correspondence and other supporting documents in relation to the decision(s) being appealed.

4.4 The Research Office will assess candidates for eligibility to serve on the Ad Hoc Appeal Board and forward a listing of eligible candidates to the Board of Directors for consideration.

4.5 The Board of Directors will establish the Ad Hoc Appeal Board from the eligible candidate listing.

4.6 The Appeal Board will assess the request for appeal against the Eligibility Criteria for Appeal.

4.7 If the request for appeal is deemed eligible, the Appeal Board will convene to discuss, deliberate and vote on the matter.

4.8 If the request for appeal is deemed eligible, the Appeal Board will invite the researcher and a representative of the REB to attend the Appeal Board meeting to address any questions in relation to the decision(s) being appealed.

4.9 The Appeal Board will inform the researcher and REB of its decision in writing.

4.10 If the request for appeal is denied, the Appeal Board will inform the researcher and REB of its decision in writing.

Part IV:

Financial and Organizational Viability

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-1**

SUBJECT: **FINANCIAL OBJECTIVES, PLANNING AND PERFORMANCE**

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1. PURPOSE AND APPLICATION

The purpose of the Financial Objectives, Financial Planning and Performance Policy is to provide further guidance and direction on the development and managing the Hospital's annual Operating and Capital budgets.

2. GUIDING PRINCIPLES

Per the Strategic Planning Policy, the Hospital's Annual Operating Plan will ensure the advancement of the strategic plan by addressing annual goals and objectives which have been set by the CEO and approved by the Board.

All employees, professional staff members, contractors, students, board members and volunteers act in a fiscally responsible manner, fulfilling their responsibilities for stewardship of the resources entrusted to the Corporation, and appropriately exercising the authority delegated to them.

3. POLICY

3.1 Financial stewardship for the Hospital will reflect:

- Financial resources are allocated annually according to the strategic priorities of the Hospital.
- The Hospital's departments and units are responsible for cost-effective operations of their functional areas, and exploring all opportunities for cost-containment, integration opportunities, savings and revenue-generation recognizing that effective financial management is one aspect of the quality outcomes and evaluation framework.
- That the Hospital will recognize the efforts of teams to generate innovative ideas and reinvest efficiencies into strategic enhancements and the development of new programs and services that fit within the strategic plan.
- Program shifts/enhancements will be supported by metrics analysis and an impact analysis or business case, as appropriate.
- Appropriate analytical support will be provided to assist with development of the impact analyses or business cases and monitoring of the plan.
- The annual operating plan and capital budget including working capital will meet the Hospital's needs as approved by the Board of Directors.

3.2 The Annual Operating Budget will:

a. Contain sufficient information to provide:

i) a reasonable projection of revenues and expenses;
ii) a separation of capital and operational items;
iii) a cash flow analysis;
iv) subsequent audit trails;
v) a borrowing requirements analysis;
vi) disclosure of significant changes in financial position;
vii) disclosure of all material planning assumptions;
viii) material changes to accounting treatment; and
ix) any internally/external restricted equity.

b. Contain Financial Objectives including:

i) a balanced budget at the GAAP reporting line;
ii) a targeted Range of a projected Operating Surplus;
iii) a targeted Working Capital Ratio; and
iv) a targeted $ level of reserves designated as operating and capital contingency.

3.3 The Annual Capital Budget

- Capital Planning will be comprised of establishing multi-year capital plans for equipment, information technology infrastructure, and facility investments with appropriate levels of annual contingency reserves to meet unanticipated investment demands.
- Capital Planning will encompass investments for day to day operations, replenishment, and strategic initiatives.
- Yearly capital equipment budgets will be recommended for Board approval based on prioritized submissions in accordance with the Hospital's Capital Committee mandate and policy.
- The capital budgeting process will be aligned with the requirements of the Ministry's Hospital Annual Planning Submission Guidelines.
- Consideration and approval of capital equipment/projects by the Board outside of the annual planning cycle, may be required based on appropriate information.

3.4 Material Deviations from the Board Approved Budgets

Any Material Deviation of actual expenditures from Board approved priorities and plan will not properly occur without prior Board approval.

Accordingly, the CEO will not, without Board approval:

- direct or approve the expenditure of designated annual revenue for other than its intended purpose;

- direct or approve the reallocation of the approved operating budget to the approved capital budget or vice-versa;
- direct or approve the expenditure of more funds than have been budgeted, or expend more funds than have been received or reasonably forecast to be received;
- direct or approve the accumulation of debt for operational requirements in an amount greater than provided within the approved working capital plan;
- direct or approve the cash position falling, at any time, below the amount needed to settle payroll and all other obligations in a timely manner, in accordance with generally accepted good business practices or the agreed terms inherent with the obligation; and
- knowingly allow any payments or filings to be overdue or inaccurately filed.

3.5 Monitoring of Financial Performance

- At a minimum, on a quarterly basis, the Board, with the assistance of the Finance and Audit Committee, will conduct a thorough assessment of the Corporation's financial performance employing a range of indicators.

- Subject to the relevant basis of accounting, financial statements will be prepared in conformance with the appropriate standards and will be presented to the Board and Finance and Audit Committee for review at each meeting.

  The statements will include performance indicators relevant to:

  - financial position;
  - operations;
  - cash flows; and
  - covenants.

- If the Board monitoring and assessment of these indicators identifies problems, the CEO will be directed to devise and implement a plan to correct them. Such plans must be submitted to and approved by the Finance and Audit Committee.

4. ROLES

4.1 The Board will ensure:

- The safeguarding of the Corporation's assets and the prudent use of its resources.
- That the Corporation is operated and managed in an efficient and effective manner according to best business and financial practices.
- That it operates within approved policies, its known and approved annual funding, its Annual Operating & Capital Plans, and its Hospital Service Accountability Agreement with the Ministry.

- That the Finance and Audit Committee, with the CEO, annually develops key financial objectives for Board approval and will monitor performance against these objectives.
- They review and approve each fiscal year an annual operating and capital budget which in turn will become the basis for the Hospital Annual Planning Submission (HAPS) and the Hospital Service Accountability Agreement (HSAA) to the Ministry/LHIN. The HSAA will be approved by the Board and signed by the Chair and the CEO, or other authorized signing officers on behalf of the Corporation by a date in compliance with its requirements.

4.2 The CEO will:

- Ensure that appropriate and effective administrative policies and procedures exist to manage operating expenses within the annual operating and capital budgets, and that these policies and procedures are monitored for compliance and reviewed annually by the Finance and Audit Committee.
- Be accountable to the Board for ensuring that key financial objectives are achieved, that the fiscal position of the Corporation is not placed at risk, and that adequate internal controls and processes are in place, monitored for compliance, and regularly reviewed by the Finance and Audit Committee as appropriate.
- Ensure that the Hospital Annual Planning Submission and operating plan aligned with the Board's established priorities.
- Will establish guidelines for the definition of capital equipment and will annually review these guidelines and ensure that a process is in place to establish multi-year capital plans for both equipment, information technology, and facility investments and ensure an annual capital project/plan and budget be developed, which will comprise part of the annual operating plan approved by the Board.

4.3 The Finance and Audit Committee will:

- Review and approve the Financial Planning Framework for hospital operations, including establishing the time frame for planning; broad service distribution and service targets, desired operating bottom-line; Ministry revenue assumptions; projected service demand growth, capital financing direction; and desired cash flow position.
- Review and approve the detailed budget assumptions and rationale including performance indicators required by the Ministry of Health and Long Term Care and/or LHIN.
- Ensure input from Fiscal Advisory Committee has been received and reviewed on the Hospital's draft Annual Planning Submission, draft annual operating and capital budgets before these documents are presented to the Board for approval.
- Review and recommend for Board consideration, the final operating plan and capital budget on a timely basis, ensuring broad planning parameters and detailed budget assumptions have been utilized.
- Regularly monitor actual performance against the approved operating plan to ensure management complies with the operating plan and resources are being appropriately reported.

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-3**

SUBJECT: **ASSET PROTECTION**

The CEO is accountable to the Board to ensure that assets are reasonably protected, adequately maintained and not placed at unnecessary risk. The CEO will ensure that appropriate administrative policies and procedures are in place and that these policies and procedures are monitored for compliance and reviewed annually by the Finance and Audit Committee.

The CEO will ensure that:

i) reasonable insurance against fire, theft and casualty losses, with an appropriate deductible, is maintained;
ii) there is appropriate property, boiler and machinery insurance coverage for all assets owned by the Corporation, which may be subject to replacement or repair as a result of theft or casualty loss;
iii) there is an asset registry;
iv) there is a program to ensure that plant, equipment and systems are well maintained, in compliance with legal requirements, and are not subjected to improper wear and tear, and that there is a proactive strategy in place to replace and renew equipment as it ages, subject to the Board of Directors approval of the working capital plan;
v) adequate liability insurance coverage is maintained for the Corporation, Directors and officers in order that they will be indemnified and saved harmless while engaged in activities on behalf of the Corporation;
vi) the Corporation insures to an appropriate extent against losses due to errors and omissions on the part of Directors, officers or employees;
vii) the Corporation, its Directors, officers and employees are not unnecessarily exposed to liability claims;
viii) there are appropriate and adequate financial internal controls for the receipt, disbursement, and processing of funds and that these controls are reviewed annually; Management will report any issues to the Finance and Audit Committee;
ix) financial reporting is consistent with Canadian Generally Accepted Accounting Principles;
x) unbonded/uninsured personnel do not have access to material amounts of funds;
xi) the Corporation is not knowingly endangered with regard to its public image or credibility; and
xii) only personnel approved within the Signing Authority policy will access funds as appropriate.

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-4**

SUBJECT: **BOARD DELEGATION OF SIGNING AUTHORITY**

1.0 PURPOSE AND APPLICATION

The purpose of the Board of Directors (**Board**) Delegation of Signing Authority is to:

- designate the authority levels for the President and Chief Executive Officer (**CEO**) and Board of Directors with respect to the purchases of goods, non-consulting services, investments and construction within the Hospital Annual Planning Submission (**HAPS**), the Hospital Service Accountability Agreement (**H-SAA**) and other like documents.

- direct the Corporation in conjunction with:

  - Administrative policies.
  - Internal budgeting policies that have been developed as part of the Hospital's system of internal control. Those policies provide direction to Hospital leaders for developing and managing the Hospital's budgets.

2.0 POLICY

2.1 President and Chief Executive Officer (CEO) Board Delegated Authority

- The CEO is accountable to the Board to ensure that the Corporation has in place policies and rules related to the Corporation's operational Signing Authority.

- The CEO is accountable to the Board for ensuring that adequate internal controls and processes are in place.

- The CEO is accountable to the Board for ensuring that compliance to Broader Public Sector Accountability Act (**BPSAA**) regarding required signing authorization is maintained.

- The Board of Directors authorizes the CEO to approve expenditures, purchase orders, invoices, contracts, investment decisions and related instructions, commitments etc. under $10 million.

- After Board approval has been obtained, the CEO has approval to authorize tender requests, contracts, contract amendments, change-directives, change-orders, progress draws, purchase orders and invoices

that remain within the budget estimates. The CEO may designate such approval which will be set forth in relevant administrative policies.

The CEO or his/her delegate, in conjunction with Chief Financial Officer **(CFO)** approval, is authorized to approve an additional major capital expenditure (i.e. medical equipment, Information Technology, Renovation Projects) of up to $5 million provided that the annual Board approved capital budget has sufficient contingency dollars to fund this expenditure.

- At the discretion of the CEO, the CEO, with notification to the Board, can delegate signing authority to an "**Acting CEO**" with the exception of sole sourced or non-competitive consulting services. Should the CEO not have an opportunity to select the "Acting CEO" signing authority will be delegated to the Chief Operating Officer (COO).

2.2 Designated Corporate Signing Officers

- The Board identifies the designated Signing Officers of the corporation and their authority.

- The Board designates the following individuals as the designated signing officers of the Corporation:

  - Chair, Board of Directors;
  - Vice Chair, Board of Directors;
  - Treasurer, Board of Directors;
  - President and CEO;
  - Chief Financial Officer;
  - Chief Operating Officer;
  - Senior Executive Staff members so designated by the CEO and set forth in relevant administrative policies.

- Any two of the above designated signing officers must sign cheques, bills of exchange or other negotiable instruments and orders for payment required for the day-to-day operation of the corporation, which are specifically included in the budget approved by the Board, or otherwise approved by the Board. This authority may not be delegated. One signatory must be a signing officer listed above who is not an employee of the Corporation, in the case of cheques, bills of exchange or other negotiable instruments in excess of $5 million. An electronic signature may be used to automate the cheque signing process, subject to appropriate safeguards.

  In addition to the above, the Board may from time to time by resolution direct the manner in which and the person or persons by whom any particular instrument or class of instruments or document may or shall be signed. Any signing officer may affix the seal of the Corporation to any instrument or document and may certify a copy of any instrument, resolution, by-law or other document of the corporation to be a true copy.

2.3 Transactions Requiring Board Authorization

Prior Board approval is required for any of the following:

1. Taking or instituting proceedings for the winding-up, reorganization or dissolution of the Corporation;

2. The enactment, ratification or amendment of any by-laws of the Corporation;

3. The sale, lease, exchange or other disposition of all or substantially all of the assets or undertakings of the Corporation;

4. The mortgaging, pledging, charging or otherwise encumbering any of the assets of the Corporation;

5. All real estate purchases and sales;

6. All related budgets for new construction and building capital renovation costs prior to any spending;

7. Establishment of and any changes to:

    i. the $ level of the Hospital's Operating Line(s) of Credit;
    ii. Financing contracts (loans, debentures and other debt instruments);
    iii. Hospital Directed investments (as per THP Investment Policy);
    iv. Trust accounts;

8. Contracts involving the procurement of goods & services in accordance with legislated BPSAA requirements and the Hospital's Signing Authority policy, namely:

    - Sole sourced consulting services greater than $5M in total value;
    - Non-competitive procurements that must be approved at a one level higher than a competitive procurement as outlined in the Hospital's Signing authority policy;
    - Any commitment, contract or transaction where a legitimate external third party requests Board approval and/or where the CEO has declared a potential, perceived, or actual conflict of interest that must be approved at a higher level.

2.4 Required Policy Approval

Pursuant to the BPSAA, the Board must approve the Hospital's approval authority schedule (**AAS**) for procurement of goods, non-consulting services, and consulting services that are allowed for procurements at different dollar thresholds. As such, the attached appendices from the Hospital's AAS (i.e. Signing Authority policy) dealing with procurements is attached to this Policy (see attached Appendices A, B, and H).

To support the Hospital's response in dealing with exceptional circumstances (such as a pandemic), the Board grants the CEO authority to establish an alternative and separate approved authority schedule (AAS) for procurements directly related to the exceptional circumstances encompassing both capital and operating items (e.g. consumables, minor equipment, services). This temporary alternative AAS will require formal Board approval within 45 days from its effective date and will remain in place for the duration of the exceptional circumstances.
All other non-related procurements will continue to follow the normal authorizations as noted outlined in Appendices A, B, and H.

3.0 EVALUATION

The Board Finance and Audit Committee will review this policy as needed and in parallel with the Signing Authority policy.

4.0 RELATED POLICIES AND PROCEDURES

- IV-5 Borrowing - POL INT
- Signing Authority - POL INT

5.0 APPROVED BY

2022/03/21 Finance and Audit Committee
2022/03/31 Board of Directors

6.0 SUPERCEDES

2021/05/13 IV-4 Board Delegation of Signing Authority (Document ID #62972)

7.0 APPENDICES

- Signing Authority Policy - Appendix A: Operating Expenditures (Non Capital)
- Signing Authority Policy - Appendix B: Capital and Other Capital Related Transactions
- Signing Authority Policy - Appendix H: Exempted Transactions

Signing Authority Policy - Appendix A: Operating Expenditures (Non Capital)

Authorization for Commitment: (Commitment may be documented via a contract, purchase order, non PO vendor invoice, etc.)	**Documentation** **Note: Purchase order (PO) issued prior to purchase**	**Required Minimum Authorization** (2 signatures required – Requestor & Approver) (VP- Vice President; CFO - Chief Financial Officer; SVP - Senior Vice President; EVP – Executive Vice President; CEO - Chief Executive Officer)	
Goods & Non Consulting Services - Procured Competitively Note 1: Authority at the discretion of the Manager; excludes catering, business expenses incurred directly for the benefit of the requisitioner (e.g. meals, travel, conferences, books), office supplies sourced from Grand and Toy, and IT equipment (phones, tablets, accessories, etc.)	PO based	Less than $1,000	Authorized Requisitioner (Note 1)
	PO based	Less than $50,000	Manager
	PO based	Less than $100,000	Director
	PO based	Less than $500,000	VP
	PO based	Less than $2,500,000	SVP and CFO
	PO based	Less than $5,000,000	EVP and CFO
	PO based	Less than $10,000,000	CEO and CFO
	PO based	Greater than $10,000,000	CEO and Board
	Non PO	Less than $10,000	Manager
	Non PO	Less than $100,000	Manager and Director
	Non PO	Less than $2,500,000	VP/SVP and CFO
	Non PO	Less than $5,000,000	EVP and CFO
	Non PO	Less than $10,000,000	CEO and CFO
	Non PO	Greater than $10,000,000	CEO and Board
Goods & Non Consulting Services - Single/Sole Sourced (Non-competitive)	All Single/Sole Sourced procurements must be PO based.	Less than $50,000	Director
		Less than $100,000	VP
		Less than $500,000	SVP and CFO
		Less than $1,000,000	EVP and CFO
		Less than $5,000,000	CEO and CFO
		Greater than $5,000,000	CEO and Board
		Only for amounts greater than $25,000	Concurrence by Hospital's Shared Services Organization (e.g. SSW) Strategic Sourcing VP and THP Finance Director/SSW Lead
Consulting Services*- Procured Competitively * See Consulting Policy for definition/illustrative examples	All consulting services must be PO based.	Less than $250,000	VP/SVP
		Less than $1,000,000	SVP and CFO
		Less than $5,000,000	EVP and CFO
		Greater than $5,000,000	CEO and Board (Chair / Vice Chair)

Authorization for Commitment: (Commitment may be documented via a contract, purchase order, non PO vendor invoice, etc.)	**Documentation** **Note: Purchase order (PO) issued prior to purchase**	**Required Minimum Authorization** (2 signatures required – Requestor & Approver) (VP- Vice President; CFO - Chief Financial Officer; SVP - Senior Vice President; EVP – Executive Vice President; CEO - Chief Executive Officer)	
Consulting Services*- Single/Sole Sourced (Non competitive) * See Consulting Policy - All Consulting services must be competitive with very limited number of exceptions	All consulting single/sole sourced procurements must be PO based.	Less than $1,000,000	VP/SVP/EVP, CFO, and CEO* * Cannot be delegated.
		Greater than $1,000,000	CEO* and Board (Chair / Vice Chair) * Cannot be delegated
		All Amounts	Concurrence by Hospital's Shared Services Organization (e.g. SSW) Strategic Sourcing VP and THP Finance Director/SSW Lead
Contract Amendments / Change Orders	Required signatures for Contract amendments is according to the appropriate signing level required for the estimated $ impact of the contract amendment. However should the contract amendment result in: • the incremental value pushing the total agreement cost into a new authority level or • scope of services/products or nature of the contractual relationship change dramatically or • there is a significant operating/legal/reputation risk(s), perceived conflict of interest, potentially being introduced etc. or • there is an external or legislated requirement or perceived need to have the most senior authorization level to be aware of the contract change. Then, the "total revised" value of the contract (original plus amendment) would need to be re-approved according to the Authorization schedule.		
Establishment, Requisitioning and/or Electronic Replenishment of Inventory (non pharmaceuticals) * PAR - the fixed quantity of an item that must be kept on hand to support daily operations.	Establishment of Predetermined PAR* Levels (new products, product conversions)		Applicable Manager
	Bi-Annual Review of Par Levels		Applicable Manager & Director
	Up to pre-determined PAR levels		Authorized Requisitioners and/or Hospital's Shared Service Organization (e.g. SSW) Procurement buyers
	For items exceeding PAR Levels with expected spend in the year: Less than $25,000		Applicable Manager
	For items exceeding PAR Levels with expended spend in the year: Greater than $25,000		Applicable Director

Authorization for Commitment: (Commitment may be documented via a contract, purchase order, non PO vendor invoice, etc.)	**Documentation** **Note: Purchase order (PO) issued prior to purchase**	**Required Minimum Authorization** (2 signatures required – Requestor & Approver) (VP- Vice President; CFO - Chief Financial Officer; SVP - Senior Vice President; EVP – Executive Vice President; CEO - Chief Executive Officer)
Pharmaceuticals (Drugs)* (PO line item based) *Effective post OneTHP Go-Live	Less than $5,000	Pharmacy Purchasing Technician
	Less than $100,000	Pharmacy Manager
	Less than $250,000	Pharmacy Director
	Greater than $250,000	Applicable VP/SVP
Unbudgeted Operating Expenditures (e.g. due to unplanned new initiatives/programs, etc.) : Approval must be obtained prior to expenditure being incurred. Not planned for within the signed and approved HAPS/H-SAA/ LSAA/ MSAA and/or within your Department budget. Any conversion of supplies budget to salaries or vice versa, are considered themselves to be "unbudgeted" items and must be approved in advance by the CFO.	All unbudgeted operating expenditures exceeding $5 million	Board of Directors and CEO
	All unbudgeted operating expenditures exceeding $2 million	EVP and CFO
	All unbudgeted operating expenditures exceeding $250,000	VP/SVP of the respective portfolio and CFO.
	All unbudgeted operating expenditures between $100,000 and $250,000	VP of the respective portfolio with communication to Director, Financial Strategy.

Signing Authority Policy - Appendix B: Capital and Other Capital Related Transactions

Authorization of:	Required Minimum Authorization
Capital Equipment* : • Non Redevelopment • Redevelopment • I/T * See THP Capitalization Policy Note: Items approved during the annual budget cycle are issued a CE# (capital equipment) tracking number. All other items approved during the year are issued a CC# (capital contingency) tracking number or a CF# (externally funded capital) tracking number.	Annual Funding available is approved by Board of Directors based on recommendation by Finance and Audit Committee. Within this Board approved available funding, the Hospital Equipment Sub Committee compiles an itemized listing of specific capital acquisitions (non-vendor specific) and obtains CFO and CEO approval on this detailed listing. Each specific approved capital acquisition is assigned a CE# tracking number (non-vendor specific) by Hospital Finance. On the Associated Contract Summary Memo, Contract and Purchase Order (now vendor specific) approvals are required for: i) Capital Equipment • Respective Hospital Management according to Appendix A and; • Finance Manager, Capital • Hospital's Shared Services Organization (e.g. SSW) Strategic Sourcing VP and THP Finance Director/SSW Lead (if sole sourced) ii) Redevelopment Equipment • Respective Hospital Management according to Appendix A, • Finance Manager, Capital • VP, Capital Planning & Redevelopment • Hospital's Shared Services Organization (e.g. SSW) Strategic Sourcing VP and THP Finance Director/SSW Lead (if sole sourced)
Construction, Redevelopment and Renovation Projects*; * See THP Capitalization Policy Note: Approval required whether approved during the annual budget cycle or during the year from a capital contingency reserve.	Annual Funding available is approved by Board of Directors based on recommendation by Finance and Audit Committee. Within this Board approved available funding, the Hospital Redevelopment Sub Committee compiles an itemized listing of specific capital construction/redevelopment /renovations projects (non-vendor specific) and obtains CFO and CEO approval on this detailed listing. Any required approval of MOHLTC determined, communicated and obtained by CFO and VP, Capital Planning & Redevelopment. (May require vendor specific information) On the Associated Contract Summary Memo, Contract (SSW/CCDC) and Purchase Order/Statement of Work (now vendor specific documentation) approvals are required as: • Director, Capital Development and/or VP, Capital Planning & Redevelopment, • Finance Manager, Capital • CFO • Hospital's Shared Services Organization (e.g. SSW) Strategic Sourcing VP and THP Finance Director/SSW Lead (if sole sourced)

Authorization of:	Required Minimum Authorization
Invoice/Progress Certificate, Change Orders/Directives & Cash Allowance Expenditure, etc.	Regardless of whether an item is part of an approved project/cost of construction or not, • Any invoice/progress certificate and cash allowance which involves a payment to a vendor, • Any change order and/or change directive (regardless of direct monetary value), • Any expenditure of a cash allowance, • Any purchase requisition/purchase order for approved furnishings, equipment or any other project expenses (e.g. moving services, consultants, etc.) Will require appropriate authorization in accordance with Appendix A $ levels. Namely, Director, Capital Development and/or VP Capital Planning and Redevelopment.
Information Technology Projects Note: These I/T projects typically are comprised of capitalized salaries & wages (both internal & external). Note: Approval required whether approved during the annual budget cycle or during the year from a capital contingency reserve.	Annual Funding available is approved by Board of Directors based on recommendation by Finance and Audit Committee. Within this Board approved available funding, the Hospital I/T Sub Committee compiles an itemized listing of specific capital construction/redevelopment /renovations projects (non-vendor specific) and obtains Chief Information Officer (CIO), CFO and CEO approval on this detailed listing. Any required approval of MOHLTC determined, communicated and obtained by CFO and CIO and/or Applicable I/T Director. (May require vendor specific information) On the Associated Contract Summary Memo, Contract and Purchase Order (now vendor specific documentation) approved by: • Respective I/T Program Management according to Appendix A and • Finance Manager, Capital • CFO and • CIO • Hospital's Shared Services Organization (e.g. SSW) Strategic Sourcing VP and THP Finance Director/SSW Lead (if sole sourced)

Unbudgeted Capital Expenditures (e.g. Required approval for budget variances):				
Contingency Requests:	**Within Budget Envelope ***			**Envelope Over Budget**
	up to $500K *	**> $500K ***		
PSC Contingency Requests	PSC, CFO	PSC, CFO, EVP		CEO & Board
General Contingency Requests	Program VP/SVP, Subcommittee Chair, CFO	Program VP/SVP, Subcommittee Chair, CFO, EVP		CEO & Board
*** As long as forecasted annual spend is within budget envelope and per Board approved budget.**				
Cost Variances on Approved CE:	**Within Budget Envelope ***			**Envelope Over Budget**
	up to $50K *	**$50K to $100K ***	**Over $100K ***	
Equipment	Subcommittee Chair, Finance Manager	Subcommittee Chair, Finance Director	Subcommittee Chair, CFO	CEO & Board
I/T	Subcommittee Chair, Finance Manager	Subcommittee Chair, Finance Director	Subcommittee Chair, CFO	CEO & Board
Redevelopment	Subcommittee Chair, Finance Manager	Subcommittee Chair, Finance Director	Subcommittee Chair, CFO	CEO & Board
Phase 3	Facilities Director, Finance Manager	Facilities Director, Finance Director	Facilities Director, CFO	CEO & Board
*** As long as forecasted annual spend is within budget envelope and per Board approved budget.**				
Unplanned Funded Capital (Foundation, CCO, MoH, Other)				
	up to $50K	**$50K to $100K**	**Over $100K**	
Equipment/IT/ Redevelopment	Subcommittee Chair, Foundation COO or Other Funding Verification, Finance Manager	Subcommittee Chair, Foundation COO or Other Funding Verification, Finance Director	Subcommittee Chair, Foundation COO or Other Funding Verification, CFO	

Signing Authority Policy - Appendix H: Exempted Transactions

A) Specific Transaction Exemptions - the following monthly transactions/invoices may be approved by the applicable Director (subject to be supported by an appropriately approved contract or agreement for the applicable period or yearly budget schedule):

Vendor	Service	Estimated Monthly Amount	Required Hospital Director Authorization
Cardinal	JIT Inventory Service	Approximates $1.0M	Director, Patient Support Services
Extendicare	McCall Management Services	Approximates $500k	Director, Primary Care, Rehab, CCC, Palliative Care & Seniors' Services
SSW	Procurement Services	Approximates $500k	Director, Finance
Blackstone / HealthPRO/ City of Toronto/Mississauga/ Hydro	Utilities	Approximates than $500k	Director, Facilities
K-BRO	Linen services	Approximates $500k	Director, Patient Support Services
Executive Corporate Credit Cards and Personal Reimbursements:	All VPs/SVPs/EVPs	All amounts pertaining to Miscellaneous Business expenses	CFO
		All amounts pertaining to: • BPS disclosed expenses (travel, meals, Hospitality) AND/OR • Reimbursements under specific Employment Contract	CEO
	CFO	All amounts	CEO
	CEO	All amounts	CFO and Board
HIROC	Insurance Premium Annual Invoice	All policies and amounts	General Counsel /Chief Compliance Officer, CFO, CEO and Board Chair
Employer Benefits Provider (e.g. Sun Life)	Premium Annual Invoice	All amounts	CHRO, EVP-CAO, CFO, CEO and Board Chair
Taxi Services	Taxi Invoices (supported by detailed taxi chits)	All amounts	Manager, Finance (Hospital Departments must comply with Taxi policy)
Paladin	Security Services	Compensation Related amounts only	Manager, Security & Parking Services (similar to internal timesheets)

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-5**

SUBJECT: **BORROWING**

1.0 PURPOSE AND APPLICATION

The purpose of the Board of Directors Borrowing Policy is to:

- designate the authority levels required, the allowable options, and purposes for the Hospital to borrow from external organizations.

2.0 POLICY

Required Approvals

In accordance with the Corporate By-law (Section 11.6), designated signing officers of the Corporation, on behalf of the organization, may from time to time borrow money from a bank. Approval from the Board, on recommendation from the Finance and Audit Committee, is required for the Corporation to borrow money.

Allowable Options and Purposes

Subject to the above pre-approvals being obtained, the Corporation may, from time to time:

i) borrow money on the credit of the Corporation;
ii) issue, sell or pledge securities (including bonds, debentures, notes or other similar obligations, secured or unsecured) of the Corporation; or
iii) charge, mortgage, hypothecate or pledge all or any of the real or personal property of the Corporation, including book debts and unpaid calls, rights and powers, franchises and undertakings, to secure any securities or for any money borrowed, or other debt, or any other obligation or liability of the Corporation.

The Corporation will only borrow money for the following purposes:

i) to secure bridge financing for working capital requirements;
ii) to secure operating financing (line of credit) to fund normal operating requirements arising from timing differences between cash inflows and expenditures;
iii) to secure capital project financing to support a capital project;
iv) to lease or finance capital equipment that is part of the Corporation's Board-approved capital project plan;
v) to lease or finance land or property consistent with the Corporation's master plan; or
vi) to support an expenditure justified by a business case with an acceptable financial return.

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-6**

SUBJECT: **INVESTMENT**

Revised May 2023

Statement of Investment Policy (IP) and Procedures

Prepared For:

Trillium Health Partners
(Hereinafter referred to as the "Hospital")

To Be Effective:
June 12, 2023

This statement of Investment Policies and Procedures (hereinafter referred to as the "Statement") describes the governance of the Hospital's investible funds.

Section 1 - Purpose of the Statement of Investment Policy (IP)

The basic goal of this IP Statement is to assist The Finance and Audit Committee of the Board of The basic goal of this IP is to assist The Finance and Audit Committee of the Board of Directors, in ensuring that the assets of the Hospital, together with any subsequent contributions and income, shall be invested in a prudent and effective manner.

This IP provides a set of written guidelines for managing the investments of the Hospital. It also provides detailed instructions and parameters for the Investment Manager(s) to follow with respect to Hospital investments. The IP will be reviewed annually by the Finance and Audit committee to ensure that it continues to reflect the Hospital's requirements.

The general objectives of the IP are to:

- establish the investment objectives, policies, and guidelines relating to any investment owned or controlled by the Hospital;
- establish the different investment groups (currently: Capital Planning Fund, Future Development Fund, and Reserve Fund) (the "**Funds**");
- identify the criteria against which the investment performance of the Funds will be measured;
- serve as a review document to guide the ongoing investment management and oversight of the Funds.

The primary purpose of the Funds is to provide resources for the pursuit of the goals and objectives of the Hospital. The prudent and effective management of the Funds has a direct impact on the achievement of these goals and objectives and the Finance and Audit Committee is responsible for ensuring that the Funds are managed in a prudent and effective manner.

Section 2 - Scope

In accordance with the Corporate By-law (Section 11.7), the Board is authorized to make or receive any investments, which the Board in its discretion considers advisable.

The Board may invest:

1. All monies given in trust to the Corporation for the use of the Corporation; and
2. All monies not required for operating expenses.

Section 3 – Allocation of Responsibilities

ack to the Board. The Committee shall:

- Establish the Statement of Investment Policies (IP) and Procedures;
- Ensure that members of the Finance and Audit Committee are in compliance with all Conflict of Interest Provisions where it relates to investments of the Hospital;
- Select one or more Investment Manager(s) to manage the investment of the Fund's assets; and if required, one or more Custodian(s) to hold the Fund's assets. Management of any other assets may be carried out internally by management, and unless specifically requested by the Board is not governed by this Statement;
- Maintain an understanding of any legal and regulatory requirements, and constraints that may apply to the Hospital's investments.
- Be responsible for delegation of any responsibilities not specifically mentioned in this Statement;
- Enter into contracts with the Investment Manager(s) and, if required, Custodian(s) mentioned above on a basis that may be terminable within 30 days;
- It is expected that the Hospital will have some pooled fund investments, which offer lower costs and sufficient diversification but are governed by the general investment policies of each fund as set by the Investment Manager. Any such policies need to be accepted by the Finance & Audit Committee prior to investment.
- The Hospital will regularly monitor all transactions performed by the Custodian and shall have access to direct electronic interchange to perform the monitoring.
- At least once every four years:

- review, amend where necessary, and approve this Statement and record such proceeding and decisions in the minutes of the Finance and Audit Committee. This review will be done having regard to the following:
  - General economic conditions.
  - The possible effect of inflation or deflation.
  - The role that each asset class plays within the Funds and their respective objectives;
  - The expected total return from income and the appreciation of capital;
  - Needs for liquidity, regularity of income and preservation or appreciation of capital;
  - An assets special relationship or special value, if any, to the purpose of the Funds.
- confirm the applicability of the underlying investment category, Debenture Repayment Fund, and review the individual performance objectives in conjunction with the short and long term cash/capital requirements of the Hospital;
- confirm the applicability of any pooled fund investments to ensure suitability to the Funds;
- oversee the performance relative to the performance objectives and make recommendations to the Board as to the selection, engagement or dismissal of an investment manager (the "**Investment Manager(s)**") to manage the Funds;
- meet with representative(s) of the Investment Manager(s) to discuss investment performance and the IP.
- review the performance of the Fund and Investment Manager(s) relative to the total Fund and Investment Manager(s) Performance targets and compliance with the IP.
- confirm ongoing appointment of the Investment Manager(s).

Any changes to the IP and / or Investment Manager(s) requires Board of Directors approval.

- At least semi-annually:
  - review the performance of the Investment Manager(s), and the Funds relative to the total Fund and Investment Manager(s) performance targets and compliance with the IP;

- At least quarterly:
  - review the financial performance of the Funds relative to the total Fund performance targets and compliance with the IP.

The Investment Manager(s) shall be required to:

- Invest the assets of the Funds in accordance with this IP;
- Notify the Hospital in writing of any significant changes in the investment manager's philosophies and policies, personnel or organization and procedures;
- Meet with the Hospital representatives as required and provide required reporting;
- For pooled and mutual funds, the investment manager will ensure custodial services are performed by a reputable third party provider; manage the Funds with the care, diligence and skill that a prudent person skilled as a professional investment manager would use in dealing with Institutional assets; and provide a copy of such pools' policies for review by the Finance & Audit Committee.
- On a quarterly basis,
  - report the financial performance of the Fund(s) against the IP objectives and performance targets as a whole and by asset class whereby:
    - during period(s) where performance is not meeting the objectives, an assessment whether results are outside the range of expected outcomes and if so, the Investment Manager(s) to submit a plan for corrective action and ongoing monitoring.
  - submit a Certificate of Compliance in accordance with this IP

The Custodian(s) shall be required to:

- Fulfill the regular duties required by law of the Custodian in accordance with the Funds;
- Provide management of the Hospital with periodic portfolio reconciliations and performance reports as required of all Fund assets and transactions during the period; and
- Provide other services from time to time as may be mutually agreed with management of the Hospital and/or the Board.

Section 4 - Investment Objectives

The assets of the Funds are to be managed with the primary objective of providing resources for the pursuit of the goals and objectives of the Hospital.

Recognizing the funding coming from the Province of Ontario, the investment objectives of the Hospital are:

1. The preservation and enhancement of capital through adequate diversification of high quality investments;
2. The achievement of the highest investment return that can be obtained with assumption of an appropriate degree of risk;
3. Maintenance of adequate liquidity to ensure availability of funds when needed by the Hospital
4. The exercise of the care, skill, diligence and judgment of a prudent investor;
5. Compliance with the Trustee Act; and
6. The Hospital will not invest in securities of corporations involved in the production, manufacture or sale of tobacco products.

Investment activities are to be undertaken in a manner designed primarily to preserve and enhance capital, and secondarily to optimize investment yield having regard to permissible investments. In all respects; maturity dates of investments will recognize the forecasted cash flow requirements of the Corporation.

Section 5 – Investment Groups that Make-up the Fund

The Fund is comprised of one category. The category has a distinct purpose managed for the Hospital.

Debenture Repayment Fund: The Primary Purpose of this “Fund” is to establish a time limited, special purpose investment reserve fund to ensure the repayment of the 40 year, $ 200M, 2018 Unsecured Series A Debenture principal at maturity on December 20, 2058.

Table 1:

<table>
<tr><th></th><th>Debenture Repayment Fund</th></tr>
<tr><td>Principles</td><td>The following strategic principles guided the approach to the Debenture Repayment.
Hospital to provide source of principal repayment.
Planning for the repayment at maturity in 2058 will commence now (rather than deferring).
Total principal amount to be repaid at maturity (rather than refinancing).
Hospital to manage the investments for the reserve.
The strategy should have flexibility such that the Board could direct that all or part of the investments be temporarily “loaned” out to fund other future emergent capital needs with provisions to ensure that, based on investment performance, THP can ensure repayment of the debenture principal by the end of the 40 year term, on December 20, 2058.</td></tr>
<tr><td>Cash Requirements</td><td>Minimal, only needed if required to temporarily access funds to support THP highest operating and / or capital needs without compromising the Primary Purpose</td></tr>
<tr><td>Time Horizon</td><td>Long term (>5 years) to terminate by December 20, 2058 (Debenture maturity date)</td></tr>
<tr><td>Liquidity</td><td>Low liquidity requirements</td></tr>
<tr><td>Risk Tolerance*</td><td>Moderate
Target minimal risk in the context of a Balanced Fund portfolio composition with an asset mix of 50% fixed income / 50% equities with +/- 10% to adapt to changing market conditions in order to meet investment objectives.
<table>
<tr><th>Asset Class</th><th>Minimum (%)</th><th>Policy (Target) (%)</th><th>Maximum (%)</th></tr>
<tr><td>Cash & Cash Equivalents</td><td>0</td><td>0</td><td>10</td></tr>
<tr><td>Fixed Income</td><td>0</td><td>50</td><td>0</td></tr>
<tr><td>Total Fixed Income</td><td>40</td><td>50</td><td>60</td></tr>
<tr><td>Canadian Equities</td><td>10</td><td>20</td><td>30</td></tr>
<tr><td>Foreign Equities:</td><td></td><td></td><td></td></tr>
<tr><td>U.S. Large Cap Equities</td><td>8</td><td>18</td><td>28</td></tr>
<tr><td>U.S. Small/ Mid Cap Equities</td><td>0</td><td>0</td><td>6</td></tr>
<tr><td>International Equities</td><td>5</td><td>12</td><td>19</td></tr>
<tr><td>Emerging Markets</td><td>0</td><td>0</td><td>10</td></tr>
<tr><td>Total Equities</td><td>40</td><td>50</td><td>60</td></tr>
</table></td></tr>
</table>

	Debenture Repayment Fund
Portfolio Management Practices	**Portfolio Rebalancing and Tactical Positioning:** by the Investment Manager(s) within the parameters set out in THP's IP which may be achieved through infusion of additional contributions either: **i.** more so in the first half of the time horizon to capture the compounding impact of reaching the Primary Purpose before the target date should Hospital funds be available **and/or** ii. at any time during the Fund's time horizon to capture opportunities during market downturns thereby lowering cost per dollar invested.
	De-risking, if any, is the intended strategy if: i. the Primary Purpose has been reached before maturity, **or** ii. prior to maturity in the event such de-risking will enable THP to achieve the Primary Purpose by the Debenture maturity date.
	Withdrawals: Withdrawals from the Fund, to be reviewed on a case by case basis, require Board of Directors approval and may be accessed: i. on surplus monies exceeding the Primary Purpose $ 200M target once reached to support the next highest priority needs of the Hospital whether for operating or capital purposes **or** ii. if the Primary Purpose of $ 200M target has not been achieved, **only under exceptional circumstances**, if such withdrawals ▪ are required to meet an urgent THP need, whether capital and/or operating **and** ▪ do not impede on the Hospital's ability to meet the Primary Purpose
Tax and Legal	The Hospital is a registered charity.

* *Investments should be structured and managed to provide for the generation of the targeted rate of investment return while assuming only the minimum, necessary amount of risk. Risk will be measured in terms of the downside risk (or risk of loss) of the investment. As appropriate, investments will maintain minimum levels of diversification in order to reduce overall risk, which may include diversification by asset class, industry sector and geography.*

Section 6 – Asset Mix, Performance Evaluation Benchmarks & Return Expectations

Asset Mix:
Asset mix or asset allocation refers to the allocation of funds among the major asset classes, including but not limited to, cash or cash equivalents, fixed income, and domestic (Canadian) and foreign equities. Since the asset mix of a fund tends to determine its risk and return characteristics, control of the fund's asset mix is the Hospital's principal means of defining the Fund's risk and return parameters. Asset classes, allocation targets (i.e. policy weight) and permissible ranges are detailed under **Table 2**.

Performance Benchmarks:
The Benchmarks can be thought of as representing a theoretical passive alternative to active management.

The portfolio Benchmark returns are calculated using the policy weights the noted indices and should be included with the Investment Manager's quarterly reporting. This equation will be used as a basis for comparison to the total return of the entire portfolio. Portfolio return should be calculated on a Time Weighted basis and should include realized and unrealized gains as well as income from all sources. Measurement against performance objectives will normally be assessed over a four-year rolling average period outlined under **Table 2.**

Debenture Repayment Fund:

Due to the long-term nature of these funds and consequent risk/return tolerance, a balanced allocation between equities and bonds is warranted. The various asset classes, benchmarks and fund weightings used for each asset class are as follows:

Table 2:

Asset Class	Benchmark	Minimum (%)	Policy (Target) (%)	Maximum (%)
Cash & Cash Equivalents	FTSE TMX 91-day T-Bill Index	0	0	10
Fixed Income	FTSE TMX Universe Bond Index	0	50	0
Total Fixed Income		***40***	***50***	***60***
Canadian Equities	S&P/TSX Index	10	20	30
Foreign Equities:				
U.S. Large Cap Equities	S&P500 Index (C$)	8	18	28
U.S. Small/ Mid Cap Equities		0	0	6
International Equities	MSCI ACWI (ex-U.S.) (C$)	5	12	19
Emerging Markets		0	0	10
Total Equities		***40***	***50***	***60***

Table 3:

Return Expectations: • **Total Fund and Investment Manager(s) Performance Targets**	**Total Debenture Repayment Fund Performance Target:** The specific financial objective for the Fund is **to achieve a rolling 4-year average period rate of return equal to or greater than 5.2%, net of fees** (or period since inception to date, if less than four years). It is recognized that this objective may not be attained every year because of market fluctuations, but it is anticipated to be attained over the rolling 4-year average period. **Investment Manager(s) Performance Target:** Benchmark +80 basis points (before fees) on a 4-year rolling average period (or period since inception to date, if less than four years)

Investment Manager(s) Review Process:

While the importance of due diligence implemented during the manager selection process cannot be understated, the ongoing review and analysis of money managers is just as important. Accordingly, a thorough review and analysis of the investment manager and performance will be conducted, specifically if:

- Overall compliance with the Investment Policy Statement guidelines is in question;
- A manager performs significantly below the agreed upon benchmark return gross of fees over a four year rolling average;
- Significant short-term loss;
- Perceived negligence.

Major organizational changes also warrant immediate review of the manager, including:

- Change in professionals (research, analysis and partners);
- Account losses in excess of the stipulated risk tolerance constraints;
- Significant growth of new business;
- Change in ownership;
- Perceived negligence.

Investment Manager(s) Servicing Requirements:

- Monthly holdings and transaction report from the Investment Manager(s);
- Quarterly reporting on the performance of the Portfolio including signed Compliance Reporting;
- Semi-annual review on the performance of the Portfolio with the Finance and Audit Committee;
- Responding to ad hoc questions that may arise from time to time.

Section 7 - Security Guidelines

1. Security Guidelines by Asset Class

Security guidelines by asset class are detailed in the Investment Manager(s) Investment Policies (IPs).

Changes to the Investment Manager(s) IP documents will be provided to the Hospital with a 60-day advance notice in writing.

2. **Derivative Instruments**

Investment in select derivative instruments may be used for hedging purposes to facilitate the management of risk or to facilitate an economical substitution for direct investments. These include derivatives that involve currency and interest rate futures and forward contracts only. Derivative instruments will not be used for speculative purposes.

3. Environmental, Social and Governances (ESG) factors

Investment managers are expected to incorporate responsible investment criteria into their investment analytics and decision-making processes giving considerations to environmental, social and governance (ESG) factors. Being a signatory of the United Nations Principles of Responsible Investing and/or members of the Canadian Coalitions of Good Governance or similar organizations

are encouraged. The Hospital wishes to negatively screen investments or industries for tobacco stocks (i.e. those stocks that derive a majority of their sales from tobacco products). The Finance & Audit Committee considers investment in tobacco stocks to be inconsistent with the goals and objectives of the Hospital and accordingly deems such stocks to be prohibited.

4. **Alternative Investments and Other Prohibited Investments**

Alternative investments include long-short equity, market neutral, high yield long/short, short equity funds and multi-strategies or fund of funds investing in funds alternative investments. Any use by Investment Manager(s) of alternative investments is prohibited without the prior written recommendation from the Finance and Audit Committee and approval by the Board of Directors, as noted in Section 3 Allocation of Responsibilities. The Finance and Audit Committee may approve the use of alternative investments subject to a review of the risk control provisions and in accordance with the operating guidelines for the individual manager.

Other prohibited investments include short selling and privately placed or restricted shares.

Section 8 - Delegation of Voting Rights

The Investment Manager(s) is employed to and will normally exercise all voting and related rights acquired through investments of the Funds. The Investment Manager(s) will exercise acquired voting rights with the intent of fulfilling the investment objectives and policies of the Fund.

Section 9 – Valuation of Investments

It is expected that all the securities held by the Fund will have an active market and therefore a valuation of the securities held by the Fund will be based on their market value.

If a security held by the Fund does not have an active market, then the Investment Manager(s) will value it at least annually using accepted principles of valuation analysis. In the absence of any meaningful market value, such securities will be held at book value.

Investments in pooled funds comprising publicly traded securities shall be valued to the unit values published by the custodian of the pooled fund.

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-7**

SUBJECT: **ENVIORNMENTAL PROTECTION**

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1. PURPOSE AND APPLICATION

To define the Environmental Policy for Trillium Health Partners. The Environmental Policy scope is as follows: A hospital providing twelve regional medical programs: Cancer, Cardiac, Diabetes, Genetics, Geriatrics, Neurosurgical, Palliative, Renal, Stroke, Thoracic, Vascular, and Women's & Children's. Related activities include but are not limited to: Patient Support Services (housekeeping and waste management), Facilities (energy and water), Stores and Supply Chain Management (materials management and spill response), and Risk (emergency preparedness and response).

2. BACKGROUND

In accordance with Trillium Health Partners Strategic Plan, THP will deliver on our "foundational goals of quality, access and sustainability" through the implementation of an Environmental Protection Policy and Environmental Management System.

An environmental management system manages risk by providing a systematic process to meet legal requirements and to set objectives and targets to improve environmental performance and patient care by reducing costs and developing process efficiencies and operational controls.

By incorporating green conservation into our day-to-day roles we can contribute to the efficient use of resources, which in turn can be reallocated to patient care.

3. GUIDING PRINCIPLES

Trillium Health Partners complies with all relevant laws, regulations and maintains an environmental management system.

4. POLICY

Trillium Health Partners is dedicated to environmental protection in our day-to-day roles to contribute to the efficient use of resources, which in turn can be reallocated to patient care, this includes:

- Implementing best management practices, procedures, and technology to avoid or reduce pollution resulting from hospital operations;

- Promoting the purchasing and/or use of materials or products that consist of recycled and/or reused materials or products, and considering the impacts of those materials and products energy consumption, water utilization, waste generation and hazardous material management;

- Complying with relevant environmental regulations, standards and codes of practice and with other requirements to which THP subscribes which relate to its environmental aspects;

- Conserving energy through efficient use and operation;

- Working to identify acceptable alternatives to hazardous materials and managing those we continue to use in a manner that will reduce potential impacts;

- Minimizing waste generated by our operations and recycling wastes where practicable;

- Monitoring the natural environment and our discharges to the environment to understand better our environmental impacts and tracking progress toward achieving objectives and targets;

- Maintaining open communication with staff, community, and other interested parties;

- Continually improving environmental performance through participation in hospital industry associations, consultation with interested parties and management reviews.

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-8**

SUBJECT: **EXTERNAL AUDIT AND NON AUDIT SERVICES**

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1. PURPOSE AND APPLICATION

- To set out broad principles of the scope and nature of the services offered by the External Auditor to Trillium Health Partners and to further detail the responsibilities of Hospital management and the THP Board Finance & Audit Committee pertaining to the External Auditors.

- To establish principles and controls designed to provide reasonable assurance that the external auditor maintains independence to ensure objectivity and integrity is maintained and effective and independent audit(s) are achieved.

- To outline approvals that are required for all services provided by the Hospital's external auditors.

1.1 Application

During the course of the day-to-day business of the Hospital, audit, accounting and tax issues may arise requiring the professional services of external advisors. Such advice may not be included in the scope of the annual external audit and the associated fees approved by the Board Finance and Audit Committee on behalf of the Board of Directors. This policy applies to all professional services rendered by the Hospital's External Auditor for audit services, audit related services, tax services, and other services.

2. GUIDING PRINCIPLES

- This policy is based on guidelines and standards issued and updated by the Canadian Professional Accountants of Ontario (e.g. Rule 204) pertaining to independence and its definition.

- That the Hospital and External Auditor will comply with the broad principles and spirit of this policy for all potential scenarios, not listed below, that may be encountered during the course of Hospital business to minimize reputational risk, procurement risk, and the risk of not maintaining independence (in fact and in appearance).

- The External Auditor is complying with their own internal policies re: maintaining independence via a quality control system which recognizes various threats to independence and applies appropriate safeguards to reduce any risk to an acceptable level or declines to provide the service.

3. DEFINITIONS

- Audit Services include all professional services rendered by the Hospital's External Auditor for the audit of the Hospital's financial statements or services that are normally provided by the external auditor in connection with MOH, OH, and other statutory & regulatory filings or engagement. This includes analysis and interpretation of accounting principles and their application. An Independent Auditor's Report is issued.

- Audit-related Services include all assurance and related services (e.g. reviews, specified audit procedures, etc.) that are reasonably related to the performance of the audit of the financial statements other than those reported as audit services.

- Tax Services include all professional services rendered by the external auditor for tax compliance, tax planning & advice, and tax recovery or resolution of tax disputes.

- Other Services include all professional services rendered by the external auditor not considered to be Audit Services, Audit-related Services, or Tax Services.

4. POLICY

Auditor Independence

4.1 The External Auditor is required to confirm its independence to the Hospital's Finance and Audit Committee:

- annually for Audit and Audit related Services
- prior to performing, each individual engagement for Tax and Other Services

4.2 A comprehensive formal review of the External Auditors (encompassing performance, independence, and potential partner rotation) will take place with the Hospital's Finance and Audit Committee at each 5 year interval.

Audit and Audit Related Services

4.4 The engagement of the External Auditor including associated fees must be approved annually by the Board Finance and Audit Committee. All Audit and Audit related Services are considered to be included in this annual approval.

4.5 Subject to meeting acceptable qualification standards and competitive fees, whenever possible, the External Auditor should be engaged to perform all Audit and Audit Related services required by the Hospital.

Should another audit firm be considered to perform Audit Services, other than the External Auditor of the Hospital, the business rationale must be documented and approved by the CFO and be approved by the Board Finance and Audit Committee, before the engagement begins.

Tax Services

4.6 Tax Services are permitted provided that the independence of the External Auditor is not impaired and must be specifically pre-approved including associated fees by the Board Finance and Audit Committee.

Other Services / Prohibited Services

4.7 Other Services must be specifically pre-approved on a case-by-case basis and only those services will be considered which would not:

- impair the independence of the External Auditor,
- cause undue reputational risk to the Hospital,
- diminish competition on future procurement of other services
- facilitate Hospital Management having significant undue influence over external audit reported results.

Subject to obtaining pre-approval by the Hospital Finance and Audit Committee, Hospital Management may arrange the provision of Other Services by the External Auditor provided that:

- The cost of a single engagement and/or the cumulative costs of multiple engagements in the fiscal year does not exceed $250,000 (taxes included).

4.8 To ensure integrity of the External Auditor, the External Auditor is restricted from providing services to the Hospital when they act in a capacity where they could be reasonably be seen to:

a) function in the role of management
b) audit their own work, or
c) serve in an advocacy role on behalf of the Hospital

4.9 For further clarity, the following Other Services are prohibited from being performed on behalf of the Hospital:

- Bookkeeping or other services related to the account records or financial statements of the Hospital;
- Financial information systems design and implementation including sign-off;
- Appraisal or valuation services, fairness opinions, or contribution in-kind reports;
- Actuarial services;
- Internal Audit functions such as approving the overall audit work plan (including the determination of internal audit risk and scope, project priorities, frequency of testing, etc.) and/or the performance of audit procedures;
- Management functions (including via staff secondments) such as:
  - authorizing, approving, executing or consummating a transaction,
  - having or exercising authority on behalf of the Hospital,

  - determining which of any recommendation of the External Auditor will be implemented,
  - reporting in a management role to those charged with governance of the Hospital;
  - internal control design and implementation including sign-off.
- Human Resource functions such as searching for candidates, negotiating compensation, or reference checking or testing;
- Broker-dealer, investment advisor, or investment banking services;
- Legal services and litigation support/expert services unrelated to the audit;
- Act as a Delegate of the Hospital CFO, for approval of the audit reports & special reports as requested by the Ministry of Health & Long Term Care.
- Any other service that the Board Finance and Audit Committee determines is impermissible.

5. ROLES AND RESPONSIBILITIES

ROLE	RESPONSIBILITY
Hospital CFO	• Throughout the year, obtain all required Board Finance and Audit Committee approvals prior to the engagement or performance of services by the External Auditor. Pre-approval requests to the Board Committee by the CFO will require a written submission which outlines: ○ the nature and description of the services contemplated (e.g. scope) ○ an evaluation of the risk of compromising auditor independence ○ a confirmation of independence by the External Auditor ○ the nature and estimate of fees along with the expected term of the engagement. • Update annually key Hospital stakeholders of any changes regarding the appointment of the Hospital's External Auditors (e.g. SSW, etc.) • Obtain assurances as required (minimally on an annual basis) that the External Auditor has maintained their independence on all engagements.
Hospital CFO	• Provide annually a summary to the Board Finance and Audit Committee all services performed by the External Auditors and their cost including any carry forwards to future fiscal periods. • Monitor overall compliance to this policy and where applicable, update the Committee during the year on any issues that may arise such as potential impairments to independence.
Shared Services West (SSW)	• Notify on a timely basis to the Hospital CFO: ○ any bids received on procurement initiatives (e.g. RFQs, RFPs, etc.) from the External Auditor and/or ○ any potential contract awards to the External Auditor.
External Auditors (the individual or firm hired to perform the annual audit of the Hospital's financial statements)	• Report to the Hospital CFO: ○ On an annual basis, all services provided. ○ On a timely basis during the year, all potential risks to independence including any submission to procurement bids.

CATEGORY: **FINANCIAL AND ORGANIZATIONAL VIABILITY**

POLICY #: **IV-9**

SUBJECT: **ASSET NAMING**

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1. PREAMBLE

The purpose of this policy is to guide consistent and ethical decision-making regarding the naming of Trillium Health Partners ("the Hospital") or Trillium Health Partners Foundation ("the Foundation") assets in recognition of financial or in-kind contributions from individuals, businesses, organizations and others (the acceptance of which is governed by the Foundation's Gift Acceptance policy).

2. POLICY

2.1 Scope

- Significant contributions made to the Foundation may be recognized by attaching the name of a person, business, society or other organization to a particular facility, program, position or other asset under the administration of the Hospital (the "**Asset**").

2.2 Responsibilities

- The President & CEO, Trillium Health Partners Foundation or their delegate is responsible for:
  - cultivating and soliciting donations from individuals, businesses, organizations and offering potential naming opportunities in recognition of their gifts;
  - working collaboratively with the Hospital to ensure naming applications are pursued in accordance with this policy;
  - working collaboratively with the Hospital Capital Planning and Redevelopment Team to complete an annual review of all naming opportunities and aligned valuations; and
  - consulting with the Hospital Capital Planning and Redevelopment Team or relevant impacted Hospital department on installation requirements for potential gifts in advance of acceptance.
- The President & CEO, Trillium Health Partners or their delegate is responsible for:
  - providing necessary guidance to the Foundation to ensure success of the naming process; and
  - ensuring meaningful consultation with stakeholders and the community concerning the adoption of a proposed building, corporate or business name in alignment with government guidance.

- The Capital Planning and Redevelopment Team, the Hospital is responsible for notifying the Foundation of areas planned for redevelopment in advance of project initiation to enable preservation of donor recognition signage in affected areas.
- The Trillium Health Partners & Trillium Health Partners Foundation Joint Donor Recognition Committee is responsible for:
  - maintaining and applying the Asset naming procedures in accordance with this policy; and
  - providing necessary guidance in regards to the physical representation of donor recognition.

3. PROTOCOLS

3.1 Assignment of Name to Assets

- Assets may be named for individuals, businesses, societies or other organizations.
- Assets will not be named for an active physician or Hospital staff member unless that person is the individual making the donation.
- Naming opportunities will not be assigned for deferred gifts or for gifts of property until the property has been liquidated. Exceptions to this may be made at the discretion of the President & CEO, Trillium Health Partners Foundation.
- The details and terms of assigned name recognition will be documented, including if appropriate in the written gift agreement for the gift in question.
- The Hospital and the Foundation reserve the right to determine or change the form of name recognition in consultation with the affected donor if circumstances warrant it.

3.2 Recognition Requirements

- Decisions related to namings in recognition of donors will be made such that the level of donation corresponds with the value of the Asset to be named. Exceptions may be approved according to the required minimum authorization commensurate with the level of recognition.
- Recognition of gifts will be approved according to the required minimum authorization level outlined in the Approvals for Asset Naming to Recognize Donors (see Appendix A). Appropriate stakeholders will be engaged prior to seeking authorization.
- The recognition expenses associated with a gift shall not exceed 3% of the value of that gift. Exceptions to this may be approved by the President & CEO, Trillium Health Partners Foundation. The Hospital and the Foundation are responsible for the joint approval of all donor recognition signage including with respect to format, size and design. If the donor wishes to change their signage for any reason (e.g. personal name change), the donor will assume 100% of the costs.
- Where donor recognition is planned as part of a redevelopment project funded in part by the Ministry of Health (the “Ministry”), the associated costs shall meet all requirements set out by the Ministry.
- The relevant authorizing representatives will consider the following criteria in making decisions about names of hospital corporations, hospital sites and hospital buildings where the building comprises all or substantially all of a hospital site:

  - whether the name could give rise to a public perception that a donor will unduly influence the operations or practices of the Hospital;
  - whether the name could undermine public confidence in the provincial health care system;
  - the name must be consistent with the Mission, Vision, and Values of the Hospital and the Foundation and with the public interest; and
  - the name should reflect the hospital's geographic location, service or clinical mandate, patient population being served, culture or heritage of the persons being served, and/or history.
- The Hospital and the Foundation will engage in appropriate consultation with stakeholders and the community concerning the adoption of a proposed corporation name prior to its approval.
- The Hospital will notify the Ministry of the anticipated adoption of any new corporate or business name.

3.3 Duration of a Naming

- Wherever possible, gift agreements shall specify the term for a naming. The Hospital and the Foundation are aware of Ministry guidance relating to hospital naming and will consider this guidance where relevant.
- In cases where the naming term has not been specified in a gift agreement, Asset names shall remain in place until significant change or redevelopment of the Asset occurs (including but not limited to when Assets are demolished, substantially altered, rebuilt, sold or no longer in use for their original purpose). Exceptions to this must be approved by the President & CEO, Trillium Health Partners and the President & CEO, Trillium Health Partners Foundation.
- Namings may also be required to change according to government direction regarding donor recognition. Any such requirement would supersede naming timeframes specified as part of this policy or in gift agreements.

4. AMENDMENTS

This policy shall be provided to any potential donor requesting it.

This policy and guidelines may be amended, or exceptions not otherwise directly noted in the policy may be permitted, at any time at the recommendation of the Trillium Health Partners & Trillium Health Partners Foundation Joint Donor Recognition Committee, in consultation with the President & CEO, Trillium Health Partners Foundation and President & CEO, Trillium Health Partners, and contingent upon the approval of the Board of Directors of both the Hospital and the Foundation.

5. APPENDICES

Appendix A – THP/THPF Consultation and Approvals for Asset Naming in Recognition

Appendix A – THP/THPF Consultation and Approvals for Asset Naming in Recognition

Level of Recognition		Description	Suggested Minimum Financial Threshold*	Required Minimum Consultation and/or Approval**	
				Trillium Health Partners Foundation	Trillium Health Partners
1	**Hospital site naming**	Name to be applied to a hospital site and/or the use of the term "hospital" as part of a naming.	$25M and above	Approval by: Board of Directors	Approval by: Board of Directors
2	**Program or service naming**	Name to be applied to a corporate-wide program or clinical service line; naming crosses multiple sites or locations.	$5M	Approval by: President & CEO	Approval by: President & CEO
3	**Centre or institute naming**	Site-specific naming to be applied to the exterior of a centre or institute.	$5M	Approval by: President & CEO	Approval by: President & CEO
4	**Prominent external feature naming**	Naming is placed on a prominent external feature. This could include building towers, parking garages, and courtyards.	$5M	Approval by: President & CEO	Approval by: President & CEO
5	**Research Chair naming**	Naming is applied to a research title or position within the organization.	$3M	Approval by: VP, Philanthropy	Approval by: President & CEO
6	**Floor, lobby, clinic or unit naming**	Naming is applied to a particular floor, internal clinic or unit or within a lobby.	$1M	Approval by: President & CEO	Approval by: EVP, Patient Care Services; Chief Administration Officer; VP, Strategy & Communications
7	**Area naming**	Naming is placed on a prominent feature wall outside a specific area. This could include alcoves, waiting areas, gardens, courtyards, auditoriums, and sacred spaces.	$500,000	Approval by: VP, Philanthropy	Consultation with: VP or SVP of impacted area; VP, Redevelopment; VP, Strategy & Communications
8	**Room naming**	Naming is placed on a prominent feature wall outside a specific room.	$15,000	Approval by: VP, Philanthropy	Consultation with: Director of impacted area; Director, Communications
9	**Specialty or equipment naming**	Naming could include equipment, chairs, beds, and other specialized items		Approval by: VP, Philanthropy	Consultation with: Director of impacted area; Director, Communications

*Recognition levels offered to donors will weigh factors that include size and scale of impact; strategic importance and profile of the Asset (e.g. of a new program); traffic, volume or visibility of the Asset; capital intensity of developing and maintaining the Asset (e.g. cost of equipment). Gifts not directed to Local Share may still qualify for recognition at the same level. Where recognition levels substantively differ from any existing agreements between the Hospital and Foundation, approval will be required from one level up or higher from the required minimum approver listed above.

**Approval constitutes documented sign-off from required individuals prior to final confirmation of a naming. Approval may or may not follow a period of engagement with impacted areas, as appropriate. It is the responsibility of the individuals with approval authority to ensure that appropriate engagement has occurred. Consultation requires at a minimum that the required individuals are informed of the proposed naming at least 15 days in advance of final authorization. Exceptions to required consultation can be established through joint agreement between the Foundation and the leadership of impacted areas.

Part V-A:

Governance Policy Framework

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-1**

SUBJECT: **GOVERNANCE AND BOARD ACCOUNTABILITY**

PURPOSE AND APPLICATION

This Policy sets out the accountability of the Board of Directors (the "**Board**") of Trillium Health Partners ("**Corporation**").

The Corporation is one hospital corporation operating three interdependent sites.

BACKGROUND

The Board governs the Corporation through the direction and supervision of the business and affairs of the Corporation in accordance with its Articles of Amalgamation, its By-Laws, vision, mission and core values, governance policies and applicable laws and regulations.

The Board adheres to a model of governance through which it provides strategic leadership and direction to the Corporation by establishing policies, making governance decisions, monitoring performance related to the key dimensions of the Corporation's mission, as well as evaluating its own effectiveness and by building relationships within the health system.

GUIDING PRINCIPLES

The Board acts at all times in the best interests of the Corporation, having regard for its accountabilities to its patients and the community served, to the Government of Ontario ("**Government**") and the Mississauga Halton Local Health Integration Network ("**LHIN**") and its relationship with other service providers.

The Board maintains a culture based on the values as approved by the Board and strives for a collaborative approach to decision-making, based on evidence, best practice, open debate and a forthright examination of all issues, while respecting and valuing dissenting views.

The Board maintains at all times a clear distinction between the governance and operation of the Corporation, while recognizing the interdependencies between them. The Board of Directors is accountable to:

The Corporation's patients and communities served for:

- the quality of the care, treatment and safety of patients;
- engaging the communities served when developing plans and setting priorities for the delivery of health care;

- considering the diversity of needs and interests in its policy formulation and decision-making;
- operating in a fiscally sustainable manner within its resource envelope and utilizing its resources efficiently and effectively across the spectrum of care to fulfill the Corporation's mission and mandate;
- advocating for and seeking resources to provide appropriate health care;
- the appropriate use of community contributions and resources;

the Government of Ontario for:

- compliance with applicable laws and regulations, policies and directions and implementation of approved capital projects;

the LHIN for ensuring that the Corporation operates in a manner that is consistent with:

- the LHIN's integrated health service plan; and
- the Hospital Service Accountability Agreement with the LHIN.

PROCEDURE

Director's Declaration

All new Board Members will complete a Director's Declaration, Appendix A, of commitment to and compliance with these principles and responsibilities, which will remain in effect until their retirement from the Board.

Disclosure

Consistent with the Board's commitment to good governance practices, timely access to information, appropriate protection of personal privacy, and appropriate protection of other information that is exempt or excluded from disclosure under the *Freedom of Information and Protection of Privacy Act* ("**FIPPA**"), the Board will make available to the public:

- the statement of Board and Director roles, responsibilities and accountabilities;
- a list of elected and ex-officio Directors;
- policies governing the Board and its committees;
- a report on the Corporation's performance as part of the Corporation's Annual Report;
- the Corporation's Quality Improvement Plan, in compliance with the *Excellent Care for All Act, 2010* (ECFAA)*;*
- information about expense claims in compliance with any directives made under the *Broader Public Sector Accountability Act, 2010* (BPSAA); and
- upon request, information that is subject to disclosure under FIPPA.

Appendix A

DIRECTOR'S DECLARATION

A Director of Trillium Health Partners (the "Hospital") acknowledges and accepts that the Board of Directors is accountable to:

(1) its patients and communities served for:

- the quality of the care, treatment and safety of patients;
- engaging the communities served when developing plans and setting priorities for the delivery of health care;
- operating in a fiscally sustainable manner within its resource envelope and utilizing its resources efficiently and effectively across the spectrum of care to fulfill the Hospital's mission and mandate;
- advocating for and seeking resources to provide appropriate health care;
- the appropriate use of community contributions and resources; and
- considering the diversity of needs and interests in its policy formulation and decision-making;

(2) the Government of Ontario for:

- compliance with applicable laws and regulations, policies and directions and implementation of approved capital projects;

(3) the Mississauga-Halton Local Health Integration Network (the "LHIN") for:

- ensuring that Trillium Health Partners operates in a manner that is consistent with:

  - the LHIN's integrated health service plan; and
  - the Hospital Service Accountability Agreement with the LHIN.

I have complied in the past and agree to comply in the future with the performance expectations as stated in the appended document Responsibilities as an Elected and Ex-Officio Director.

As a Director, I confirm that I do not have a conflict of interest which would prevent me from serving as a Director pursuant to the Conflict of Interest provisions in Section 6.1 of the Corporate By-law and in the Board Policy Manual.

I hereby consent to act as a Director of the Hospital. I also hereby consent pursuant to the provisions of Section 5.3 of the Corporate By-Law to the holding of meetings of the Board of Directors or of any committee of the Board of Directors by means of such telephone, electronic or other communication facilities as permit all persons participating in the meeting to communicate with each other simultaneously and instantaneously. These consents will continue in effect from year to year so long as I am a Director. I agree to abide by the confidentiality provisions in the Corporate By-Law, Board Policy Manual and in the Hospital's privacy policies.

I undertake to advise the Hospital in writing of any change of address as soon as possible after such change.

This Director's Declaration may be executed in one or more counterparts, each of which shall be deemed an original and all of which shall be taken together and deemed to be one instrument. Delivery by email of an originally executed counterpart of the signature page to this Director's Declaration shall be effective as delivery of an original executed counterpart of this Director's Declaration. There is no requirement for delivery of an original executed signature.

Dated:

Signature:

Print Name:

Address:

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-2**

SUBJECT: **ROLE AND RESPONSIBILITIES OF THE BOARD OF DIRECTORS**

POLICY

The Board governs by fulfilling the following roles:

Policy Formulation

Establish policies to provide ***guidance*** to those empowered with the responsibility to lead and manage operations.

Decision-Making

On matters that specifically require Board approval, choose from alternatives that are consistent with Board policies and that are in the best interest of the Corporation.

Oversight

Monitor and assess organizational processes and outcomes.

Responsibilities of the Board

Strategic Direction

- Consider key stakeholders and health care needs and engage with the community served, the LHIN and other health service providers when developing plans and setting priorities for the delivery of health care as required under the *Local Health System Integration Act*;
- Establish and periodically review the Corporation's mission, vision and core values;
- Contribute to the development of and approve the strategic plan of the Corporation, confirming that it is aligned with community need, Ministry policy, the LHIN integrated health services plan and promotes where appropriate integration with other health service providers;
- Conduct a review of the strategic plan as part of a regular annual planning cycle;
- Review the Board's decisions for consistency with government policy, the LHIN's integrated health service plan, and the Corporation's mission, vision, core values and strategic plan; and
- Monitor and measure corporate performance regularly against the approved strategic plan and Board approved performance indicators.

Excellent Management

- Select and appoint the CEO;
- Establish measurable annual performance expectations in co-operation with the CEO; assess CEO performance annually and determine compensation;
- Delegate responsibility and authority to the CEO for the management and operation of the Corporation and require accountability to the Board;
- Select and appoint the Chief of Staff;
- Establish measurable annual performance expectations in co-operation with the Chief of Staff; assess Chief of Staff performance annually and determine compensation;
- Delegate responsibility and authority to the Chief of Staff for the supervision of the practice of medicine, dentistry, midwifery and extended class nursing in the Corporation and require accountability to the Board;
- Approve the plans for CEO and Chief of Staff succession;
- Review and approve the CEO's and Chief of Staff's succession plans for the senior management team and clinical chiefs, including executive development;
- Appoint department chiefs and other medical leadership positions, on the recommendation of the Chief of Staff, as required under the Corporation's Professional Staff By-law and the *Public Hospitals Act;* and
- Establish and monitor implementation of policies to provide the framework for the management and operation of the Corporation in compliance with applicable laws and regulations.

Program Quality and Effectiveness

- Review and approve the Chief of Staff's human resources plan for the Professional Staff annually;
- Review the credentialing process for the Professional Staff annually and be assured by the Chief of Staff as to the effectiveness and fairness of this process;
- Approve appointments, reappointment and privileges for Professional Staff based on the human resources plan and review of recommendations by the Medical Advisory Committee;
- Provide oversight of the credentialed Professional Staff through the Chief of Staff, and the Medical Advisory Committee and if necessary or advisable, effect the restriction, suspension or revocation of privileges of any credentialed Professional Staff member as provided under the *Public Hospitals Act* and the Professional Staff By-law;
- Review and approve the Quality Improvement Plan and approve a process and schedule for monitoring Board-approved performance metrics related to quality of care, patient safety and organizational risk;
- Review policies that provide a framework for addressing ethical issues arising from care, education and research in the Corporation; and
- Receive timely reports from the CEO and Chief of Staff on plans to address variances from performance standards, and oversee implementation of the remediation plans.

Financial and Organizational Viability

- Review and approve the Hospital Annual Planning Submission including the capital and operating budget; approve the Hospital Services Accountability Agreement and monitor financial performance against the budget and performance indicators;
- Review and approve the multi-year financial plans and operate within the Hospital Services Accountability Agreement;
- Review financial and organizational risks and risk mitigation plans regularly;
- Approve an investment policy and monitor compliance;
- Review the financial reporting process, management information systems, internal controls and business continuity plans annually;
- Review policies on asset protection, purchases, contracts, leases, borrowing and signing authority; and
- Review quarterly financial reports and approve the annual audited financial statement.

Board Effectiveness

- Recruit Directors and where appropriate Non-Director members of committees, who are skilled, experienced, reflective of the communities we serve and committed to the Corporation and plan for the succession of Directors and Board Officers;
- Establish a comprehensive Board orientation program and ongoing Board education;
- Establish Board goals and an annual work plan for the Board and its committees and monitor the Board's timely receipt of appropriate information to support informed policy formulation, decision-making and monitoring;
- Establish and periodically review policies concerning governance structures and processes to maximize the effective functioning of the Board;
- Establish a policy and process for evaluating the performance of the Board as a whole and of individual Directors that fosters continuous improvement.

External Relationships

- Monitor the establishment and maintenance of good relationships with the Ministry of Health and Long Term Care and other government Ministries in fulfilling its obligations under provincial policies and with the LHIN in fulfilling the Corporation's Hospital Services Accountability Agreement;
- Review the Corporation's fulfillment of its role as a regional resource and referral centre within the LHIN region by fostering effective coordination of patient care and positive working relationships with other hospitals and community health care providers;
- Monitor the establishment and maintenance of good relationships with the University of Toronto Mississauga and other educational institutions in fulfilling its mission as a community affiliate of the University of Toronto Faculty of Medicine;
- Review the mechanisms in place for effective two-way communication within the Corporation with Professional Staff, staff, volunteers, foundations and with its members, community stakeholders, including elected officials and political leaders, the media, donors, and the broader public.

Support and Relationships with the Foundation

Strong and positive relationships between the Corporation and the foundation are essential at several levels:

- The Foundation Board Chair or a designate will be a member of the Hospital Board of Directors as an ex-officio, voting Director.
- The Board will support the foundation in their endeavours.
- Individual Directors are expected to support the foundation, and are encouraged to contribute financially to the foundation in their fundraising efforts.
- Regular communications will be essential and achieved through a number of mechanisms, such as:
  - a semi-annual meeting between designated representatives of the Board and the foundation's boards of directors to review strategic priorities, fundraising needs and areas for collaboration and alignment of fundraising initiatives;
  - the foundation chair will be asked to present a brief annual report at the annual meeting; and
  - regular meetings between the CEO and the CEO of the foundation will be scheduled related to capital equipment priorities and operational matters related to allocation of the foundation's donations to the Corporation.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-3**

SUBJECT: **RESPONSIBILITIES AS AN ELECTED AND EX-OFFICIO DIRECTOR**

PURPOSE AND APPLICATION

The following is a statement of responsibilities for both elected and ex-officio Directors, which should also be understood as the Board of Directors ("**Board**") Code of Conduct. The legal expectations of ex-officio Directors are the same as those expected of elected Directors.

Exceptions to Board process requirements for ex-officio Directors are noted.

GUIDING PRINCIPLES

Fiduciary Duty and Duty of Care

As a fiduciary of Trillium Health Partners (the "**Corporation**"), a Director acts ethically, honestly, and in good faith with a view to the best interests of the Corporation and in so doing, supports the Corporation in fulfilling its mission and discharging its accountabilities. A Director exercises the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. Directors with special skill and knowledge are expected to apply that skill and knowledge to matters that come before the Board.

A Director does not represent the specific interests of any constituency or group. A Director acts and makes decisions that are in the best interest of the Corporation as a whole. A Director commits to the vision, mission and core values of the Corporation and complies with the *Public Hospitals Act*, the *Corporations Act*, other applicable laws and regulations, the Corporation's Articles of Amalgamation and by-laws, and Board policies.

Exercise of Authority

A Director carries out the powers of office only when acting as a member during a duly constituted meeting of the Board or one of its committees. A Director respects the responsibilities delegated by the Board to the Chief Executive Officer (CEO) and Chief of Staff, avoiding interference with their duties but insisting upon accountability to the Board and reporting mechanisms for assessing organizational performance.

Conflict of Interest

A Director does not place him/herself in a position where his/her personal interests conflict with those of the Corporation. A Director complies with the Conflict of Interest provisions in Section 6.1 of the Corporate By-law and the Board Policy Manual.

Team Work

A Director maintains effective relationships with Directors, management and stakeholders by working positively, cooperatively and respectfully with others in the performance of his/her duties while exercising independence in decision making.

Participation

A Director expects to receive relevant information in advance of the meetings and reviews pre-circulated material and comes prepared to Board and committee meetings and educational events, asks informed questions, and makes a constructive contribution to discussions. A Director considers the need for independent advice to the Board on major corporate actions.

Formal Dissent

A Director reviews the minutes of the previous meeting on receipt and insists that they record any Director's disclosure, abstinence or dissent. A Director who is absent from a Board meeting is deemed to have supported the decisions and policies of the Board taken in his/her absence unless he or she formally records a dissenting view with the Board secretary. While an absent Director may formally record a dissenting view at the next meeting at which the Director is in attendance, this does not change the decision reached by the Board.

Board Solidarity

The official spokesperson for the Board is the Chair or the Chair's designate. A Director supports the decisions and policies of the Board in discussions with outsiders, even if the Director holds another view or voiced another view during a Board discussion or was absent from the Board meeting. A Director refers requests for statements on behalf of the Board to the Chair.

Confidentiality

Every Director shall respect the confidentiality of the information of the Corporation, including matters brought before the Board and all committees, keeping in mind that unauthorized disclosure of information could adversely affect the interests of the Corporation.

Time and Commitment

A Director is generally expected to commit the necessary time required to fulfill Board and committee responsibilities including preparation for and attendance at Board meetings, assigned committee meetings and events.

A Director is expected to attend a minimum of 80% of the meetings of the Board and 80% of committee meetings of which he/she is a member in person or by electronic means. Directors who fail to meet the attendance requirements are subject to review by the Chair

and may be asked to step down from the Board. All Directors are expected to serve on at least one Board committee and to represent the Board and the Corporation in the community when requested by the Chair.

Skills, Expertise and Essential Competencies

A Director actively contributes specific skills and expertise and possesses the following essential competencies and qualities which are necessary for all Directors to fulfill their responsibilities:

- personal and professional integrity, wisdom and judgment;
- a commitment to ethical standards and behaviour;
- experience in and understanding of governance including the roles and responsibilities of the Board and individual Directors and the difference between governance and management;
- ability to participate assertively and communicate effectively as a member of the team with other members of the Board and senior management; and
- ability to think critically and ask relevant questions at a strategic level.

Education

A Director seeks opportunities to be educated and informed about the Board and the key issues in the Corporation and broader health care system through review of the Board Orientation Manual, participation in Board orientation and ongoing Board education.

Evaluation and Continuous Improvement

A Director is committed to a process of continuous self-improvement as a Director. All Directors participate in evaluation of the Board and elected Directors participate in individual–Director peer assessment and act upon results in a positive and constructive manner.

Fundraising Activity

A Director supports the fundraising activities of the foundations.

POLICY

All Directors will complete a Director's Declaration of commitment to and compliance with these responsibilities annually.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-5**

SUBJECT: **GUIDELINES FOR THE SELECTION OF DIRECTORS**

POLICY

Balance within the Board

- The Board as a whole should be seen by the community it serves, government and the broader community as capable, experienced and well able to govern the organization; and
- The membership of the Board and its committees should be drawn widely to achieve a balance of skills and expertise needed for the Board to fulfill its governance roles and responsibilities and to genuinely reflect the breadth, depth and diversity of the community it serves so it can maintain the confidence of all it serves.

Board Skills and Expertise

While the Board will give priority to recruitment of different skills, expertise and experience over time, the Directors should collectively possess a range of specific skills, expertise and experience (as described in Appendix 1) from among the following:

- audit, accounting and finance;
- senior level business leadership in a complex corporate environment
- governance;
- strategic planning;
- community leadership;
- construction, project management (may be a time-limited requirement);
- information systems management/technology;
- marketing, communications and media/public relations;
- quality, risk management and performance measurement;
- law;
- government relations
- public policy and research;
- knowledge of health care systems;
- human resource management; and
- health education.

Director Qualities and Competencies

Beyond the range of skills and expertise identified above, the essential competencies and qualities that are necessary for all Directors to fulfill their responsibilities include:

- experience in and understanding of governance including the roles and responsibilities of the Board and individual Directors and the difference between governance and management;
- personal and professional integrity, wisdom and judgment;
- a commitment to ethical standards and behaviour;
- an ability to work and communicate effectively as a member of the team with other Directors and senior management; and
- ability to think critically and ask relevant questions at a strategic level.

As defined in the *Corporate By-law* (Article 4 Section 4.4), no person shall be qualified for election or appointment as a Director if he or she:

a) is less than 18 years of age;
b) has the status of a bankrupt;
c) except as required by the *Public Hospitals Act*, is a current employee of the Corporation or Professional Staff member.

Appendix 1: Descriptions of Skill, Expertise and Experience

Area of Skill, Expertise and Experience	Description
Audit, Accounting and Finance	Experienced in applying generally accepted accounting principles and preparing, auditing and/or analyzing financial statements. Additionally, understanding of appropriate financial controls and management practices required to achieve key financial metrics. A minimum of one Board member who is a Professional Accountant in good standing is required.
Community Leadership	Experienced in inspiring change and influencing others within the community through a visible civic leadership role in one or more organizations that may include a governing body, a community service organization, a religious institution, or a philanthropic endeavor.
Construction/Project Management	Experienced in providing leadership in large-scale planning, development, and/or project design and implementation.
Governance	Experienced in best practice principles associated with organizational structure, processes, accountabilities and decision making, current governance issues and trends, and direct prior governance experience in a community based or a not-for-profit organization.
Government Relations	Experienced in dealing with or working alongside regional, provincial and/or federal government or regulatory bodies. Skilled at understanding the complex nature of government decision making and forging effective relationships in order to influence decision making.
Health Care	Experienced in senior health care leadership or a practitioner with deep experience and/or understanding of health care operations, funding and systems.
Health Education	Experienced health educator. Understands oversight role operating a facility that provides interprofessional education, including medical teaching and applied research
Human Resource Management	Experienced in and strong understanding of organizational structure and development, human resources oversight, compensation, performance management, change management, talent management, and succession planning.
Information Systems Management/Technology	Experienced in leading the implementation and/or management of complex information technology systems and processes. High degree of sophistication in information technology risk management.
Law	Experienced lawyer in good standing with the Law Society of Upper Canada with a sophisticated practice in corporate, commercial, regulatory or governance-related fields.
Marketing, Communications and Media/Public Relations	Experienced in private or public sector corporate communications, marketing and media, public and stakeholder relations.

Area of Skill, Expertise and Experience	Description
Public Policy and Research	Experienced in influencing and shaping public policy and/or leading operations and change within an environment heavily influenced by public policy, including public and broader public sector organizations. Published researcher with experience in research operations, funding and management within large organizations.
Quality, Risk Management and Performance Measurement	Experienced in identifying, planning for and implementing strategies to drive continuous quality improvement and to mitigate organizational risks. Skilled in understanding the effective use of performance measurement to achieve this. Includes the ability to understand and ensure the effective oversight of a comprehensive enterprise risk management system, including the prioritization of relevant risks and ensuring appropriate risk levels.
Senior Business Leadership	Experienced in leading others in a large, complex organization. Know what it is to lead, articulate a vision, monitor risks and measure performance to achieve positive results. Skilled in complex change management and communications.
Strategic Planning	Experienced in oversight and development of a strategic planning process and plan. Understanding and evaluating strategic plans including updates provided on developments affecting the strategy.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-6**

SUBJECT: **BOARD SIZE AND COMPOSITION**

In accordance with the *Corporate By-law* (Article 4 Section 4.1), the Board will consist of:

a) the following elected Directors:

i) from the annual Members' meeting in 2023, 15 elected Directors;

ii) from the annual Members' meeting in 2024, and while the Trillium HealthWorks Committee is active, 14 elected Directors; and

iii) from the annual Members' meeting following on the date in which the Board confirms all roles and responsibilities of the Trillium HealthWorks Committee have been completed and the Trillium HealthWorks Committee is dissolved , 12 elected Directors,

who satisfy the criteria set out in Section 4.3 of the *Corporate By-law* and who are elected by the Members in accordance with Section 4.8 of the Corporate By-law or appointed in accordance with Section 4.10 of the *Corporate By-law*; and

b) the following five ex-officio non-voting Directors:

i) the Chief Executive Officer;
ii) the Chief of Staff;
iii) the President of the Professional Staff;
iv) the Vice President of the Professional Staff; and
v) the Chief Nursing Executive.

c) the following two ex-officio voting Directors:

i) the Chair of the Foundation or a designate; and
ii) the Dean of Medicine of the University of Toronto or a designate

In accordance with the *Corporate By-law* (Article 4 Section 4.9), each Director shall be eligible for re-election provided that such Director shall not be elected or appointed for a term that will result in the Director serving more than nine consecutive years. In determining a Director's length of service as a Director, service prior to the coming into force of the *Corporate By-law* at The Credit Valley Hospital or at Trillium Health Centre shall be excluded. Despite the foregoing a Director may, by Board resolution, have his/her maximum term as a Director extended for the sole purpose of that Director succeeding to

the office of Chair or serving as Chair. Despite the foregoing, where a Director was appointed to fill an unexpired term of a Director, the partial term shall be excluded from the calculation of the maximum years of service.

The Directors of the Corporation will be entitled to serve a maximum of nine years, normally based on three, three-year terms. However, to achieve the staggering of terms required by the *Corporations Act* and the *Public Hospitals Act*, each of the 14 initial elected Directors will be assigned an initial term of one, two or three years reflecting Director preference where possible.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-7**

SUBJECT: **BOARD STANDING COMMITTEE PRINCIPLES**

As per the *Corporate By-law* (Article 8), the Board may establish committees from time to time. The Board shall determine the duties of such committees. The Board committees shall be:

- Board Standing Committees, being those committees whose duties are normally continuous; and
- Special Committees, being those committees appointed for specific duties whose mandate shall expire with the completion of the tasks assigned.

The Board may establish a committee to function as an executive committee and may delegate to such committee any powers of the Board, subject to such restrictions, as may be imposed by the Board by resolution.

This Policy is intended to supplement the *By-law* provisions.

Board Standing Committees

The following Board Standing Committees will be established:

- Finance and Audit Committee;
- Governance and Human Resources Committee;
- Quality and Program Effectiveness Committee;
- Priorities and Planning Committee; and
- Medical Advisory Committee.

If a committee is to function as an executive committee, the Terms of Reference of such a committee will so provide.

Board Standing Committee Principles

a) Relationship between the Board and Board Standing Committees

i) The Board will approve Terms of Reference and membership of the Board committees annually on the recommendation of the Governance and Human Resources Committee as soon as possible following the annual meeting.

ii) The Board will monitor the performance of its Board committees at each regular Board meeting through minutes or a summary written report and a verbal report by the committee chair related to specific recommendations of the Board committee for approval by the Board.

iii) The Terms of Reference for Board committees will be reviewed annually by the respective committee, which will make recommendations to the Governance and Human Resources Committee and thereafter to the Board for approval as appropriate.

iv) Board committees may not speak or act for the Board except when formally given such authority for specific and time-limited purposes. Such delegation will be framed so as to not conflict with the authority delegated to the CEO.
v) Unless otherwise specified, Board committees may not commit or bind the Corporation to any course of action and no decision of a committee is binding on the Board until approved or ratified by the Board.
vi) Unless otherwise authorized to do so, a Board committee may not engage independent legal counsel or consulting advice without prior Board approval.
vii) The Chair, Vice-Chair, or CEO may, at any time, call a special meeting of a Board Standing Committee.

b) Mandate of Board Standing Committees

i) The number and type of committees should support the Board in fulfilling its defined responsibilities and maximizing the participation of individual Directors.
ii) The Board as a whole is responsible and accountable for the work that is done on its behalf by committees, task groups, etc.
iii) The mandate for each Board Standing Committee, including the function of the executive committee, is outlined in a Terms of Reference. Terms of Reference for the Medical Advisory Committee are set out in the *Professional Staff By-Law*.
iv) Board Standing Committees should establish annual goals, work plans and work products for Board approval.
v) The Board, through the Governance and Human Resources Committee should conduct a periodic review of Board Standing and Special Committees to ensure the continuing relevance of their mandate and membership.

c) Membership

i) The responsibility for Board Standing Committee participation should be balanced among all Directors.
ii) All Directors (including ex-officio Directors) should be expected to serve on at least one Board Standing Committee.
iii) Subject to specific exceptions by the Board, or in accordance with law, the majority of Board Standing Committee members should be elected Directors.
iv) Subject to the approval by the Board, non-Directors (community members) may be appointed to serve on designated Board Standing Committees.
v) Board Standing Committee Terms of Reference should specify a defined number of members including both elected and ex-officio Directors and additional non-Director (community) members as appropriate.
vi) The Chair, Vice-Chair and members of Board Standing Committees are appointed annually by the Board on the recommendation of the Governance and Human Resources Committee, following a canvas of Directors for their interests and preferences.
vii) With the exception of the Quality and Program Effectiveness Committee, whose members including hospital staff are defined by legislation, hospital management and staff (with the exception of ex-officio Directors who are specifically identified as committee members), are resources to the Board Standing Committees.
viii) All members of Board Standing Committees will be considered voting members, unless otherwise designated.
ix) Each Board Standing Committee will be supported by appropriate professional and administrative staff resources.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-8**

SUBJECT: **POSITION DESCRIPTION FOR THE CHAIR**

POLICY

Role Statement:

- The Chair, working collaboratively with the CEO, provides leadership to the Board, ensures the integrity and effectiveness of the Board's governance process and represents the Board to outside parties, including the LHIN (or successor agency), the boards of health system partners and the media.
- The Chair co-ordinates the activities of the Board in fulfilling its governance responsibilities and facilitates co-operative relationships among Directors and between the Board and CEO and the Board and Chief of Staff.
- The Chair ensures that all matters relating to the Board's mandate are brought to the attention of, and discussed by, the Board.
- The Chair is an ex-officio member of all Board committees but may elect to share this responsibility with a Vice-Chair.

Responsibilities:

- **Board Meetings**
  - Establish agendas in collaboration with the CEO that are aligned with the annual Board goals, work plan and current issues and preside over meetings of the Board;
  - Facilitate and advance the business of the Board, ensuring that meetings are effective and efficient for the performance of governance work;
  - Utilize a practice of referencing Board policies in guiding discussions in order to support the decision-making processes of the Board;
  - Ensure that the Board hears all sides of a debate or discussion and that meetings are conducted according to applicable legislation, By-laws, governance policies and Rules of Order;
  - Ensure that a schedule of Board meetings is prepared annually and is reflective of current Board issues and/or interests.

- **Direction**
  - Serve as the Board's central point of official communication with the CEO and the Chief of Staff with respect to both Board policy direction and decisions and matters of interest/ concern to individual Directors;
  - Guide and counsel the CEO and the Chief of Staff regarding the Board's expectations and concerns;

- In collaboration with the CEO, develop the standards and format for reporting by Board committees and the management team which will ensure that the Board has appropriate information to make informed decisions.

- **Performance Appraisal**

  - Participate as a member of the Governance and Human Resources Committee in monitoring and evaluating the performance of the CEO and Chief of Staff through an annual process as outlined in Board policies on “CEO Performance Evaluation” and “Chief of Staff Performance Evaluation”, respectively.

- **Work Plan**

  - With the assistance of the Governance and Human Resources Committee, ensure that a work plan is developed and implemented for the Board that includes annual goals for the Board and embraces continuous improvement.

- **Representation**

  - Ensure that the Board is appropriately represented at the Corporation’s functions, other official functions and to the public at-large;
  - Serve as the Board’s exclusive contact with the media, unless otherwise delegated;
  - Serving as the Board’s representative, the Chair will cultivate a collegial working relationship with the LHIN (or successor agency), peer hospital board chairs and CEOs and other internal and external stakeholders.

- **Reporting**

  - Report regularly and promptly to the Board regarding issues that are relevant to its governance responsibilities;
  - Report to the annual meeting of the members of the Corporation concerning the operations of the Corporation.

- **Board Conduct**

  - Set a high standard for Board conduct and enforce policies and By-laws regarding Director conduct.

- **Mentorship**

  - Serve as a mentor to other Directors;
  - Ensure that all Directors contribute fully;
  - Address issues associated with underperformance of individual Directors.

- **Succession Planning**

  - Ensure succession planning occurs within the Governance and Human Resources Committee for the CEO, Chief of Staff and the Board.

- **Other Duties**
  - The Chair performs such other duties as the Board determines from time to time.

- **Skills, Attributes and Experience**

The Chair will demonstrate the following personal qualities, skills and experience:

- all of the personal attributes required of a Director;
- leadership;
- strategic and facilitation skills;
- tact, diplomacy and impartiality;
- political acuity;
- ability to effectively influence and build collaborative relationships within the Board;
- ability to build strong relationships between the Corporation and stakeholders;
- ability to establish trusted advisor relationship with the CEO, Chief of Staff and other Directors;
- ability to make the necessary time commitment and required flexibility in work schedule to meet the requirements of this leadership role;
- ability to communicate effectively with the Board, senior management, Government Ministries and agencies including LHIN (or successor agency) and the community; and
- record of achievement in one or several areas of skills and expertise required within the Board.

Term

The Chair shall be elected by the Board on the recommendation of the Governance and Human Resources Committee to serve a two-year non-renewable term. If a Director assumes the position of Chair in the eighth year of his/her term, the Director's term may be extended by one year to accommodate the tenure of Chair, which is two years.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-9**

SUBJECT: **POSITION DESCRIPTION FOR THE VICE CHAIR**

POLICY

Role Statement

The Vice-Chair works collaboratively with the Chair. He or she supports the Chair in fulfilling his/her responsibilities. The Vice-Chair shall have all the powers and perform all the duties of the Chair in his/her absence.

Responsibilities

Board Chair Substitute

Assume the duties of the Chair in the Chair's absence or disability, or as requested by the Chair, including representing the Board and the Corporation at official functions and to the public at-large.

Board Conduct

Maintain a high standard for Board conduct and uphold policies and by-laws regarding Director conduct.

Mentorship

Serve as a mentor to other Directors.

Committee Membership

Serve as a member of the Priorities and Planning Committee; may also serve as a Board Standing Committee chair and/or share the responsibility with the Chair for serving as ex-officio member of designated Board Standing Committees.

Skills, Attributes and Experience

The Vice-Chair will demonstrate the following personal qualities, skills and experience:

- all of the personal attributes required of a Director;
- leadership;
- strategic and facilitation skills;
- tact, diplomacy and impartiality;

- political acuity;
- ability to effectively influence and build collaborative relationships within the Board;
- ability to build strong relationships between the Corporation and stakeholders;
- ability to establish trusted advisor relationship with the CEO, Chief of Staff and other Directors;
- ability to make the necessary time commitment and required flexibility in work schedule to meet the requirements of this leadership role;
- ability to communicate effectively with the Board, senior management, Government Ministries and agencies including the LHIN and the community; and
- record of achievement in one or several areas of skills and expertise required within the Board.

Term

Under normal circumstances, the Vice-Chair shall be elected by the Board on the recommendation of the Governance and Human Resources Committee for two one-year terms. At the completion of the first year, the Vice-Chair and the Board will be asked to confirm the appointment of the Vice-Chair for the second year. The Director who is serving as Vice-Chair in the second year of the Chair's term will be designated Chair-elect.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-10**

SUBJECT: **POSITION DESCRIPTION FOR TREASURER**

Role Statement
The Treasurer is a Director and works collaboratively with the Chair, CEO and Chief Financial Officer to support the Board in fulfilling their fiduciary responsibilities.

Responsibilities:

- ***Reporting Requirements***
  Keep up to date on audit, financial and compliance reporting requirements.

- ***Mentorship***
  Serve as a mentor to other Directors.

- ***Committee Membership***
  Serve as Chair of the Finance and Audit Committee and a member of the Priorities and Planning Committee.

- ***Committee Chair***
  Establish agendas in collaboration with the staff support and preside over meetings of the Finance and Audit Committee and fulfill the other responsibilities of a Committee chair as per the Position Description of a Committee Chair.

- ***Audited Financial Statement***
  Present to the Members of the Corporation at the annual meeting as part of the annual report, an audited financial statement of the Corporation and the report thereon of the independent auditors.

Skills and Expertise
The Treasurer will demonstrate the following personal qualities, skills and experience:

- all of the personal attributes required of a Director;
- financial expertise and literacy. An accounting designation would be an asset;
- ability to chair a meeting such that decisions are made in a manner that is respectful and efficient;
- willingness and ability to commit time to the Board and committee responsibilities of Treasurer;
- a record of achievement; and
- the ability to communicate efficiently and effectively.

Term
The Treasurer shall be elected annually by the Board on the recommendation of the Governance and Human Resources Committee for a maximum of three one-year terms. In exceptional circumstances and with Board approval, the term may be extended.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-11**

SUBJECT: **POSITION DESCRIPTION FOR SECRETARY**

PURPOSE AND APPLICATION

The Secretary, who is the Chief Executive Officer ("**CEO**"), works collaboratively with the Chair to support the Board of Directors ("**Board**") in fulfilling its fiduciary responsibilities.

GUIDING PRINCIPLES

The Secretary supports the Chair in maintaining a high standard for Board conduct and uphold policies and By-Laws regarding Director conduct, with particular emphasis on fiduciary responsibilities.

- Skills, Attributes and Experience

  The Secretary will demonstrate the following personal qualities, skills and experience:

  - all of the personal attributes required of a Director;
  - knowledge of law, regulation and policy concerning the Corporation, including legal compliance and reporting requirements;
  - demonstrate the utmost corporate integrity; and
  - the ability to communicate effectively.

- Term

  The Secretary shall be appointed by the Board for the duration of his/her appointment as CEO.

POLICY

The Secretary is accountable for:

- Document Management:

  - keeping a roll of the names and addresses of the Members. Ensure the proper recording and maintenance of minutes of all meetings of the Corporation, the Board and its Committees;
  - attending to correspondence on behalf of the Board;
  - the safekeeping of minute books, documents, registers and the seal of the Corporation and ensure that the same are maintained as required by law;

- ensuring that all reports are prepared and filed as required by law or requested by the Board;

- Trust Instruments and Investment Funds:
  - maintaining copies of all testamentary documents and trust instruments by which benefits are conferred upon the Corporation and providing related information to the Office of the Public Guardian and Trustee (OPGT), as required by the *Charities Accounting Act*;
  - providing an account to the Board, through the Finance and Audit Committee, at least semi-annually, of investment funds and all funds held in trust by the Corporation;

- Meetings:
  - giving such notice as required by the Corporate By-Law or by-law of all meetings of the Corporation, the Board and its Committees;
  - attending all meetings of the Corporation, the Board and its Committees;

- Other:
  - performing such other duties as may be required of the Secretary by the Board; and

- Delegation:
  - as Secretary, the CEO may delegate the performance of a duty or duties assigned to the Secretary to the Board Relations Lead or any other person(s) as approved by the Board, but retains responsibility for ensuring the proper performance of such duties. However, such delegation is understood to be mandatory when the Board is considering matters relating to the CEO.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-12**

SUBJECT: **POSITION DESCRIPTION FOR A BOARD STANDING COMMITTEE CHAIR**

POLICY

Role Statement

A Board Standing committee chair, working collaboratively with the Chair to support the Board in fulfilling its fiduciary responsibilities and with assigned staff support, provides leadership to the committee. He or she ensures that the terms of reference of the committee are followed. He or she effectively manages issues to promote effective dialogue. He or she respects that the committee has no direct management role with staff.

Responsibilities:

- **Agendas**
  - Establish agendas in collaboration with staff support and preside over meetings of the committee.
- **Work Plan**
  - With the assistance of staff support, develop a work plan for the committee.
- **Leadership**
  - Effectively lead each committee meeting in a manner that encourages thoughtful participation and promotes understanding of complex issues;
  - Ensure a fair discussion, especially when differences and conflicting opinions arise.
- **Expertise**
  - Serve as a leader on the matters addressed in the committee's terms of reference.
- **Advise Board Chair**
  - Advise the Chair on the key issues addressed by the committee.
- **Reports**
  - After each committee meeting, with the assistance of staff support, prepare a decision support summary for submission to the Board.

- **Mentorship**

  - Serve as a mentor to committee members and develop a succession plan for the Board Standing committee chair.

- **Skills, Attributes and Experience**

  A Board Standing committee chair will demonstrate the following personal qualities, skills and experience:

  - all of the personal attributes required of a Director;
  - interest and experience related to the work of the committee;
  - ability to chair a meeting such that decisions are made in a manner that is respectful; and
  - willingness and ability to commit time to the responsibilities of the Board Standing committee chair.

Term

Board Standing committee chairs shall be elected annually by the Board on the recommendation of the Governance and Human Resources Committee for a maximum of three one-year terms. In exceptional circumstances and with Board approval, the term may be extended.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE POLICY FRAMEWORK**

POLICY #: **V-A-13**

SUBJECT: **CONFLICT OF INTEREST**

POLICY

Refer to the *Corporate By-law* Article 6 for specific direction regarding conflict of interest related to contracts.

Preamble

This conflict of interest policy is intended to ensure the highest business and ethical standards and the protection of the integrity of the Board.

This policy guides Directors, with a real, potential or perceived conflict of interest, on how to declare their conflict and the process for dealing with conflict situations.

Directors owe a fiduciary duty to the Corporation. Included in that duty is the requirement to avoid conflicts of interest. The term “conflict of interest” refers to a situation where financial, professional or other personal considerations may compromise, or have the appearance of compromising, a Director’s judgment in carrying out his/her fiduciary duties as a Director.

All Directors must understand their duties when a conflict of interest arises. The principles set out in this policy are to be regarded as illustrative. Directors are required to meet both the letter and spirit of this policy.

Examples of Conflict of Interest

Situations where a conflict of interest might arise cannot be set out exhaustively.

Conflicts of interest generally arise in the following circumstances:

1. When a Director is directly or indirectly interested in a contract or proposed contract with the Corporation. For example: Directors are bidding on or doing contract work for the Corporation.

2. When a Director acts in self-interest or for a collateral purpose. When a Director diverts to his/her own personal benefit an opportunity in which the Corporation has an interest.

3. When a Director has a conflict of “duty and duty”. This might arise when:

i) the Director serves as a board member or officer of another corporation that is related to; has contractual relationship with; has the ability to influence the Corporation policy; or has any dealings whatsoever with the Corporation; or

ii) the Director is also a director or officer of another corporation, related or otherwise, and possesses confidential information received in one boardroom that is of importance to a decision being made in the other boardroom. The Director cannot discharge the duty to maintain such information in confidence as a director of one corporation while at the same time discharging the duty to make disclosure as a director of the other corporation.

4. When a Director uses for personal gain information (for example related to human resources financial aspects of the Corporation, or related to patient care) received in confidence only for the Corporation's purposes.

5. When a Director and his/her family will gain or be affected by the decision of the Board. For example, a Director or member of the Director's family may benefit from a specific health care service or program that the Corporation is considering.

Special Considerations for the Corporation

The Corporation's unique governance structure creates automatic potential conflicts. These structural conflicts need not be a bar to participation in most aspects of the Board's deliberations. In these circumstances, the Directors are aware of the potential for conflict of interest and as a practical matter it should not be necessary to make note of the potential conflict in regular Board proceedings. Where the potential for conflict might not be obvious, the potential conflict of interest should be declared and recorded in the minutes so that all Directors are aware of the situation. This places an extra burden on Directors to be acutely aware of when their actions and/or other responsibilities might create a conflict and follow the procedures in this policy to protect themselves and the best interests of the Corporation.

Conflict of Interest Process

- **Application**

  All Directors, including *ex-officio* Directors, and all non-Director members of Board committees must follow the conflict of interest process.

- **By-laws**

  The *Corporate By-law* contains provisions concerning conflict of interest that must be strictly adhered to in the matters described in the by-laws. The *Corporate By-law* reflects the requirements of the *Corporations Act*. The process set out in the *Corporate By-law* applies to direct and/or indirect interest in a contract or proposed contract. There are, however, other conflict situations beyond those specifically covered in the by-laws and this policy also addresses those conflicts and sets out the process to be followed when a conflict or potential conflict arises.

Process

- **By-laws**: All Directors must comply with the conflict of interest requirements of the *Corporate By-law*.

- **Conflicts and Potential Conflicts outside the By-laws**: Not all conflicts or potential conflicts may be satisfactorily resolved by strict compliance with the *Corporate By-law*. There might be cases where a conflict or perceived conflict of interest might be harmful to the Corporation notwithstanding compliance with the *Corporate By-law*.

- **Self-Identified**: In these circumstances, if the Director has a real, potential or perceived conflict, the Director will disclose the conflict at the earliest opportunity and will describe its nature and extent. If a Director is uncertain whether a conflict exists, the Director will err on the side of disclosure. The Director and the Board will then follow the **Process for Resolution** outlined below.

- **Potential Conflict Identified by Another Director**: If any Director believes that another Director:

  i) has breached his/her duties to the Corporation;

  ii) is in a position where there is potential breach of duty to the Corporation;

  iii) has an actual or potential conflict of interest; or

  iv) has behaved or is likely to behave in a manner that is not consistent with the highest standards of public trust and integrity and such behaviour may have an adverse impact on the Corporation;

  then the Director will refer the other Director to the **Process for Resolution**.

- **Process for Resolution**

  The actual, potential or perceived conflict will be referred to the following process for resolution:

  1. The Director must declare to the Board or committee the nature and extent of the interest as soon as possible and not later than the meeting at which the matter is to be considered. If a declaration is made at a committee meeting, it must be repeated at the next Board meeting to assure disclosure to the full Board.

  2. The Director may remain present for the purpose of answering questions prior to the discussion and the vote.

  3. The Director shall not be present during discussion of the matter in which he or she has a conflict or a potential conflict of interest (real or perceived), shall not attempt in any way to influence the voting and shall not vote.

4. In the event that a Director or a Board committee member discloses a conflict or potential conflict of interest (real or perceived) and refrains from, and is not present during the vote, the meeting quorum shall not be affected.

5. Where the matter of the conflict is unclear, the Director shall refer the matter to the chair of the Governance and Human Resources Committee or where the issue may involve the chair of the Governance and Human Resources Committee, to a member of the Governance and Human Resources Committee who is not in conflict, with notice to the CEO.

6. The chair of the Governance and Human Resources Committee (or member of the Governance and Human Resources Committee who is not in conflict as the case may be) will either: (1) resolve the matter informally or (2) refer the matter to the Governance and Human Resources Committee for resolution.

7. If the matter cannot be resolved in accordance with (7) above to the satisfaction of the chair of the Governance and Human Resources Committee (or member of the Governance and Human Resources Committee who is not in conflict as the case may be), the matter will be referred to the full Board for review.

8. If the matter cannot be resolved to the satisfaction of the Board, the chair of the Governance and Human Resources Committee (or member of the Governance and Human Resources Committee who is not in conflict as the case may be) shall forward it to dispute resolution.

- **Dispute Resolution Mechanism**

  If the matter cannot be resolved following the **Process for Resolution**, the Board may appoint an acceptable non-Director to independently review (and call on such resources as necessary to review) the matter in question and make a recommendation to the Board.

- **Minutes**

  At the beginning of every Board and every Board Committee Meeting, members will be reminded of the Governance conflict of interest policy and requested to declare any potential conflicts of interest.

  If there are no disclosures, the minutes will reflect this accordingly.

  The Board will record every disclosure of a real, potential and perceived conflict of interest and its general nature in the minutes.

- **No Accountability for Profits**

  If a Director has disclosed a conflict of interest in compliance with this policy, the Director is not accountable to the Corporation for any profits the Director may realize from the decision.

- **Failure to Disclose**

  If a Director knowingly fails to disclose a conflict of interest as required by this policy, the Director may be asked to resign or may be subject to removal from office pursuant to the *Corporate By-law* and the *Corporations Act*.

  A Director's failure to comply with this policy does not, in or of itself, invalidate any decision made by the Board.

- **Public Disclosure**

  The Corporation will make this policy, as amended from time to time by the Board, available to the general public.

Part V-B:

Governance Process

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-1**

SUBJECT: **NOMINATION PROCESS FOR THE BOARD OF DIRECTORS**

POLICY

The nominations process sets out a systematic, transparent, accountable and fair process by which the Board, with the advice and assistance of the Governance and Human Resources Committee, will recommend a slate of candidates for approval by the Board and subsequent election by the Members at the annual meeting.

Each year, at least four months before the annual meeting, the Governance and Human Resources Committee will:

a) determine the number of vacancies in the office of Directors and will include in this number incumbent Directors who are eligible for re-election.
b) using the *Guidelines for the Selection of Directors*, review the Board profile of skills and expertise of incumbent Directors and identify the specific skills and expertise that are required to fill vacancies. Where an incumbent Director is seeking re-election, in addition to the foregoing criteria, the Governance and Human Resources Committee will take into consideration that individual's self-evaluation of his/her own performance as a Director, his/her history as a Director and the contribution that he/she has made to the Corporation;
c) publicly advertise actual vacancies on the Board in a manner to be determined by the Governance and Human Resources Committee and may include regional daily and weekly papers, the Corporation's website etc., including a summary of the responsibilities as a Director and the *Guidelines for Selection of Directors*. It is not the intent to advertise vacancies where an incumbent Director is seeking re-election and following evaluation as outlined in (b) above is viewed as suitable for reappointment;
d) invite formal applications by interested individuals on a standard form to be provided by the Corporation, which will be submitted to the Secretary and forwarded to the chair of the Governance and Human Resources Committee for review.
e) identify a short-list of candidates for interview by the Governance and Human Resources Committee and interview and evaluate the short-listed candidates against the criteria set out in the *Guidelines for the Selection of Directors*;
f) obtain personal references and criminal reference checks for the candidates selected for nomination as Directors; and
g) recommend to the Board a slate of candidates for Directors equal to the number of vacancies for approval by the Board and for subsequent election by the Members at the annual meeting.
h) In the event of a mid term vacancy of an elected Board Member, the Board may request that the Governance and Human Resources Committee initiate a process to select a replacement Board Member.

As per the *Corporate By-law* (Article 4 Section 4.8), nominations made for the election of Directors at a Members' meeting may be made only by the Board in accordance with the *Corporate By-law* and the *Guidelines for the Selection of Directors*. For greater certainty, no nominations shall be accepted by the Members that are not submitted and approved by the Board in accordance with the Board-approved process. The decision of the Board as to whether or not a candidate is qualified to stand for election shall be final.

Consistent with best practice, the Governance and Human Resources Committee will maintain a roster of candidates eligible for election to the Board Members and look for opportunities to keep these candidates engaged.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-2**

SUBJECT: **NOMINATIONS PROCESS FOR BOARD OFFICERS**

POLICY

The selection process for Board officers will be a systematic, transparent, accountable and fair process.

The Governance and Human Resources Committee is responsible for ongoing succession planning for leadership on the Board and the recommendation of a slate of officers including the Chair, Vice-Chair, Treasurer and Secretary.

The Treasurer shall be selected in accordance with the process for the selection of the chair of the Finance and Audit Committee.

Under normal circumstances, the CEO will act as the Secretary and work with the Board Liaison to execute their responsibilities.

Under normal circumstances, it is assumed that there will be succession from the position of Vice-Chair to Chair. Therefore, under normal circumstances, the Governance and Human Resources Committee process for selection of Board officers is focused on the position of Vice-Chair.

The following process will be followed by the Governance and Human Resources Committee:

1. No later than four months before the completion of the second one-year term of an incumbent Vice-Chair, the Governance and Human Resources Committee will canvass the Directors for expressions of interest in being considered for the position of Vice-Chair or nomination of another Director, based on the position description and qualifications for Vice-Chair and Chair.

2. Based on the information received from Directors, the Governance and Human Resources Committee will develop an inventory of candidates for Vice-Chair.

3. The Governance and Human Resources Committee and/or a subcommittee of the Governance and Human Resources Committee will interview potential candidates, having regard for the position description and qualifications for Chair and Vice-Chair and the results of their Director evaluations.

4. If members of the Governance and Human Resources Committee are also seeking election as Vice-Chair, the Governance and Human Resources Committee will exclude potential candidates from committee deliberations in relation to this position.

5. Where there are multiple candidates for the position of Vice-Chair, the Governance and Human Resources Committee will:

   i) canvass the Board on the perceived strengths and weaknesses of the potential candidates and agree on a nominee to recommend for appointment by the Board at the first Board meeting following the annual meeting.

   ii) provide a list of the candidates to the Board for a vote by secret ballot at the first Board meeting following each annual meeting.

6. No later than four months before the completion of the initial one-year term of a Vice-Chair, the Governance and Human Resources Committee will confirm with a Vice-Chair that he/she wishes to be elected for a second one-year term and canvass the Directors to confirm their support for a Vice-Chair to be elected for a second one-year term on the understanding that he/she would subsequently be elected by the Board to the position of Chair.

7. If a Vice-Chair does not wish to/have the support of the Board to be elected for a second one-year term, the Governance and Human Resources Committee will initiate the process for selection of a Vice-Chair outlined above. In this event, a new Vice-Chair would serve a one-year term, before standing for election as Chair.

8. In the event of a mid term vacancy in the office of Chair, the Board, after reviewing the recommendation of the Governance and Human Resources Committee, may appoint a Vice-Chair as Chair or appoint another elected director as Chair.

9. In the event of a mid term vacancy in the office of Vice-Chair, the Board, after reviewing the recommendation of the Governance and Human Resources Committee, may appoint another elected director as Vice-Chair.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-3**

SUBJECT: **NOMINATIONS PROCESS FOR THE CHAIR, DIRECTORS AND NON-DIRECTOR MEMBERS OF BOARD STANDING AND SPECIAL COMMITTEES**

POLICY

The nominations process for the Director and non-Director members of Board Standing and Special Committees will be a systematic, transparent, accountable and fair process.

The Board of Directors (the "Board"), on the recommendation of the Governance and Human Resources Committee, will appoint the Director and non-Director members of the Board Standing and Special Committees.

Special Committees include Sub-Committees.

Guidelines for the Appointment of Directors to Board Standing and Special Committees

1. Annually, as part of the nominations process for Directors, the Governance and Human Resources Committee will canvass each Director to obtain expressions of interest in serving on specific Board Standing and Special Committees for the coming year, including interest in assuming responsibilities as committee chairs and vice-chairs.

2. In nominating specific Directors for assignment to Board Standing and Special Committees the Governance and Human Resources Committee, in consultation with the incumbent Board Chair and Vice-Chair, will have regard for:

   i) preferences of Directors;
   ii) balance of skills and expertise;
   iii) prior experience in relation to matters before the committee;
   iv) the expectation that, over the course of a Director's service, each Director will serve on at least three (3) Board Standing or Special Committees including the Quality and Program Effectiveness Committee; and
   v) other criteria as determined by the Board.

3. Unless otherwise provided, the Chair or Vice-Chair, as designated by the Chair, and the CEO will be *ex officio* members of all Board Standing and Special Committees.

4. Each Board Standing Committee will be composed of at least three (3) elected Directors.

5. Each Board Special Committee will be composed of at least two (2) elected Directors.

6. The Board, on the recommendation of the Governance and Human Resources Committee, will appoint the chair and, if desired, the vice-chair, of each Board Standing and Special Committee. Each chair and vice-chair of a Board Standing or Special Committee will be a Director.

7. The vice-chair will normally chair the Board Standing or Special Committee in the absence of the chair. However, there is no automatic succession from vice-chair to chair of the Board Standing or Special Committee.

Guidelines for the Appointment of Non-Directors to Board Standing and Special Committees

1. The Finance and Audit Committee and the Quality and Program Effectiveness Committee may include two (2) non-Director members. The Trillium HealthWorks Committee may include one (1) non-Director member. The non-Director members of Board Standing and Special Committees will be appointed annually by the Board for a maximum of four (4) one (1) year terms.

2. Annually as part of the nominations process, the Governance and Human Resources Committee may:

    a) determine the number of vacant positions for non-Director community members of Board Standing and Special Committees;
    b) identify the specific skills and expertise that are required to fill these vacancies;
    c) publicly advertise vacancies in a manner to be determined by the Governance and Human Resources Committee and may include regional daily and weekly papers, the Corporation's website etc., including a summary of the responsibilities as a member of a Board Standing or Special Committee;
    d) invite formal applications by interested individuals on a standard form to be provided by the Corporation, which will be submitted to the Secretary and forwarded to the chair of the Governance and Human Resources Committee for review;
    e) identify a short-list of candidates for interview by the Governance and Human Resources Committee and interview and evaluate the short-listed candidates against the criteria established by the Governance and Human Resources Committee;
    f) obtain personal references and criminal reference checks for the candidates selected for appointment by the Board; and
    g) recommend the required number of candidates to the Board for appointment as non-Director community members of Board Standing and Special Committees at the first Board meeting following the annual meeting.

3. Notwithstanding the foregoing, the chair, vice-chair, if any, and members of the Medical Advisory Committee will be appointed in accordance with the *Professional Staff By-law*.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-4**

SUBJECT: **ONGOING BOARD EDUCATION**

POLICY

The Board recognizes that the continuing education of the Directors is an important requirement of effective governance and that it is essential that Directors be fully informed on the background and context of the issues they are called upon to address. A firm commitment to continuing education is the responsibility of each Director and a factor to be considered in the election or re-election of a Director.

An ongoing Board education program will be established each year that is consistent with the goals and objectives of the Board for that year. It is expected that each Director will participate in the ongoing education process.

Directors will be canvassed annually for expressions of interest to attend external meetings and conferences. The potential interest will be discussed with the Governance and Human Resources Committee within the context of the overall allocation for external Board education. The number of Directors attending will be based on the value of the conference or meeting, as assessed by the Governance and Human Resources Committee, and the estimated cost. The Chair may from time to time determine that a limit be placed on attendance at any one session.

The annual operating budget will include an estimate of Board expenses for conferences. Directors attending conferences and meetings will be reimbursed for all permissible expenses. All Directors who attend these meetings are encouraged to provide a report to the Board.

Components of the ongoing education process may include:

i) **Internal and External Resources**: Additional resources and expertise may be made available to support the orientation program e.g. staff to present and provide an introduction to issues in their area; external speakers; attendance at sponsored events etc.

ii) **New or Returning Director Orientation** will take place in a timely manner as soon as possible after the election or appointment of a Director. An orientation session will be scheduled, and will include:

- an introduction to and tour of the Corporation, including a meeting with the CEO, the Chief of Staff, Chair, and other members of the senior management team;
- overview of Governance Roles and Responsibilities and Staff/Board Relationships;
- performance status and future challenges with regard to funding, quality and utilization, benchmarking and performance indicators, accreditation; and

- the Corporation's relationships with health system partners.

Other components of the orientation may include:

- **Reference Manual**: Content will include: legal documents; information on the Corporation including its Board policies; and Ministry information.
- Mentoring: Each new Director may be paired with a mentor on the Board who is an experienced Director assigned by the Chair to assist the new Director in understanding how the Board functions. The mentor will attend orientation sessions with his/her initiates, sit with them at Board meetings, ask if the information presented was clear, and answer any questions about the meeting.

iii) **Assessment of Development Needs:** Directors will be asked annually to identify their development needs. Mechanisms to identify those needs may include: survey of Directors; feedback on previous education sessions; diagnostic questionnaires; feedback from Directors' self-evaluations.

iv) **Presentations at Board Meeting:** The Governance and Human Resources Committee, in consultation with the CEO, will develop an annual program of information/education presentations, which may be included as part of the Board's regular meetings or presented at scheduled times as the Board may direct.

v) **Ontario Hospital Association sponsored Education Sessions and Programs:** Directors are encouraged to participate in educational opportunities offered by the Ontario Hospital Association. Reasonable expenses of attending and/or participating in such events will be reimbursed according to established policy.

vi) **Other Relevant Education Programs:** Directors may attend relevant educational programs sponsored by organizations other than the Corporation. Reasonable expenses of attending and/or participating in such programs will be reimbursed according to the established policy with the prior written approval of the Chair.

vii) **Annual Board Retreat:** The annual Board retreat will be scheduled. At each retreat, the strategic plan will be reviewed to ensure that progress is being made toward its achievement. Additionally, the retreat should focus on other relevant areas within the *Roles and Responsibilities of the Board*, reflecting the Board's annual work plan. The retreat should be conducted at a reasonable cost, with clear objectives and expected outcomes.

To enhance both the hands-on practical experience and hospital orientation, all Directors are encouraged to take the Ontario Hospital Association trustee introductory orientation at some point during their first term as a Director. All costs associated with their attendance will be borne by the Corporation.

As Directors assume the office of Chair, Vice-Chair or Treasurer they are required to attend an Ontario Hospital Association conference offered to assist them in transitioning to this new position within the Board. All costs associated with their attendance would be borne by the Corporation.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-5**

SUBJECT: **BOARD GOALS AND BOARD WORK PLAN**

PURPOSE AND APPLICATION

On an annual basis, the Board of Directors ("**Board**") will establish Board goals consistent with Trillium Health Partner's (the Corporation's) vision, mission and core values, the strategic plan and key issues that are a priority for the Board in the coming year. The Board goals will be reflected in the direction for the Board Standing and Special Committees and a Board Work Plan.

POLICY

The Board will review its progress toward the achievement of the annual Board goals on a frequent basis.

The Board will also establish an annual Work Plan for the Board that addresses its role and the following key areas of *responsibility*:

- Strategic Direction
- Excellent Management
- Program Quality and Effectiveness
- Financial and Organizational Viability
- Board Effectiveness
- External Relationships

The Board will evaluate its success in the achievement of its Work Plan on an annual basis.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-6**

SUBJECT: **BOARD MEETINGS**

PURPOSE AND APPLICATION

This Policy outlines the framework for conducting Board of Directors ("**Board**") meetings.

BACKGROUND

The Chair, in consultation with the Chief Executive Officer ("**CEO**"), is responsible for developing an agenda for each Board meeting that is aligned with the Board's roles and responsibilities, the Board work plan and the annual goals and objectives. The Chair has discretion to table items to the next regularly scheduled Board meeting, if time considerations unduly limit any discussion.

GUIDING PRINCIPLES

The Chair, in collaboration with the CEO, will develop standards for Board meeting packages that include timelines for distribution, formats for reporting to the Board and the level of detail that is to be provided. Requests for additional information will be assessed by the CEO and reviewed regularly by the Chair to ensure optimal Board functioning.

Where necessary, Kerr and King "Procedures for Meetings and Organizations" will guide the Board and Chair in dealing with procedural matters.

Guests

Guests may attend Board meetings with the consent of the meeting on the invitation of the Chair or CEO.

Regular Board Meetings (Corporate By-Law, sections 5.1 and 5.2)

The Board will meet at such times and in such places as may be determined by the Board, the Chair, Vice-Chair or the CEO.

The Board may appoint one or more days for regular Board meetings at a place and time named. A copy of any Board resolution fixing the place and time of regular Board meetings will be given to each Director forthwith after being passed and no other notice will be required for any such regular meeting.

Special Board Meetings (Corporate By-Law, section 5.1)

Special Board meetings may be called by the Chair, Vice-Chair or the CEO and will be called by the Secretary upon receipt of the written request of three Directors.

POLICY

Voting (Corporate By-Law, section 5.8)

Each voting Director present at a Board meeting shall be entitled to one vote on each matter. A Director shall not be entitled to vote by proxy. Every question arising at a Board meeting or Board committee meeting shall be decided by a majority of votes.

A Director may abstain from voting. An abstention will not be considered a vote cast.

If there is a tie vote, the chair of the meeting will not have a second vote to break the tie; instead, the motion will be considered not to have passed.

Agendas and Information Packages

The Board package will normally be sent to Directors one week in advance of the meeting to allow for review and preparation. All reports to the Board will be in writing.

Corporate reports and recommendations to the Board from the CEO, Chief of Staff and Board Standing Committees will use consistent templates as appropriate to support the respective Board roles concerning the agenda items, i.e. policy formulation, decision-making and monitoring.

Items circulated after the package has gone out or handed out at the Board meeting will only be discussed if, in the opinion of the Chair, the item is of an urgent nature or should not be held until the next Board meeting. It is expected that the Board Chair will only allow such items to be brought forward and considered under exceptional circumstances.

Communication to the Public arising from Board Meetings

Meetings of the Board and Board Standing and Special Committees are not open to the public or the media. However, the Board values the importance of ensuring that the community is properly informed in a timely way of Board decisions and has access to information related to corporate planning and priority setting.

Consistent with the Board's commitment to good governance practices, timely access to information, appropriate protection of personal privacy, and appropriate protection of other information that is exempt or excluded from disclosure under the *Freedom of Information and Protection of Privacy Act* ("**FIPPA**"), the Board will make available to the public the following arising from Board meetings:

- a report on the Corporation's performance as part of the Corporation's Annual Report;
- the Corporation's Quality Improvement Plan, in compliance with the *Excellent Care for All*

Act, 2010 (ECFAA); and
- upon request, information that is subject to disclosure under the FIPPA.

Additional information on the Corporation's communication with the public are found in Board Policy *V-A-2 Roles and Responsibilities of the Board of Directors*.

PROCEDURE

The Board has the right to move *in-camera* and to restrict attendance to the Directors only for any meeting or part of a meeting if the Board deems an *in-camera* session to be necessary to protect the interests of the corporation, the public or a person.

Any attendees who are not Directors will be excluded from the in-camera meeting. However, guests may be permitted to attend all or a portion of the *in-camera* session with the consent of the Chair or CEO.

In-camera meetings may include both formal and informal in-camera sessions and will allow for time alone, as needed, for the CEO/Chief of Staff (COS)/Chief Nursing Executive (CNE), either individually or together in any combination, and for the Elected Directors only to meet alone.

A separate agenda will be prepared for *in-camera* sessions indicating the items to be considered during the session. The agenda and any supporting materials will be sent via separate e-mail to the attendees of the applicable in-camera session only or provided in hard copy for the meeting in order to be handled and secured in a manner that respects the nature of the material.

A Board motion is required to move into, and to rise from, an *in-camera* session.

Following any meeting, the Chair may discuss matters arising, as appropriate, with the CEO.

Examples of matters which may generally be dealt with in an *in-camera* session are listed in Appendix A.

Appendix A - In-Camera sessions

Matters which may generally be dealt with in an *in-camera* session include, but are not limited to:

- Senior leadership succession planning, performance or compensation matters
- Patient-specific issues
- matters relating to an individual Board member or a prospective Board member
- individual employee or professional staff matters
- donor specific issues
- professional staff appointments, re-appointments and changes in privileges
- any other matters where personal information about an individual will or may be revealed
- labour relations and matters pertaining to collective bargaining or terms of employment, including negotiations or potential negotiations
- litigation or potential litigation, including administrative tribunal matters
- receipt of advice that is subject to solicitor-client privilege, including communications necessary for that purpose
- the security of property of the corporation
- contract negotiations or disputes
- the acquisition, disposition, lease, exchange or expropriation of, or improvements to, real or personal property, if the Board considers that disclosure might reasonably be expected to harm the interest of the corporation
- Board self-evaluation
- information that is exempt from disclosure under the *Freedom of Information and Protection of Privacy Act* (FIPPA)
- other matters that, in the opinion of the majority of directors, the disclosure of which might be prejudicial to an individual or to the best interests of the corporation
- consideration of whether an item is to be discussed *in-camera*

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-7**

SUBJECT: **BOARD AND INDIVIDUAL DIRECTOR EVALUATION**

POLICY

The Board will utilize an annual evaluation protocol to ensure continuous improvement. The evaluation will examine the processes and structure of the Board as a whole, as well as its committees. The Board evaluation process will also ensure continuous improvement of individual Directors.

Each Director will participate in a confidential evaluation of the performance of the Board as a whole and of his/her own performance as a Director in alternating years. The scope of the evaluation will include an assessment of the effectiveness of the Board as a whole in fulfilling its roles and responsibilities and of the processes and structure of the Board and its committees. It will also include a 360 and self-assessment of the performance of individual Directors in fulfilling their responsibilities.

The purpose of evaluation is to:

i) ensure continuous improvement of the Board, Board Standing and Special Committees and individual Directors;
ii) obtain input for succession planning for the Board and Board officers and re-elections of Directors;
iii) identify Directors' education and development needs; and
iv) ensure an opportunity to provide feedback on effectiveness of Board and Board committee meetings.

The Governance and Human Resources Committee will establish the annual process for evaluation of the Board and individual Directors based on the *V-A-2 Role and Responsibilities of the Board of Directors Policy* and the *V-A-3 Responsibilities as an Elected and Ex-Officio Director Policy*. Respondent anonymity will be respected; survey respondents will not be required to identify themselves. External resources may be used as appropriate to ensure an effective process.
The Governance and Human Resources Committee will provide a summary report of the evaluation of the Board as a whole to the Board including key issues to be addressed to ensure continuous improvement of the Board, as a whole.

The Chair of the Board and/or the Chair of the Governance and Human Resources Committee will provide feedback to individual Directors on their performance.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-8**

SUBJECT: **RECEIPT OF GIFTS BY INDIVIDUAL DIRECTORS**

PURPOSE AND APPLICATION

This policy outlines the principle for the acceptance of gifts by individual Board Directors.

POLICY

Directors will not use their authority or position for personal gain and will maintain integrity in all of their dealings with Trillium Health Partners (the "Corporation").

Individual Directors, in the course of their duties as Directors, may not accept gifts of any kind from sponsors, agencies, consultants, professional advisors or contract providers if acceptance of a gift could create a perception of impropriety. If an impropriety is believed to have occurred, the gift is to be returned or declined.

If a Director is in doubt about the propriety of any situation, the matter may be brought forward to the Board of Directors for discussion and decision.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-9**

SUBJECT: **BOARD MEMBER RECOGNITION**

PURPOSE AND APPLICATION

At the end of his/her service, a Director will be recognized with a token of appreciation, recognizing his/her years of service provided to the Board of Directors ("**Board**"). This token of appreciation will be presented to the retiring Director at the last regular Board meeting marking the end of his/her service.

POLICY

This token of appreciation will be presented to the retiring Director at the last regular Board meeting marking the end of his/her service.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-10**

SUBJECT: **REIMBURSEMENT OF BOARD DIRECTOR EXPENSES**

PURPOSE AND APPLICATION

This policy outlines the process for the approval and reimbursement of expenses related to a member's role on the Board of Directors ("**Board**") of Trillium Health Partners ("**Corporation**").

GUIDING PRINCIPLES

- The process for the reimbursement of Director expenses is consistent with the organization's *Business Expenses, Travel and Transportation, Meals and Other Allowable Expenses - P&P* expense and travel policies and practices for other employees of the Corporation.

  Exceptions may be permitted at the discretion of the Chair of the Board of Directors ("**Chair**").

- Directors are insured under the Corporation's Travel Accident Policy for accidental death and dismemberment in the principal sum of $250,000 while travelling on the Corporation's business. The cost of any additional trip insurance is not reimbursable.

POLICY

Directors are encouraged to attend Board meetings, committee meetings, annual meetings and other Members' meetings, conferences and educational events, as reasonably required to properly discharge their duties. Directors will be reimbursed for expenses associated therewith.

Director expenses will be made public in keeping with the requirements under the *Broader Public Sector Accountability Act, 2010* (BPSAA).

PROCEDURE

The Director will submit a signed THP expense claim form, together with supporting receipts or proof of payment, to the Board Relations Lead, for review by the Senior Vice-President, Corporate Services & Chief Financial Officer ("**CFO**"). Receipts are not required for mileage and reasonable tips for porter, hotel room services and taxis.

The CFO and Board Chair will approve the expense claim. The Board Relations Lead will arrange for the Director to be reimbursed.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-11**

SUBJECT: **RESIGNATION AND/OR REMOVAL OF A DIRECTOR**

POLICY

Resignation of a Director

A Director may resign his/her office by delivering a written resignation to the Secretary. The resignation will be effective at the time it is received by the Secretary or at the time specified in the resignation, whichever is later.

Vacation of Office of a Director

In accordance with the *Corporate By-law* (Section 4.5), the office of a Director will automatically be vacated:

i) if a Director resigns the office by delivering a written resignation to the Secretary of the Corporation;
ii) if the Director becomes bankrupt; or
iii) if he or she becomes a person referred to in the *Corporate By-law* Section 4.4 (c) except by Board resolution.

Removal of a Director

Under extreme circumstances and in highly unusual situations it may become necessary to remove a Director from the Board. In accordance with the *Corporate By-law* (Section 4.6), the office of a Director may be vacated by a simple majority Board resolution passed in accordance with this policy. Reasons for removing a Director may relate to any of the following:

i) failure to comply with the confidentiality provisions of the *Corporate By-law* (Section 13.1);
ii) failure to comply with the conflict of interest requirements;
iii) failure to fulfill the fiduciary duties of a Director;
iv) failure to comply with the attendance policy for Board meetings;
v) inappropriate or lack of participation and contribution to effective discussion and Board decision making; and
vi) illegal, unethical or inappropriate activities, which may damage the Corporation's reputation.

The Governance and Human Resources Committee is responsible for recommending the removal of a Director, to the Board based on the foregoing reasons. Before making a

recommendation to the Board, the Governance and Human Resources Committee will follow the following procedures:

i) The Director in question will be treated fairly and with respect.
ii) The Director will be given notice of applicable reason for removal.
iii) The Director will be given the opportunity to respond (for example, attendance can improve, conflict of interest can be examined and questions of conduct can be reviewed).
iv) The Director will be notified of the final consideration and action of the Board.

Post-Service

Upon retirement, resignation, vacation or removal from the Board, a Director must:

i) securely destroy or return all confidential material relating to the Corporation;
ii) eturn any manuals or other material (e.g. letterhead, business cards, access cards etc.) that may be re-used by another Director; and
iii) return any equipment owned by the Corporation in the possession of the Director.

The Secretary will be responsible for ensuring that all such equipment and materials are returned or securely destroyed.

CATEGORY: **BOARD EFFECTIVENESS - GOVERNANCE PROCESS**

POLICY #: **V-B-12**

SUBJECT: **REVIEW OF BOARD POLICIES**

POLICY

In keeping with best practices in governance, the Governance and Human Resources Committee will complete an overall annual review of the Board policies to ensure compliance with the *By-laws* and applicable laws, and will make recommendations to the Board for revisions as required.

Each Board Standing Committee will review its policies for appropriateness, detail and whether it should be a Board policy. Each Board Standing Committee will develop a review schedule and report to the Governance and Human Resources Committee. All policies should be reviewed every five years or sooner, if necessary. All new policies will be reviewed by the Governance and Human Resources Committee.

The Secretary will be responsible for ensuring that all Board policies are reviewed and revised consistent with Board approval.