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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.”

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. Consequently, the Board policies are organized according 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

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 five 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 (Policy V-B-13).

**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;

“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
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
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 Vice President, Human Resources and Organizational Development 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.

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

The CEO will identify to the 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.
**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 (CEO Position Description) 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.
The President and Chief Executive Officer (‘the CEO’) of Trillium Health Partners is appointed by, and is directly accountable to the Board of Directors (‘the Board’), reporting through the Chair, for ensuring the organization functions within the framework of the strategic plan and policies established by the Board of Directors.

The CEO will have overall responsibility for the operations and administration of the organization.

The CEO will attend to both the internal and external dimensions of the role, by discharging the following responsibilities:

Internal Organization Environment:

1. Provide clear and decisive leadership
2. Create the necessary structures, processes, and systems that will result in the best possible clinical outcomes and patient experiences
3. Ensure the resources of the organization (financial, human, and capital assets) are aligned and managed in keeping with the strategic plan
4. Instill and cultivate a spirit of research, innovation and education
5. Continue to build a fair and equitable workplace including strong relationships with physicians
6. Ensure compliance with all applicable legislative requirements
7. Lend strong support to the Foundations

External Health Care System Environment:

1. Champion health system partnerships and linkages with the community and other health care providers locally and provincially
2. Forge and sustain relationships at both the municipal and provincial government levels
3. Facilitate a mutually beneficial relationship with the University of Toronto, Mississauga Academy of Medicine that is supportive of teaching excellence
The following leadership competencies are required in this position:

Creating Vision and Leading Change
- Creates, and is able to execute, on a vision.
- Success in working with broad constituent groups to achieve innovation and transformational change in complex health care environments.
- Models the behaviour and demonstrates understanding of the requisite leadership skills required to lead leaders through continuous transformation and change.

Influence
- Ability to inspire enthusiasm, broad commitment and organizational capability for the vision and shared mission and purpose.
- The courage, curiosity and intellectual capacity to identify bold solutions to complex problems and is able to capitalize upon new ideas, tools and technology.
- Ability to build exceptional relationships with diverse external partners and stakeholders.

Leading Others
- Outstanding communications ability.
- High capacity for developing respectful and supportive interpersonal relationships.
- Commitment to quality and embraces best practices in all activities.
- Supports, coaches and mentors others, particularly members of the senior management team, in achieving their personal best.
- Leads by example within the organization and demonstrates accountability for her/his personal behaviours and practices.

Results Driven
- Identifies tangible goals as part of the solution to complex problems and demonstrates leadership in achieving these objectives.
- The ability to develop, lead and sustain a culture that values innovation, learning, teaching, research, and a highly collaborative integrative and efficient approach to achieve the best patient outcomes.

Sound Judgement
- The ability to balance risks with knowledge, wisdom, and intellectual capacity, and bases all decisions on the well-being of patients and families, fiscally sound practices and the vision and goals of the organization.
The Board is responsible for appointing the CEO as well as managing and evaluating their performance. Performance evaluation of the CEO 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 CEO. It also allows the opportunity for discussion of core competencies and personal development goals.

Upon the recommendation of the Chair, the Board will establish measurable annual performance objectives in cooperation with the CEO, assess CEO performance annually, and determine CEO compensation.

The performance review process provides an opportunity to recognize the CEO’s level of performance, to collaboratively develop the Corporation’s priorities for the next fiscal year to present to the Board for approval, and to plan strategies to support the CEO and the Corporation’s operations as articulated in its operational plan.

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 CEO’s performance.

iv) The operational plan should include reference to the CEO’s expectations for senior management team members, thereby promoting a consistent and continuous approach to performance measurement across the senior management team.

Process:

1. The CEO will develop annual performance objectives in consultation with the 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 CEO performance review process will be the responsibility of the Chair and the Chair of the Human Resources Committee, in consultation with the CEO. The review process will commence annually in the month of October (mid-year review) and March-April (year-end review).

3. The Chair and Chair, Human Resources Committee will review the CEO’s performance against the objectives on a semi-annual basis and will report the outcome of the review to the Board in an *in camera* session.

4. Feedback will be gathered from all Directors annually on the performance of the CEO and such feedback will be documented in writing. The Chair and Chair, Human Resources Committee will then compile the feedback and develop the performance review documentation.

5. The Chair and Chair, Human Resources Committee will provide a report to the Board, in an *in camera* session, on the CEO’s performance relative to both achievement of the goals and the assessment of core competencies.

6. The Chair will communicate the results of the evaluation to the CEO.
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 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 Human Resources Committee, the Board will approve the incentive compensation calculation.

The Board Chair and Chair of the 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.

1, In keeping with all relevant legislation.
1. PURPOSE AND APPLICATION

This policy outlines the process for the approval and reimbursement of CEO expenses.

2. 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 the Corporation.

Exceptions may be permitted at the discretion of the Chair of the Board of Directors (“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 Chair prior to any trip taking place.
3. 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, while carrying out duties and traveling for the Corporation.

CEO expenses will be made public in keeping with the requirements under the Broader Public Sector Accountability Act, 2010.

4. 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.

5. RESPONSIBILITY

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6. COMMUNICATION

Following its approval by the Board of Directors, this Policy will be published on the THP Hub, on the Policies & Procedures website.

7. APPROVED BY

2017/TBD Governance & Human Resources Committee.
2017/TBD Board of Directors

8. SUPERCEDES

2012/08/31 II-6 CEO Expense Reimbursement and Travel

Version: 1.0 Document ID #: 29613
9. **POLICY AUTHOR**

   Board Relations Lead, Corporate Governance
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.
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.
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.
The Chief of Staff (COS) is responsible directly to the Board of Directors, reporting through the Chair, for ensuring that the medical staff organization functions within the framework of the policies established by the Board of Directors.

The Chief of Staff, in addition to being the Chair of the Medical Advisory Committee, will have overall responsibility for:

- physician accountability, engagement, performance and discipline*
- medical administration**
- medical research**
- academic affairs***

* Reporting to the Chair of the Board and the Board
** Reporting to the CEO
*** Reporting to the CEO and Medical Academy

LIST THE SPECIFIC DUTIES OR RESPONSIBILITIES:

Administrative Duties of the Chief of Staff:

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

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

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

(d) participate in the corporation’s administrative team for the purpose of providing input into formulating and evaluating policies, priorities, allocation of resources and general management strategies;

(e) ensure his/her duties are assumed by a departmental chief when absent from the hospital;
(f) ensure, with the chief executive officer:

i. the promotion, establishment and maintenance of cooperative relations between the employees, patients, visitors, physicians, midwives and administration;

ii. that the standards of the Canadian Council of Health Services Accreditation are reviewed and implemented;

iii. the overall direction and management of medical research and academic affairs;

iv. the co-ordination of future planning and development of the hospital is consistent with the hospital’s strategic plan;

(g) Be a member of the Senior Management Team of the hospital.

*Medical Supervisory Duties of the Chief of Staff:*

a) be responsible to the Board for the credentialed professional staff organization 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 Act and other relevant legislation;

b) be the chair of the Medical Advisory Committee;

c) advise the Medical Advisory Committee and the Board with respect to the quality of credentialed professional staff diagnosis, care and treatment provided to the patients of the hospital;

d) assign, or delegate the assignment of, a member of the credentialed professional staff to discuss in detail with any member of the medical staff any matter which is of concern to the chief of medical staff and to report the discussion to the chief/co-chief of the appropriate department;

e) assign, or delegate the assignment of, a 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/co-chief of the appropriate department;

f) when necessary:

i. under emergency conditions, and whenever possible in consultation with the appropriate department chief, restrict or suspend temporarily any or all privileges of any member of the credentialed professional staff until such time as an emergency 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.

g) ensure there is a process for participation in continuing medical education and medical research;

h) support an effective process of medical staff self-government through the medical staff association; and

i) support the process of program management by participating in its development and by providing advice regarding program management issues which influence patient care.

**Supervisory Role for Medical Department Chiefs and Programme Physician Directors:**

a) Ensure a process for the regular review of the performance of chiefs of departments and program physician directors;

b) Delegate appropriate responsibility to the chiefs of departments, and

i. receive and review recommendations from chiefs of departments regarding new appointments, reappointments and changes in status including changes in privileges;

ii. ensure chiefs of departments complete annual reviews and make recommendations concerning appointments and reappointments and that all recommendations are forwarded to the credentials committee.
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.
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 package1, 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 Human Resources Committee will approve the incentive compensation calculation.

The Board, through the 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.

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1 In keeping with all relevant legislation
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.
1. PURPOSE AND APPLICATION

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. PROCEDURE FOR REPORTING COMPLAINTS

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

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).

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. 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.

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

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 the 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/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. SUPPORT 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.

7. EDUCATION/COMMUNICATIONS

There will be a full communications plan for Individuals on the new integrated Whistleblowing Policy. The communications will include a message from the CEO, Frequently Asked Questions, and an overview of the complaints process. The Policy will be posted on the Hospital’s intranet.
site(s). On an annual basis, the Hospital will communicate reminders to Individuals about the process for reporting complaints, including anonymous complaints.

8. RELATED POLICIES

2008/06/17 CVH Code of Conduct - POL  
2010/06/29 CVH Code of Conduct - PRO  
2010/08/06 THC Code of Conduct - PRO  
2012/07/03 Professional Staff Code of Conduct – POL INT  
2006/03/17 CVH Workplace Harassment - POL  
2006/03/17 CVH Workplace Harassment - PRO  
2012/03/30 CVH THC Conflict of Interest – POL INT

9. APPROVED BY

2012/08/29 Senior Management Team  
2012/10/11 Risk Management Committee (tbc)  
2012/11/06 Governance Committee (tbc)  
2012/11/16 Board of Directors (tbc)

10. SUPERCEDES

2008/02/29 CVH Whistleblowing - POL  
2008/02/29 CVH Whistleblowing - PRO  
2010/07/29 THC Whistleblower Policy - POL
### APPENDIX A - FILING OF COMPLAINTS SUMMARY CHART

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

Correspondence to the Board

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*
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.
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.
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 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 stakeholder input from those with less power and influence.

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

- **Relevance:** Stakeholders agree on relevant 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.
7. RESPONSIBILITY

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<td>Corporate Administrative Policies</td>
<td>VP Quality, Education, &amp; Patient Relations</td>
<td>Regional Ethics Program</td>
<td>Board of Directors</td>
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8. EDUCATION/COMMUNICATIONS

The IDEA Framework is introduced to all new staff during corporate orientation and to new Board Members as part of their on-boarding process. There is also an on-line education module on the IDEA Framework. Hypothetical cases using the IDEA Framework are available on the thpHUB.

9. EVALUATION

Feedback about the IDEA Framework is sought from relevant stakeholders including patients and their families.

10. REFERENCES

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).

11. APPROVED BY

2017/05/25 Board Governance and Human Resources Committee
2017/06/01 Board of Directors

12. SUPERCEDES

2012/08/31 III-3 IDEA Framework - POL INT

13. POLICY AUTHOR

Regional Ethics Program

14. APPENDICIES

Appendix A - Ethical Decision-Making Framework
Appendix A

IDEA¹: Ethical Decision-Making Framework

1. **Identify the Facts.**
   - Clinical/Medical Indications
   - Individual Preferences
   - Evidence
   - Contextual Features
   
   Ask: *What is the ethical issue?*

2. **Determine** the Relevant Ethical Principles.
   - Nature & Scope
   - Relative Weights
   
   Ask: *Have perspectives of relevant individuals been sought?*

3. **Explore** the Options.
   - Harms & Benefits
   - Strengths & Limitations
   - Laws & Policies
   - Mission, Vision, Values
   
   Ask: *What is the most ethically justifiable option?*

4. **Act.**
   - Recommend
   - Implement
   - Evaluate

   Ask: *Are we (am I) comfortable with this decision?*

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₁ IDEAS Framework calculated by the Trillium Health Partners - Policies & Procedures Team.
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 positive work environment consistent with applicable laws;
- promote a climate of understanding and mutual respect for the dignity and worth of every person;
- be courteous and tactful in all interactions;
- respect the customs and beliefs of individuals consistent with the mission of the Corporation;
- strive towards equity and fairness and work with honesty, integrity, respect and good faith;
- be sensitive to potential barriers to accessibility;
- provide for equal rights and opportunities without discrimination; and
- promote respectful relationships with health care partners and community stakeholders.
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.
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.

- 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.
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 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 research subjects.

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 subjects 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 subjects. 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 human subjects research 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 FederalWide 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 subject research protocols based on whether or not human subjects 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 subjects that is conducted under the auspices of the Corporation. Specifically, the REB will review all human subjects 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 subject 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 subjects 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.
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.

5. RESPONSIBILITY

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<td>Research Office</td>
<td>Board of Directors</td>
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<td>policies</td>
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6. EDUCATION/COMMUNICATIONS

The Policy will be posted on the Hospital’s intranet site(s) and external website.
7. RELATED POLICIES
III-8 Research - POL

8. APPROVED BY
2013/05/30 Board of Directors
Part IV: 
Financial and Organizational Viability
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.

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<td>Corporate administrative policies</td>
<td>Senior Vice President, Corporate Services &amp; Chief Financial Officer</td>
<td>Governance and Human Resources Committee</td>
<td>Board of Directors</td>
</tr>
</tbody>
</table>

### 6. EVALUATION

On an annual basis, the Board Governance and Human Resources Committee will review this policy.

### 7. RELATED POLICIES AND PROCEDURES

- I-1 Strategic Planning - POL INT
- II-13 Reporting on Compliance - PRO INT
- IV-3 Asset Protection - POL INT
- IV-4 Delegation of Signing Authority - PRO INT
- IV-5 Borrowing - POL INT
- IV-6 Investment - POL INT
- V-A-2 Role and Responsibilities of the Board of Directors - PRO INT

### 8. APPROVED BY

- 2017/05/25 Board Governance and Human Resources Committee
- 2017/06/01 Board of Directors

### 9. SUPERCEDES

- 2012/08/31 IV-I Financial Objectives - POL INT
- 2012/08/31 IV-2 Financial Planning and Performance - POL INT
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.

APPROVED BY

2015/03/26 Board Governance and Human Resources Committee
**1.0 PURPOSE AND APPLICATION**

The purpose of the Board of Directors 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 HAPS and H-SAA.

- directs the organization 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 Corporate Signing Authority.

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

- The Board of Directors authorizes the CEO to approve expenditures, purchase orders, invoices, contracts, investment decisions and related instructions, commitments etc. under $5 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, in conjunction with SVP/CFO approval, is authorized to approve an additional 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.

In the absence of the President and CEO, the CEO can delegate the signing authority to the Acting CEO who will approve expenditures under $5 million with the exception of sole sourced or non-competitive consulting services. Note: The delegation of authority to an Acting CEO will be discussed and concurred with by the Board Chair in advance, where possible (e.g. for planned absences) and immediately (for unplanned absences).

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 are 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;
- 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 $5,000,000. 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; and
6. All related budgets for new construction and building capital renovation costs prior to any spending.
7. Establishment of and any changes to the $ level of the Hospital's Operating Line(s) of Credit.
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 $1M 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 procurements where the CEO has declared a potential, perceived, or actual conflict of interest that must be approved at a higher level.

3.0 EVALUATION

On an annual basis, the Board Governance and Human Resources Committee reviews this policy.

4.0 RELATED POLICIES AND PROCEDURES

- Borrowing - POL INT
- Signing Authority - PRO INT

5.0 APPROVED BY

2017/01/10 Governance and Human Resources Committee
2017/01/26 Board of Directors

6.0 SUPERCEDES

2016/04/12 IV-4 Board Delegation of Signing Authority
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,
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.

3.0 EVALUATION

On an annual basis, the Board Governance Committee reviews the policy.

4.0 RELATED POLICIES AND PROCEDURES

IV-4 Board Delegation of Signing Authority – POL INT
Signing Authority – PRO INT

5.0 APPROVED BY

2017/03/30 Board of Directors

6.0 SUPERCEDES

2016/04/12 IV – Borrowing – POL INT
Revised May 2016
Statement of Investment Policy and Procedures

Prepared For:

Trillium Health Partners
(Hereinafter referred to as the “Hospital”)

To Be Effective:
November 21, 2016

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

The basic goal of this Statement 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 Statement 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 Statement 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 Statement 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

The Finance and Audit Committee oversees investment management of the Fund and is responsible to report back to the Board. The Committee shall:

- Establish the Statement of Investment Policies 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 (dated, signed and kept on file at the Hospital).

- 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 annually:
  - 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 categories, Capital Planning Fund, Future Development Fund, and Reserve Fund and review their individual performance objectives in conjunction with the short and long term cash/capital requirements of the Hospital by fiscal year;
o confirm the applicability of any pooled fund investments to ensure suitability to the Funds;
o 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”) to manage the Funds;
o meet with representative(s) of the Investment Manager(s) to discuss investment performance and the Statement.

• At least semi-annually:
o review the performance of the Investment Manager(s), and the Funds relative to the performance objectives;

• At least quarterly:
o review the financial performance of the Funds and compliance with the Statement.

The Investment Manager(s) shall be required to:

• Invest the assets of the Funds in accordance with this Statement;

• 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.

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 & Return Expectations

There are three categories of accounts that make up the Funds. Each category has distinct needs managed for the Hospital.

Capital Planning Fund: This fund was established to hold investments where the proceeds will cover the clearly identified cash flow requirements of the Hospital’s approved five year capital plan.

Future Development Fund: This fund was established to provide funds for the developing needs and plans of the Hospital as it grows beyond that five year horizon.

Reserve Fund: This fund is comprised of monies that accumulate from time-to-time from operations that are in excess of amounts required in the Capital Planning Fund and are not identified by the Finance Committee and the Board as appropriate for inclusion in the Future Development Fund. Practically, a minimum of $75 million must be managed separately as cash, while the remaining fund may be committed to investments offering higher returns, possibly with decreased liquidity, but without taking equity risk.
<table>
<thead>
<tr>
<th>Capital Planning Fund</th>
<th>Future Development Fund</th>
<th>Reserve Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Requirements</strong></td>
<td>Minimal – only needed if required to roll down into the Capital Planning Fund in the absence of funds in the Cash Reserve.</td>
<td>▪ As needed for capital or operating calls outside those in the five year capital plan</td>
</tr>
<tr>
<td>As needed in the context of the five year capital plan of the Hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time Horizon</strong></td>
<td>Long term (&gt; 5 years)</td>
<td>Short term Less than 5 years on a rolling basis</td>
</tr>
<tr>
<td>Short term Less than 5 years on a rolling basis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Liquidity</strong></td>
<td>Very low liquidity requirements</td>
<td>▪ $75 million minimum cash requirement</td>
</tr>
<tr>
<td>Less than 5 years on a rolling basis</td>
<td></td>
<td>▪ Lower liquidity needed on the balance</td>
</tr>
<tr>
<td><strong>Risk Tolerance</strong>*</td>
<td>▪ Moderate</td>
<td>▪ Low</td>
</tr>
<tr>
<td>▪ Low</td>
<td>▪ Target minimal risk in the context of a balanced fixed income/stock portfolio</td>
<td>▪ Minimal tolerance to volatility</td>
</tr>
<tr>
<td>▪ Minimal tolerance to term risk and volatility</td>
<td></td>
<td>▪ Some liquidity risk acceptable if the Reserve is large</td>
</tr>
<tr>
<td>▪ Reasonable credit risk allowed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Cash flow matching is an option</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Return Requirement</strong></td>
<td>Net long term return goal is to achieve a targeted return after management fees in excess of an agreed Benchmark.</td>
<td>Net return goal will be set in the context of what vehicles are employed.</td>
</tr>
<tr>
<td>Net long term return goal is to achieve a targeted return after management fees in excess of an agreed Benchmark.</td>
<td>Net long term return goal is to achieve a minimum return of the rate of inflation (CPI) over 4-year rolling periods to maintain the real value of the capital. A secondary Benchmark target is based on standard market indices applied to the long term strategic asset mix of the fund.</td>
<td></td>
</tr>
<tr>
<td><strong>Tax and Legal</strong></td>
<td>The Hospital is a registered charity</td>
<td></td>
</tr>
</tbody>
</table>

*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

Asset allocation or mix refers to the allocation of funds among the major asset classes, including but not limited to, cash, domestic bonds, and domestic and international 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 and permissible ranges are detailed below.

Capital Planning Fund

The investments in this fund are subject to the following limitations:

1. No limit on total exposure to Government of Canada, provincial or corporate issues, subject to internal limits as follows:
   a. 10% maximum in any one province
   b. No more than 25% of the corporate weight to be private placements
   c. No more than 10% of the Fund assets in any single corporate issuer
   d. No more than 5% of the Fund assets in any single BBB issuer
2. Minimum A-1 or R-1 rating per issue for short term paper and BBB for term debt, with BBB exposure limited to 45% of the Fund
3. No more than 10% of the total market value of a pooled fund investment shall be invested in foreign currency issues of Canadian borrowers; with no foreign currency segregated holdings permitted
4. The Fund may hold segregated bond issues with a maximum maturity equal to the longest capital need being matched or pooled fund investments with a maximum duration of one year more than the duration of the Benchmark

Reserve Fund

The Investment of a required Basic Cash Reserve (an amount sufficient to produce a Working Capital Ratio of 1.0 or $75 million, whichever is greater) or “BCR” shall be confined to bank deposits of the seven largest Schedule I banks (TD, RBC, Scotia, CIBC, BMO, National Bank and Laurentian Bank), or short term paper obligations of Federal or Provincial Governments with a maturity date of less than one year. (Ratings will be a minimum of “R-1 or A-1”)

Amounts in excess of the required BCR may be invested in investment grade fixed income vehicles, including GIC’s, with a term to maturity up to five years and an average duration less than three years. Obligations of Federal or Provincial Governments, chartered banks, major trust companies or top quality corporate credits with minimum of “A” rating are allowed.

In addition, up to 50% of the total Cash Reserve in excess of the BCR may be invested in a pool of short term fixed income investments that includes conventional first mortgages and mortgages guaranteed under the National Housing Act (Canada). Once again, the average duration will be less than three years.
Future Development Fund

Due to the long-term nature of these funds and consequent risk/return tolerance, a balanced allocation between equities and bonds is warranted.

Ranges:

<table>
<thead>
<tr>
<th>Asset Class</th>
<th>Minimum</th>
<th>Target</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Equities</td>
<td>15%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Foreign Equities</td>
<td>15%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Total Equities</td>
<td>40%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Government of Canada</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Issues</td>
<td></td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Total Fixed Income</td>
<td>35%</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>Total Cash</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

The Equity investments in this fund:

1. All equities must be listed or intended for listing on a recognized exchange
2. The percentage of the market value of the portfolio invested in any single sector will not exceed the greatest of 20%, the sector weight plus 10 percentage points, or 1.5 X the weight of the sector, using the most recent quarter-end data. As well, the portfolio will hold securities representing a minimum of 6 of the current 10 sectors.
3. No more than 8% of the total market value of the total Equity section shall be invested in the securities of any one company. Appreciation may be allowed to a limit of 10%.
4. No equity holding in the Fund shall exceed 5% of that company’s total outstanding voting shares

The Fixed Income investments in this fund:

1. Up to 100% in Government of Canada issues
2. Up to 75% in provincial issues
   a. 25% maximum in any one province
   b. 15% maximum in any one BBB province
3. Corporate issues are limited to 70% of fund assets
   a. No more than 25% of the fund assets to be private placements
   b. No more than 10% of the fund assets in any single corporate issuer
   c. No more than 5% of the Fund assets in any single BBB issuer
4. Minimum BBB rating per issue, with maximum total BBB exposure limited to 20%.
5. Maximum 30% exposure to mortgage-backed securities
6. No more than 20% of the total market value of the Fixed Income section shall be invested in foreign currency issues of Canadian borrowers
Section 7 - Performance Evaluation Benchmarks

The Benchmarks can be thought of as representing a theoretical passive alternative to active management. The various asset classes and benchmarks used for each are as follows:

<table>
<thead>
<tr>
<th>Asset Class</th>
<th>Comparable Benchmark Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money Market</td>
<td>FTSE TMX 91-day T-Bill index</td>
</tr>
<tr>
<td>Canadian Short-term Bonds</td>
<td>FTSE TMX Short-term Bond index, or FTSE TMX Short-term Corporate Bond index</td>
</tr>
<tr>
<td>Canadian Mid-term Bonds</td>
<td>FTSE TMX Mid-term Bond index</td>
</tr>
<tr>
<td>Canadian Bonds</td>
<td>FTSE TMX Universe Bond index</td>
</tr>
<tr>
<td>Canadian Equities</td>
<td>S&amp;P/TSX index</td>
</tr>
<tr>
<td>Foreign Equities</td>
<td>MSCI World ex Canada index (Cdn$)</td>
</tr>
</tbody>
</table>

The various fund benchmark weightings are defined below. The portfolio Benchmark returns are calculated using the neutral weighting of the above 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 rolling four-year periods.

**Capital Planning Fund Benchmark:** As noted in the chart above, a Benchmark is set each year as a function of expected cash flows in the Hospital’s Five-year Capital Plan.

Whether using pooled fund investments to closely match or segregated investments to cash match the planned capital needs, the Benchmark would have relative weights of three above components (being the FTSE TMX 91 Day T-Bill Index; the FTSE TMX Short Term Corporate Bond Index; and the FTSE TMX Mid Term Bond Index) designed to replicate the duration of the Capital Plan cash flows. The Manager is expected to better the Benchmark over four year time periods by 10 basis points.

For example, the Benchmark for the first year of the current Five-year Capital Plan would be 55% FTSE TMX 91 Day T-Bill Index; 45% FTSE TMX Short Term Corporate Bond Index; 0% FTSE TMX Mid Term Bond Index, producing a duration closely matching the 1.3 duration of the Capital Plan cash requirements.

**Reserve Fund Benchmark:** The BCR portion Benchmark will be based on the prevailing prime rate less 175 basis points.

When invested in bonds and mortgages, the remainder of the fund will be measured against a Benchmark of the FTSE TMX Short Term Bond Index.

A portfolio of GIC’s will be compared to a standard of 91-day T-Bills plus 30 basis points.
Future Development Fund Benchmark:

The benchmark is comprised of the following components and weightings:

- 5% - FTSE TMX 91-day T-Bill index, plus
- 45% - FTSE TMX Universe Bond index, plus
- 25% - S&P TSX index, plus
- 25% - MSCI World ex Canada index.

Investment Manager 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.

Servicing Requirements

- Monthly statements from the Investment Managers;
- Quarterly review meeting with the Finance and Audit committee and perhaps the Board;
- Monthly holdings and transaction report;
- Quarterly reporting including compliance report.

Section 8 - Security Guidelines

Unless otherwise stipulated above, general guidelines for each asset class are as follows:

1. Money market investments

    Investments may include Government, Agency obligations, Corporate issues, Commercial paper, Bankers acceptances, Cash and other such instruments as deemed prudent by the investment manager. The minimum credit quality per issue shall be R-1 as rated by a respected agency and maturities to be less than one year.
2. Fixed Income
   
i) Investments may include Investment Grade, Government, Agency obligations and corporate issues (including NHA mortgage-backed and other asset-backed securities).
ii) The minimum quality rating per holding, at issue, shall be BBB as rated by a respected bond rating agency.
iii) The maximum exposure to foreign currency securities is 20%.

The number of individual Government of Canada bond holdings will not be subject to any limitations.

Recognized Fixed Income Rating Agencies:

   a) Dominion Bond Rating Agency;
   b) Standard and Poor’s;
   c) Fitch (foreign issuers only) and
   d) Moody’s Investor Services.

3. Canadian Equities
   
i) The number of individual equity holdings is a minimum of 20;
   ii) Equity securities to be listed on the Toronto Stock Exchange.

4. US Equities
   
i) The number of individual equity holdings is a minimum of 20;
ii) Investment in American Depository Receipts (ADRs) are permitted up to a maximum of 10% of the total asset class or pool;
iii) Equity securities to be listed on a major stock exchange.

5. International Equities
   
i) The number of individual equity holdings is a minimum of 40;
ii) Investment in emerging markets is permitted up to a maximum of 15% of the total asset class or pool;
iii) Equity securities to be listed on a major stock exchange.

6. Derivative Instruments

Derivatives in the form of exchange traded futures may be used for interest rate management and foreign currency hedging purposes only. At all times, the total notional exposures from all futures transactions shall not exceed the notional value of the fund.

7. 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 below in Section 4. 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.

The Finance and Audit Committee considers tobacco stocks (those stocks which derive a majority of their sales from tobacco products) to be inconsistent with the goals and objectives of the Hospital and accordingly deems such stocks to be prohibited.

Section 9 - 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 10 – 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.
1. PURPOSE AND APPLICATION

To define the Environmental Policy for Trillium Health Partners.

The environmental management system scope is as follows: A hospital providing thirteen medical programs: Anesthesia, Diagnostic Imaging, Emergency Medicine, Primary Care, Complex Continuing Care, Rehab, and Senior’s Services, Cardiac Health, Laboratory Medicine, Medicine, Mental Health, Neurosciences/Muscular-Skeletal Services, Oncology, Surgery, Women’s Health and Children’s Health. Related activities include but are not limited to: Corporate Services (Housekeeping, Facilities Maintenance, Waste Management and Materials Management) and Emergency Management.

2. BACKGROUND

In accordance with Trillium Health Partners Strategic Plan, environmental sustainability is supported through the implementation of an environmental management system.

In order to deliver on our “vision for a healthier community based on a complete system of care” we recognize the potential environmental impact of our operations; and subsequent potential effect on patients, staff, and the community.

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.

In accordance with the ISO14001 standard, this Environmental Protection Policy document is required to support the ISO14001 multi-site registration. ISO 14001 is an international standard for environmental management systems. The Mississauga Hospital and Queensway Health Centre have maintained this multi-site registration since 2004.

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 green conservation in our day-to-day roles to contribute to the efficient use of resources, which in turn can be reallocated to patient care and protecting the environment, 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 environmental audits, participation in hospital industry associations, consultation with interested parties and management reviews.

5. RESPONSIBILITY

<table>
<thead>
<tr>
<th>Type of Policy</th>
<th>Policy Sponsor</th>
<th>Endorsing Authority</th>
<th>Approval Authority</th>
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</thead>
<tbody>
<tr>
<td>Corporate administrative policies</td>
<td>Vice President, Capital Planning, Redevelopment and Corporate Services</td>
<td>Priorities and Planning Committee</td>
<td>Board of Directors</td>
</tr>
</tbody>
</table>
6. EDUCATION/COMMUNICATIONS

The policy will be included in the Annual Mandatory Environmental Awareness Training through the Learning Management System (LMS) to maintain awareness of the environmental policy and programs.

7. REFERENCES AND ACKNOWLEDGEMENTS

Environmental Management System Documentation – PRO
Environmental Management System Resources; Roles; Responsibility and Authority- PRO

8. RELATED POLICIES

Emergency Management – POL INT

9. APPROVED BY

2013-09    Risk Management Committee
2013-09    Governance Committee

10. SUPERSEDES

2006-03    Environmental Management Pol A5-4 (CVH version)
2011-04    Board of Directors Environmental Protection Policy (THC version)
2008-05    Board of Directors Environmental Protection Principle - 3700

11. APPENDICES

APPENDIX A – DEFINITIONS AND ACRONYMS

Environmental Policy: overall intentions and direction of an organization related to its environmental performance as formally expressed by top management.

EMS: Environmental Management System
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 advice of external consultants. 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 MOHLTC, MHLHIN, and other statutory & regulatory filings or engagement. This includes analysis and interpretation of accounting principles and their application along with advice on accounting policies. 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. These services are more consultative in nature.

- 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. RESPONSIBILITIES

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<tr>
<th>ROLE</th>
<th>RESPONSIBILITY</th>
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| 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. |

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Document ID #: 33938

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UNCONTROLLED WHEN PRINTED ()
Trillium Health Partners – Policies & Procedures

Title: IV-8 External Audit and Non Audit Services - P&P INT
Folder Name: //Kernel Root\Trillium Health Partners\Corporate Policies and Procedures\Board of Directors\Financial and Organizational Viability

<table>
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<tr>
<th>ROLE</th>
<th>RESPONSIBILITY</th>
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<tbody>
<tr>
<td>Committee</td>
<td>all services performed by the External Auditors and their cost including any carry forwards to future fiscal periods.</td>
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<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>Shared Services West (SSW)</td>
<td>• Notify on a timely basis to the Hospital CFO:</td>
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<td></td>
<td>o any bids received on procurement initiatives (e.g. RFQs, RFPs, etc.) from the External Auditor and/or</td>
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<td></td>
<td>o any potential contract awards to the External Auditor.</td>
</tr>
<tr>
<td>External Auditors (the individual or firm hired to perform the annual audit of the Hospital's financial statements)</td>
<td>• Report to the Hospital CFO:</td>
</tr>
<tr>
<td></td>
<td>o On an annual basis, all services provided.</td>
</tr>
<tr>
<td></td>
<td>o On a timely basis during the year, all potential risks to independence including any submission to procurement bids.</td>
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</tbody>
</table>

6. RELATED DOCUMENTS
Terms of Reference for the Board Finance and Audit Committee

7. RELATED POLICIES
• IV-4 Board Delegation of Signing Authority – POL INT
• Signing Authority – PRO INT

8. APPROVED BY
2015/03/26 Board Governance and Human Resources Committee

9. SUPERCEDES
Not Applicable.

10. APPENDICES
Not Applicable.

Policy Author: Barbara Baca, Finance Project Director and SSW Lead
Part V-A: Governance Policy Framework
1. **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.

2. **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.

3. **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
Trillium Health Partners – Policies & Procedures

| Title: | V-A-1 Principles of Governance and Board Accountability - POL INT |
| Folder Name: | Kernel Root\Trillium Health Partners\Corporate Policies and Procedures\Board of Directors\Board Effectiveness: Governance Policy Framework |

(“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.

4. 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.

5. RESPONSIBILITY

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<thead>
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<tr>
<td>Corporate administrative policies</td>
<td>Senior Vice President, Strategy, People &amp; Corporate Affairs</td>
<td>Governance &amp; Human Resources Committee</td>
<td>Board of Directors</td>
</tr>
</tbody>
</table>

6. COMMUNICATION

Following its approval by the Board, this Policy will be published on the thpHUB, on the Policies & Procedures website.

7. APPROVED BY

2017/09/11 Governance & Human Resources Committee.
2017/09/28 Board of Directors

8. SUPERCEDES

2012/08/31 V-A-1 Principles of Governance and Board Accountability - POL INT (Document ID 21503)
2014/08/31 V-A-4 Directors Declaration - POL INT (Document ID 21510)

9. POLICY AUTHOR

Board Relations Lead, Corporate Governance

10. APPENDICES

- Appendix A – Director’s Declaration
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:
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.
1. 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.

2. 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.

3. **POLICY**

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

4. **RESPONSIBILITY**

<table>
<thead>
<tr>
<th>Type of Policy</th>
<th>Policy Sponsor</th>
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<td>Board of Directors</td>
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5. **COMMUNICATION**

Following its approval by the Board, this Policy will be published on the thpHUB, on the Policies & Procedures website.

6. **APPROVED BY**

2017/09/11 Governance & Human Resources Committee.
2017/09/28 Board of Directors

7. **SUPERCEDES**

2012/08/31 VA-3 Responsibilities as an Elected and Ex-Officio Director - POL INT (Document ID 21509)

8. **POLICY AUTHOR**

Board Relations Lead, Corporate Governance
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**

<table>
<thead>
<tr>
<th>Area of Skill, Expertise and Experience</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Audit, Accounting and Finance</td>
<td>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.</td>
</tr>
<tr>
<td>Community Leadership</td>
<td>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.</td>
</tr>
<tr>
<td>Construction/Project Management</td>
<td>Experienced in providing leadership in large-scale planning, development, and/or project design and implementation.</td>
</tr>
<tr>
<td>Governance</td>
<td>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.</td>
</tr>
<tr>
<td>Government Relations</td>
<td>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.</td>
</tr>
<tr>
<td>Health Care</td>
<td>Experienced in senior health care leadership or a practitioner with deep experience and/or understanding of health care operations, funding and systems.</td>
</tr>
<tr>
<td>Health Education</td>
<td>Experienced health educator. Understands oversight role operating a facility that provides interprofessional education, including medical teaching and applied research.</td>
</tr>
<tr>
<td>Human Resource Management</td>
<td>Experienced in and strong understanding of organizational structure and development, human resources oversight, compensation, performance management, change management, talent management, and succession planning.</td>
</tr>
<tr>
<td>Information Systems Management/Technology</td>
<td>Experienced in leading the implementation and/or management of complex information technology systems.</td>
</tr>
<tr>
<td>Area of Skill, Expertise and Experience</td>
<td>Description</td>
</tr>
<tr>
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<tr>
<td>and processes. High degree of sophistication in information technology risk management.</td>
<td></td>
</tr>
<tr>
<td>Law</td>
<td>Experienced lawyer in good standing with the Law Society of Upper Canada with a sophisticated practice in corporate, commercial, regulatory or governance-related fields.</td>
</tr>
<tr>
<td>Marketing, Communications and Media/Public Relations</td>
<td>Experienced in private or public sector corporate communications, marketing and media, public and stakeholder relations.</td>
</tr>
<tr>
<td>Public Policy and Research</td>
<td>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.</td>
</tr>
<tr>
<td>Quality, Risk Management and Performance Measurement</td>
<td>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.</td>
</tr>
<tr>
<td>Senior Business Leadership</td>
<td>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.</td>
</tr>
<tr>
<td>Strategic Planning</td>
<td>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.</td>
</tr>
</tbody>
</table>
In accordance with the Corporate By-law (Article 4 Section 4.1), the Board will consist of:

a) the following elected Directors:
   
i) until the annual Members’ meeting in 2013, 14 elected Directors; and
   
ii) from the annual Members’ meeting in 2013 until the annual Members’ meeting in 2014 (and thereafter, unless otherwise specifically provided by the Corporation By-law), 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.

b) 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.
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.
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, 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, 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 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.
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.
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.
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1. 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.

2. 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.

2.1 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.

2.2 Term

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

The Secretary is accountable for:

3.1 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;

3.2 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;

3.3 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;

3.4 Other:

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

3.5 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.
4. RESPONSIBILITY

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5. COMMUNICATION

Following its approval by the Board, this Policy will be published on the thpHUB, on the Policies & Procedures website.

6. APPROVED BY

2017/09/11 Governance & Human Resources Committee.
2017/09/28 Board of Directors

7. SUPERCEDES

2012/08/31 V-A-11 Position Description for the Secretary - POL INT (Document ID 21505)

8. POLICY AUTHOR

Board Relations Lead, Corporate Governance
Role Statement

A 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 committee chair.

Skills, Attributes and Experience

A 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 committee chair.

Term

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.
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
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.

1. 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.
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; or

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.
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, 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.

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:
   - preferences of Directors;
   - balance of skills and expertise;
   - prior experience in relation to matters before the committee;
   - the expectation that, over the course of his/her service as a Director, each Director will serve on at least three Board Standing or Special Committees including the Quality and Program Effectiveness Committee; and
   - 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 elected Directors.

5. Each Board Special Committee will be composed of at least two 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 non-Director members. The non-Director members of Board Standing and Special Committees will be appointed annually by the Board for a maximum of four one 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.
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.

- **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.

- **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.

- **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.

- **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.
1. **PURPOSE AND APPLICATION**

On an annual basis, the Board of Directors ("Board") will establish Board goals consistent with Trillium Health Partners'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.

2. **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.
3. **RESPONSIBILITY**

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4. **COMMUNICATION**

Following its approval by the Board, this Policy will be published on the thpHUB, on the Policies & Procedures website.

5. **APPROVED BY**

2017/09/11 Governance & Human Resources Committee.
2017/09/28 Board of Directors

6. **SUPERCEDES**

2013/04/01 V-B-5 Board Goals and Board Work Plan - POL INT (Document ID 22441)

7. **POLICY AUTHOR**

Board Relations Lead, Corporate Governance
1. PURPOSE AND APPLICATION

This Policy outlines the framework for conducting Board of Directors ("Board") meetings.

2. 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.

3. 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.

4. 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.

5. 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.

### 6. RESPONSIBILITY

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### 7. COMMUNICATION

Following its approval by the Board, this Policy will be published on the thpHUB, on the Policies & Procedures website.

### 8. APPROVED BY

2017/09/11 Governance & Human Resources Committee.
2017/09/28 Board of Directors

### 9. SUPERCEDES

2013/09/23 VB-6 Board Meetings - POL INT (Document ID 23103)

### 10. POLICY AUTHOR

Board Relations Lead, Corporate Governance

### 11. APPENDICES

- Appendix A: In-Camera Sessions
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
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 third party 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 Roles and Responsibilities of the Board and the Roles and Responsibilities of Individual Directors. 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.
1. **PURPOSE AND APPLICATION**

   This policy outlines the principle for the acceptance of gifts by individual Board Directors.

2. **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.

3. **RESPONSIBILITY**

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4. **COMMUNICATION**

   Following its approval by the Board, this Policy will be published on the thpHUB, on the Policies & Procedures website.

5. **APPROVED BY**
6. SUPERCEDES

2012/08/31 V-B-8 Receipt of Gifts by Individual Directors - POL INT (Document ID 21502)

7. POLICY AUTHOR

Board Relations Lead, Corporate Governance
CONTENTS
(Ctrl + click on links below to go directly to each section)

1. Purpose and Application
2. Policy
3. Responsibility
4. Communication
5. Approved By
6. Supersedes
7. Policy Author

1. 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.

2. 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.

3. RESPONSIBILITY

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5. APPROVED BY

2017/09/11 Governance & Human Resources Committee.
2017/09/28 Board of Directors
6. SUPERCEDES

2012/08/31 V-B-9 Board Member Recognition - POL INT (Document ID 24192)

7. POLICY AUTHOR

Board Relations Lead, Corporate Governance
CONTENTS
(Ctrl + click on links below to go directly to each section)

1. Purpose and Application
2. Guiding Principles
3. Policy
4. Procedure
5. Responsibility
6. Communication
7. Approved By
8. Supercedes
9. Policy Author

1. 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").

2. GUIDING PRINCIPLES

2.1 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").

2.2 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.

3. 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).

4. **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.

5. **RESPONSIBILITY**

<table>
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<th>Type of Policy</th>
<th>Policy Sponsor</th>
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<td>Corporate administrative policies</td>
<td>Senior Vice President, Strategy, People &amp; Corporate Affairs</td>
<td>Governance &amp; Human Resources Committee</td>
<td>Board of Directors</td>
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6. **COMMUNICATION**

Following its approval by the Board, this Policy will be published on the thpHUB, on the Policies & Procedures website.

7. **APPROVED BY**

2017/09/11 Governance & Human Resources Committee.
2017/09/28 Board of Directors

8. **SUPERCEDES**

2012/08/31 V-B-10 Reimbursement of Board Director Expenses - POL INT (Document ID 21493)

9. **POLICY AUTHOR**

Board Relations Lead, Corporate Governance
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) return 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.
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.