ST. MARY'S GENERAL HOSPITAL
Kitchener, Ontario

BOARD OF TRUSTEES POLICIES
SECTION 010

Please also refer to the St. Joseph's Health System Policy Manual on the SJHS Board website (an individual access login will be provided on request through the SJHS office).

GOVERNANCE PROCESS	
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010-003	Board Members Succession/Nomination
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010-005	Board of Trustees and Standing Committee Evaluation
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FINANCE	
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HUMAN RESOURCES	
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010-204	Nepotism
CUSTOMER RELATIONS	
010-400	Open Board Meetings
010-401	Delegations to the Board of Trustees

Guidelines for Policy Development for St. Mary's General Hospital Board of Trustees

1) LEGISLATION

It is understood that St. Mary's fully complies with all applicable legislative and regulatory requirements, by-laws, and policy documents.

2) RESOURCE

The Ontario Hospital Association's *Guide to Good Governance* is used as the principal resource for Board policy development.

3) PROCESS

The development of new policies may result from new legislation, direction from the Chair, President and/or the Board of Trustees, or recommendations from Board Committees and the Senior Leadership Team.

4) REVIEW

Board policies will be reviewed on an ongoing basis and at least once every three years.

ST. MARY'S GENERAL HOSPITAL
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POLICY ORIGIN: Board of Trustees POLICY NO: 010-001

SECTION TITLE: Governance Process

TOPIC: Board Leadership – Succession/Nomination

POLICY STATEMENT:

The SMGH Board of Trustees ('the Board') shall choose its nominees for the positions of Board Chair, Vice Chair and Treasurer, and upon approval by the Board, shall submit its recommendations for these positions to the Annual Meeting of the St. Joseph's Health System (SJHS) for approval.

Ex-officio members of the Board are not eligible to serve as Chair, Vice Chair or Treasurer of the Board.

These leadership positions shall normally hold office for a maximum of two (2) years.

PROCEDURES:

1. At the March meeting, the Mission and Governance Committee (M&G), shall appoint a nominating committee comprised of the Board Chair (who shall serve as Chair of the committee), the Past Chair, and the current Vice Chair, none of whom shall be eligible to hold the position of Vice Chair designate.

2. Based on an assessment of skill sets and past performance as a board member, evaluation by peers through the bi-annual board assessment process, and the willingness and interest to devote the necessary time to the task of Vice Chair, a board member will be chosen to fill the role. Early in its deliberations the Committee will consult with the President of the Hospital regarding its choice.

3. The Vice Chair will typically be nominated as Chair of the Board at the expiration of the term of the incumbent Board Chair and should be recruited with that expectation. Special circumstances, as determined by M&G, in consultation with the nominating committee, may require that someone other than the Vice Chair be recommended to succeed the incumbent Board Chair.

4. Trustees who have chaired a Board Committee will be eligible to be

nominated as Vice Chair. However, under special circumstances, other members of the Board may be eligible for nomination.

5. The Treasurer designate will be selected and recommended by the same nominating committee.

6. The nominating committee will present its report to the M&G Committee in early May and upon approval, the M&G Committee will submit the names of the candidates to the Board of Trustees at the May Board meeting

7. Upon approval by the Board of Trustees, the names of the candidates will be submitted to the SJHS Board at their annual meeting in June for appointment.

8. If, for any reason, a Board Chair, Vice Chair, or Treasurer resigns or is otherwise unable to complete a full term in office, M&G will recommend a replacement to the Board within thirty (30) days of receiving such notice.

APPROVAL:	Governance Committee - May 6, 1996 Board of Trustees - May 22, 1996
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEW:	Governance Committee - January 1998; Mission and Governance Committee – January 2017; May 2017 Board of Trustees - January 1998
REVISED:	Governance Committee – January 2003, May 2006, November 2008; Mission and Governance Committee – May 2017 Board of Trustees - May 2003, May 2006, November 2008; May 2017

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-002

SECTION TITLE: Governance Process

TOPIC: Board Committee Members – Succession/Nomination

POLICY STATEMENT

The Mission and Governance Committee (M&G) shall ensure that vacancies on Board Committees are filled with qualified individuals from the community, in accordance with Article 25 of the Hospital By-laws.

PROCEDURES:

1. Annually, typically early in the calendar year, the Chair of M&G will initiate a process to determine the intention of current Board Committee members to continue to serve on a Board Committee for the following year. As part of this process the Chair will review with each Committee Chair each member's adherence to policy number 010-012 Code of Conduct for Members of Board of Trustees and Members of Board Committees.

2. To replace retiring/resigning members, the Chair of M&G will strike a Nominating Committee and shall act as its chair.

3. A call for interest will be put forth and applications received will be reviewed by the Nominating Committee. The Nominating Committee will then determine and interview potential candidates. The names of successful candidates will be included in the Nominating Report for approval by the Board of Trustees and recommendation to the St. Joseph's Health System (SJHS) Board of Directors.

4. The names of Board Committee nominees will be forwarded to the Chief Executive Officer of SJHS for consideration by the SJHS Board of Directors, in accordance with SJHS policy.

5. If a member of a Board Committee fails to complete the term of appointment, the resulting vacancy is to be filled, if possible, within sixty (60) days in accordance with Article 17 of the Hospital By-laws. When the Chair of a Committee cannot complete his/her full term, the Chair of the Board will appoint a new Committee Chair.

6. The Chair of M&G will seek the support of the Committee Chairs in providing a mentor to new community members of Board Committees and in providing transitional support to the new community member in understanding the role of the Board Committees and issues that come before them.

APPROVAL:	Governance Committee - March 2006 Board of Trustees - May 2006
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEW:	Mission and Governance Committee – November 2013; January 2017 Board of Trustees – November 2013
REVISED:	Governance Committee - November 2008 Board of Trustees - November 2008; April 2017

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-003

SECTION TITLE: Governance Process

TOPIC: Board Members – Succession/Nomination

POLICY STATEMENT

The Mission and Governance Committee (M&G) shall ensure that vacancies on the Board of Trustees (the 'Board') are filled with qualified individuals from the community, in accordance with Article 3 Section 2 of the Hospital By-laws.

PROCEDURES:

1. Annually, typically early in the calendar year, the Chair of the Governance Committee will initiate a process to determine the intention of current Board members to continue to serve on the Board of Trustees for the following year. As part of this process the Chair will review with the Board Chair each Board member's adherence to policy number 010-012 Code of Conduct for Members of Board of Trustees and Members of Board Committees.

2. To replace retiring/resigning members, the Chair of M&G will strike a Nominating Committee and shall act as its chair.

3. A call for interest will be put forth and applications received will be reviewed by the Nominating Committee. The Nominating Committee will then determine and interview potential candidates. The names of successful candidates will be included in the Nominating Report for approval by the Board of Trustees and recommendation to the St. Joseph's Health System (SJHS) Board of Directors.

4. The names of Board nominees will be forwarded to the Chief Executive Officer of SJHS for consideration by the SJHS Board of Directors, in accordance with SJHS policy.

5. If an elected member of the Board of Trustees fails to complete the term of appointment, the resulting vacancy is to be filled, if possible, within sixty (60) days in accordance with Article 17 of the Hospital By-

laws. When the Chair of a Committee cannot complete his/her full term, the Chair of the Board will appoint a new Committee Chair.

6. The Chair of M&G will seek the support of the Board Chair in providing a mentor to new community members of the Board and in providing transitional support to the new community member in understanding the role of the Board and committees and issues that come before them.

APPROVAL:	Governance Committee - May 6, 1996 Board of Trustees - May 22, 1996
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEW:	Governance Committee – January 2003; Mission and Governance Committee – November 2013; January 2017 Board of Trustees – May 2003; November 2013
REVISED:	Governance Committee - January 1998, January 2002, January 2006, March 2006, November 2008 Board of Trustees - January 1998, May 2006, November 2008; April 2017

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POLICY ORIGIN:	Board of Trustees	POLICY NO: 010-004
SECTION TITLE:	Governance Process	
TOPIC:	Board of Trustees and Standing Committee Community Members Peer Review	

POLICY STATEMENT

The Board of Trustees (the "Board") is committed to governance best practices. The performance of individual Trustees and community members of Standing Committees will be reviewed to identify areas of strength as well as areas for development and to determine the most appropriate committee membership.

PROCESS

Board of Trustees

1. Trustees will be evaluated every two (2) years.

2. The review will be completed during the months of February/March using a web based version of the Board Peer Review Form (see attached). The members being reviewed will be asked to rate themselves. All other members will be asked to complete a review of the individuals being reviewed as outlined in the Board Peer Review Form. Information will be collated.

3. The Chair of the Board of Trustees (the "Board Chair") and Vice Chair will provide feedback to individual Board members during the months of April/May and will discuss plans and available resources for member development and appropriate committee membership. The Vice Chair and the Chair of the Mission and Governance Committee (M&G) will provide feedback to the Board Chair. The Board Chair and the M&G Chair will provide feedback to the Vice Chair. Feedback will consist of verbal feedback and/or one page summary of the peer reviews.

4. A mentor will be assigned to all new Trustees and will provide feedback during the first year of a term.

5. The results of the individual Board member review will be taken into account when considering renewal terms for incumbent members.

Standing Committee Community Members

1. Community members of Standing Committees entering their final year of a renewable term will be evaluated by their Standing Committee peers prior to reappointment. Community members are encouraged to rate themselves.

2. The Committee Chair will provide feedback.

To ensure confidentiality, administration of the evaluation survey will be managed by an independent third party provider and will not be reviewed by the executive team of the Hospital and only the unanimous results will be reviewed by those providing feedback as noted above.

APPROVAL:	Mission and Governance Committee – May 2014 Board of Trustees – May 2014
DISTRIBUTION:	Master Manual, Board of Trustees
REVIEWED:	Board of Trustees – April 2017
REVISED:	Mission and Governance Committee – January 2017

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Board of Trustees Peer Review Form

Name of Member to be Reviewed:	
Name of Member Completing:	Date:

Scoring				
1 *Rarely/never meets expectations*	**2** *Occasionally/ sometimes meets expectations*	**3** *Consistently/ regularly meets expectations*	**4** *Always meets expectations*	**NA** *Do not know/not observed*

Member Performance Indicators	1	2	3	4	NA	Comments
Core Factors						
1. Shows a sensitivity (or understanding) and comfort with the Catholic values that are a part of the culture of the organization.						
2. Approaches all agenda items from the stance of upholding the organization's mission, vision and values and strategic directions.						
Contribution Factors						
3. Contributes the time necessary to be an effective member & comes prepared for meetings						
4. Appears to understand key performance indicators for Board oversight, e.g. quality and financial indicators.						

5.	Contributes meaningfully and knowledgeably to Board/Committee discussion.					
6.	Thinks strategically in assessing the issues before the Board and offers alternatives.					
7.	Willing to take on leadership responsibilities.					
8.	Supports Board decisions – acts as one on all Board actions once the decision has been made.					
9.	Supports and promotes activities of the Foundation through attendance at Foundation events or otherwise.					
Communication Factors						
10.	Articulates his/her views clearly and succinctly in respectful ways.					
11.	Listens effectively and considers all opinions.					
12.	Has a good working relationship with Board Members and Community members.					

If this Board Member is the Board Chair or Committee Chair, please answer the following:

Chair Performance Indicators		1	2	3	4	NA	Comments
1.	Ensures that the Board/Committee is addressing meaningful issues that are relevant to their governance responsibilities (i.e., hospital, ministry, LHIN, Long-term Care, etc.)						
2.	Manages meetings so they are constructive, focused and effective – sets clear objectives						

3. Ensures that the concerns of the Board/Committee are reflected in meeting agendas.						
4. Provides effective leadership, with the President and senior management, to the organization's planning process.						
5. Allows appropriate time for strategic planning.						
6. Manages conflicts of interest effectively.						
7. Encourages the full contribution of and participation by all members of the Board/Committee by creating an open atmosphere for Board/Committee members to ask questions or dissent freely.						
8. Maintains open channels of communication with Board/Committee members between meetings.						

Please answer the following questions:

1. What are the most positive ways that this member contributes to the work of the Board?
2. What could this member do to improve his/her contribution to the work of the Board?

References:
1. St. Joseph's Health System
2. Ontario Hospital Association, *Guide to Good Governance*, *2nd Edition*
3. Catholic Healthcare Partners
4. Grand River Hospital, Cambridge Memorial Hospital, Guelph General Hospital
5. Faith Life

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-005

SECTION TITLE: Governance Process

TOPIC: Board of Trustees and Standing Committee Evaluation

POLICY STATEMENT

Members of the Board of Trustees (the "Board") will conduct a regular evaluation of the effectiveness of the Board and its Standing Committees.

The Board's objectives are to promote effective delivery of responsible governance by assessing the success of the Board in setting direction for the Hospital, formulating policy and monitoring the application of Board policy and, as a committee-of-the whole, planning for the programmatic, fiscal and physical future of the Hospital.

PROCEDURES

Every two (2) years, the Mission and Governance Committee (M&G) will initiate a Board and Committee evaluation process.

The Ontario Hospital Association (OHA) Governance Centre of Excellence "Board Self-Assessment Tool" and the supplementary St. Joseph's Health System (SJHS) Mission Survey will be the tools utilized to assess Board effectiveness. The OHA tool is administered by OHA and information can be found at:
http://www.thegce.ca/RESOURCES/Pages/boardselfassessment.aspx

M&G will review and analyze collated results. A summary of results will be presented to the Board and, based on the results, M&G will submit recommendations to the Board that will address Board performance and opportunities for improvement.

Ongoing monthly or quarterly evaluations of Board meetings and Standing Committees will be conducted and feedback will be shared with members by the Chair of the Board or Chairs of Standing Committees.

APPROVAL: Governance Committee - January 1998
Board of Trustees - January 1998

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DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEW:	Governance Committee – January 2003, November 2005, March 2006 Board of Trustees – May 2003, May 2006, January 2013; April 2017 Mission and Governance Committee – January 2013
REVISED:	Governance Committee - January 2002; Mission and Governance Committee – January 2017 Board of Trustees – January 2002

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-006

SECTION TITLE: Governance Process

TOPIC: Confidentiality

PURPOSE

To ensure that confidential matters are not disclosed until disclosure is authorized by the Board of Trustees (the "Board").

POLICY STATEMENT

The Trustees owe to the Hospital a duty of confidence not to disclose or discuss with another person or entity or, to use for their own purpose, confidential information concerning the business and affairs of the Hospital received in their capacity as Trustees, unless otherwise authorized by the Board.

Article 6 of the By-laws:

6.1 Every Trustee, officer and employee of the Hospital shall respect the confidentiality of matters brought before the Board of Trustees, keeping in mind that unauthorized statements could adversely affect the interests of the Hospital.

6.2 The Board of Trustees shall give authority to the Chair and the President of the Hospital to make statements to the news media or public about matters brought before the Board of Trustees.

Application:
This policy applies to all Trustees and community representatives and staff.

CONFIDENTIAL MATTERS AND PROCEDURE

The business of the Board is conducted in both open and closed sessions. The public, including the media, may attend the open session of the Board. Matters considered by the Chair of the Board of Trustees (the "Board Chair") and/or President to be inappropriate for discussion in public, are dealt with

in closed or in-camera sessions. By definition, these discussions are to remain confidential until such time as the Chair declares them to be non-confidential.

The Board and committee members shall not breach Board confidentiality, including refraining from discussing confidential matters with non-Board members, keeping written and electronic communications from being read by non-board members and destroying confidential communications if security cannot be guaranteed.

Notwithstanding that information disclosed or matters dealt with in an open session are not confidential, no Trustee shall make any statement to the press or the public in his/her capacity as a Trustee unless such statement has been authorized by the Board and/or Board Chair.

Upon appointment to the Board of Trustees or Standing Committee, the Trustee or Community member will read and sign "Confidentiality Agreement for Volunteers" (see attached).

APPROVAL:	Governance Committee - January 1998 Board of Trustees - January 1998
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEW:	Governance Committee – January 2003 Board of Trustees – May 2003, January 2013 Mission and Governance Committee – January 2013
REVISED:	Governance Committee: January 2002, November 2005, March 2006; Mission and Governance Committee – January 2017 Board of Trustees – January 2002, May 2006; April 2017

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-007

SECTION TITLE: Governance Process

TOPIC: Education Policy

POLICY STATEMENT

To help prepare them to exercise their responsibilities as members of the Board, the Hospital expects its Trustees to take advantage of relevant educational opportunities and is, therefore, prepared to assist in underwriting pre-approved educational expenses.

In order to effectively undertake the business of governing the Hospital, Trustees shall avail themselves of educational opportunities on subjects relevant to their task.

PROCEDURES

Members of the Board and its Committees will be offered both internal and external educational opportunities. Internally, the Mission and Governance Committee (M&G) will annually consider recommendations from the President regarding educational programs both at the time of Board and Committee meetings and at other convenient times. Externally, with the approval of the Board Chair, members may attend meetings and conventions where relevant subjects are discussed.

A member will apply to the Board Chair for reimbursement for attending an approved external educational session and a budget for that attendance will be identified by the President. Upon returning from the education session, the member may submit a request for reimbursement of reasonable expenses for travel, food and lodging, etc., all supported by appropriate receipts. Any dispute over a submitted request will be decided by the Board Chair and Vice-Chair of the Board.

APPROVAL: Governance Committee - June 1995
Board of Trustees - June 1995

DISTRIBUTION: Master Manuals, Board of Trustees

REVIEW: Governance Committee – November 1997, January 2003
Board of Trustees – May 2003

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REVISED:	Governance Committee - January 2002, November 2005 Board of Trustees - March 2002, May 2006, January 2013; April 2017 Mission and Governance Committee – January 2013, January 2017

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-008

SECTION TITLE: Governance Process

TOPIC: Environmental Policy

POLICY STATEMENT

St. Mary's General Hospital is a community-oriented organization, which is committed to the protection of the natural environment by providing patient and community health care services and operating our facility in an environmentally responsible manner. We will strive for continual improvement in our environmental performance and the prevention of pollution through the following goals:

Corporate Commitment
We will comply with all applicable legislation, regulations and other requirements that apply to the hospital's environmental activities, and, wherever possible, we will do our best to exceed requirements as legislated.

Protection of Natural Resources
We will contribute to the conservation of natural resources and minimize the release of pollutants through environmentally sound decisions and processes.

Reduce, Reuse, Recycle
We will reduce, reuse and recycle waste wherever possible in order to optimize our utilization of available resources.

Waste Disposal
We will dispose of all waste responsibly to protect the health and safety of our employees, the community, and the environment.

Purchasing Practices
We will continually evaluate our purchasing practices in order to minimize adverse environmental impacts.

Communication and Staff Education
We will ensure that staff, patients, volunteers and physicians are aware of the environmental policies, procedures, and issues within the hospital, through the use of formal training and communication programs.

Environmental Objectives and Targets
We will set and review measurable environmental objectives and targets, and report on our environmental performance.

Monitoring and Evaluation
We will monitor our progress against program goals, and review training, procedures and resources, in order to continually improve our environmental performance set forth in this policy.

Administrative Support
We will support the appropriate administrative structure to ensure institutional compliance with this policy.

APPROVAL:	MEQ/CR Committee - February 3, 2000 Board of Trustees – February 23, 2000
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEW:	MEQC – May 2003 Board of Trustees – January 24, 2001, January 2002, May 2003, August 2005, September 2006, September 2007; April 2017
REVISED:	Mission and Governance Committee – January 2013; March 2017

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-009

SECTION TITLE: Governance Process

TOPIC: Gift Acceptance and Sponsorships

POLICY STATEMENT

Gifts and sponsorships are clearly important to the financial and professional well-being of the Hospital. However, to protect the reputation and professionalism of the Hospital, the acceptance of gifts and the development of sponsorships may only be negotiated within clear and specified parameters.

All gifts received by the Hospital will be channeled through St. Mary's General Hospital Foundation where they will be receipted, acknowledged, recorded for audit, historic, and recognition purposes. The Foundation will be notified of all gifts and sponsorships before any definitive negotiations and/or agreement takes place.

Hospital approval will be sought by the Foundation for specifically designated gifts in order to most appropriately meet the Hospital's needs and priorities.

Reviewed/Revised:	Ethics Committee – January 17, 2001 Senior Management Committee – Feb. 20, 2001 Hospital Managers' Group – March 29, 2001 Mission, Ethics, Quality/Customer Relations – April 5, 2001
Reviewed:	Mission and Governance Committee - January 2013 Board of Trustees – April 25, 2001, May 2006, January 2013; April 2017
Revised:	Mission and Governance Committee - January 2017

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-010

SECTION TITLE: Governance Process

TOPIC: Conflict of Interest Guidelines

1.0 Purpose

All Board of Trustees (the 'Board') and Board Committee members have a duty to ensure that the integrity of the decision-making processes of the Board are maintained by ensuring that they and other members of the Board are free from all conflicts in their decision making. It is inherent in a Trustee's fiduciary duty that conflicts of interest be avoided or disclosed. It is important that all Trustees understand their obligations when a conflict of interest arises.

2.0 Scope

This policy applies to all Trustees and Officers including ex-officio Trustees, and all non-Board Committee Members (collectively referred to as "Trustees" for the purposes of this policy).

3.0 Definitions

3.1. "conflict of interest" refers to a situation or circumstance that creates a risk or a reasonable perception that a Trustee's duty to SMGH could be unduly influenced by another interest (be it private, personal or public). A Trustee has a potential conflict of interest when that Trustee or a "relative" has the ability to influence directly or indirectly a Board decision or action that leads or could lead to a personal, financial or professional benefit for the Trustee or his/her relative or when a Trustee's interest or actions are inconsistent with the interests of the Hospital. Conflict of Interest situations may be characterized as:

a) Actual (e.g., the Board is obliged to approve a contract award in a competitive process where the company employing the Trustee has an interest);
b) Potential (e.g., the company employing the Trustee's spouse is considering bidding on a Hospital contract that will be approved by the Board); or

c) Perceived (e.g., although a hiring/contract award decision was made by the executive team and merely reported to the Board, the Trustee's failure to excuse him/herself from the discussion could reasonably undermine the integrity and/or reputation of the Hospital and the Board). There may be cases where the perception of a conflict of interest or breach of duty (even where no conflict exists or breach has occurred) may be harmful to the Hospital, notwithstanding that there has been compliance with SMGH Administrative By-Laws and policies. In such circumstances, the process set out in this policy for addressing Actual or Potential conflicts and breaches of duty shall be followed.

All references to a 'conflict of interest' in this policy include a reference to an Actual, Potential and Perceived conflict of interest;

3.2. "Officers" means officers appointed by the Board including the President, Executive Vice President, the Secretary, the Treasurer and others who perform functions for the Hospital similar to those normally performed by such officers.

3.3. "relative" refers to a Trustee's spouse (including common-law and same sex), child, sibling, parent, uncle, aunt, niece, nephew, grandparent, grandchild, step-child, step-parent, as well as a mother-, father-, son-, daughter-, brother-, or sister-in-law, and any other person living with the Trustee in a dependent or conjugal relationship; and

3.4. "interest" means that the Trustee or his/her relative has a personal, pecuniary, financial, employment or ownership interest in, or relationship with, another corporation, partnership or person.

4.0 Policy

4.1 Trustees shall make all reasonable efforts to avoid situations in which they may be in a position of conflict of interest. The Hospital Administrative By-laws contain provisions with respect to conflict of interest that must be strictly adhered to.

In addition to the Hospital Administrative By-laws, the process set out in this policy shall be followed when a conflict of interest arises.

4.2 Examples of Conflict of Interest

A conflict of interest arises in any situation where a Trustee's duty to act solely in the best interest of SMGH and to adhere to his or her fiduciary duties is compromised or impeded by any other interest, relationship or duty of the Trustee. A conflict of interest also includes circumstances where the Trustee's duties to the Hospital are in conflict with other duties owed by the Trustee such that the Trustee is not able to fully discharge the fiduciary duties owed to the Hospital.

Due to the range and complexity of the Hospital's activities, it is not possible to provide an exhaustive list of all conflict of interest situations. While some situations will be clearer than others, Trustees are urged to err on the side of caution. Conflicts of interest generally arise in the following situations:

(i) Transacting with the Hospital
- When a Trustee transacts with the Hospital directly or indirectly.
- When a Trustee has a material direct or indirect interest in a transaction or contract with the Hospital.

(ii) Interest of a Relative
When the Hospital conducts business with suppliers of goods or services or any other party of which a relative or member of the household of a Trustee is a principal, officer, employee or representative;

(iii) Gifts
When a Trustee or relative of the Trustee or any other person or entity designated by the Trustee, accepts gifts, payments, services or anything else of more than a token or nominal value from a party with whom the Hospital may transact business (including a supplier of goods or services) for the purpose of (or that may be perceived to be for the purpose of) influencing an act or decision of the Board;

(iv) Acting for an Improper Purpose
When Trustees exercise their powers motivated by self-interest or other improper purposes. Trustees must act solely in the best interest of the Hospital. Trustees who are nominees of a particular group must act in the best interest of the Hospital even if this conflicts with the interests of the nominating party;

(v) Appropriation of Corporate Opportunity
When a Trustee diverts to his or her own use, an opportunity or advantage that belongs to the Hospital;

(vi) Duty to Disclose Information of Value to the Hospital
When Trustees fail to disclose information that is relevant to a vital aspect of SMGH' affairs; and

(vii) Serving on Other Corporations
A Trustee may be in a position where there is a conflict of "duty and duty". This may arise where the Trustee serves as a Trustee of two corporations that are completing or transacting with one another. It may also arise where a Trustee has an association or relationship with another entity. For example, if two corporations are both seeking to take advantage of the same opportunity, a Trustee may be in possession of confidential information received in one boardroom or related to the matter that is of importance to a decision being made in the other boardroom. The Trustee cannot discharge the duty to maintain such information in confidence while at the same time discharging the duty to make disclosure. The Trustee cannot act to advance any interest other than those of the Hospital.

4.3 Process for Resolution of Conflicts of Interest and Addressing Breaches of Duty

(i) Disclosure of Conflicts
A Trustee who is in a position of conflict of interest shall immediately disclose such conflict to the Board by notification to the Chair of the Board (Board Chair) or Vice Chair. Where the Board Chair has a conflict, notice shall be given to the Vice Chair. The disclosure shall be sufficient to disclose the nature and extent of the interest. Disclosure shall be made at the earliest possible time and, where possible, prior to any discussion and vote on the matter. A Trustee may solicit information and advice from sources of his/her choosing, including the Hospital staff, as to whether a particular set of circumstances places a Trustee in a conflict of interest position. Where a Trustee seeks advice from the Hospital staff, the Trustee must understand that such staff are not obligated to provide any such advice and should recognize that any staff response is provided solely on an advisory, but not determinative, basis.

Where (i) a Trustee is not present at a meeting where a matter in which the Trustee has a conflict of interest is first discussed and/or voted upon, or (ii) a conflict of interest arises for a Trustee after a matter has been discussed but not yet voted upon by the Board (or Board Committees as the case may be), or (iii) a Trustee becomes conflicted after a matter has been approved, the Trustee shall make the declaration of the conflict of interest to the Board Chair or Vice Chair as soon as possible and at the next meeting of the Board.

If a Trustee becomes interested in a contract or transaction after it is made or entered into, the disclosure shall be made as soon as possible after the Trustee becomes so interested.

A Trustee may make a general declaration of the Trustee's relationships and interest in entities or persons that give rise to the conflicts.

(ii) Abstain from Discussions
The Trustee who has declared a conflict of interest shall not be present during the discussion or vote in respect of the matter in which he or she has a conflict of interest and shall not attempt in any way to influence the voting.

4.4 Process for Resolution of Conflict of Interest and Addressing Breaches of Duty

A Trustee may be referred to the process outlined below in any of the following circumstances:

(i) Circumstances for Referral
Where any Trustee believes that he or she or another Trustee:
(a) has breached his or her duties to the Hospital;
(b) is in a position where there is a potential breach of duty to the Hospital;
(c) is in a situation of conflict of interest; or
(d) 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 behavior may have an adverse impact on the Hospital.

(ii) Process for Resolution
The matter shall be referred to the following process:

(a) Refer matter to the Chair or where the matter may involve the Chair, to the Vice Chair, with notice to the President.
(b) The Chair (or Vice Chair, as the case may be) may either (i) attempt to decide the matter, or (ii) refer the matter to an ad hoc sub-committee of the Board established by the Chair (or Vice Chair, as the case may be), which shall report to the Board. The sub-committee may seek internal and external advice as needed.
(c) If the Chair or Vice Chair elects to attempt to decide the matter and the matter cannot be decided to the satisfaction of the Chair (or Vice Chair, as the case may be), the Trustee referring the matter and the Trustee involved, then the Chair (or Vice Chair, as the case may be) shall refer the matter to the process in (b) (ii) above.
(d) A decision of the Board by majority resolution shall be determinative of the matter.

It is recognized that if a conflict of interest, or other matter referred cannot be decided to the satisfaction of the Board (by simple majority resolution) or if a breach of duty has occurred, a Trustee may be asked to resign or may be subject to removal pursuant to the Hospital Administrative By-laws.

4.5 Perceived Conflicts

It is acknowledged that not all conflicts of interest may be satisfactorily resolved by strict compliance with the Hospital Administrative By-laws. There may be cases where the perception of a conflict of interest or breach of duty (even where no conflict of interest exists or breach has occurred) may be harmful to the Hospital notwithstanding that there has been compliance with the Hospital Administrative By-Laws. In such circumstances, the process set out in this policy for addressing conflicts of interest and breaches of duty shall be followed.

It is recognized that the perception of conflict of interest or breach of duty may be harmful to the Hospital even where no conflict exists or breach has occurred and it may in the best interest of the Hospital that the Trustee be asked to resign.

ST. MARY'S GENERAL HOSPITAL
(the 'Hospital')
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-011

SECTION TITLE: Governance Process

TOPIC: Community Representation on Board Committees

POLICY STATEMENT

The Mission and Governance Committee (M&G) shall ensure there will be representatives from the community appointed to Standing Committees of the Board except for the Executive Committee.

PROCEDURES:

1. Annually, typically early in the calendar year, the Chair of M&G will initiate a process to advertise and invite members of the public to apply to serve on a Hospital Board Committee for a two year, renewable term to an aggregate maximum of six (6) years of service.

2. The President and the Nominating Committee will screen applications. Potential candidates will be interviewed by the Nominating Committee.

3. The names of successful candidates will be included in the Nominating Report for approval by the Board of Trustees and recommendation to the St. Joseph's Health System (SJHS) Board of Directors.

4. The names of Board Committee nominees will be forwarded to the Chief Executive Officer of the SJHS for consideration by the SJHS Board of Directors, in accordance with SJHS policy.

5. If a community member of a Board Committee fails to complete the term of appointment, the vacancy will be filled by the Nominating Committee at the request of the Chair of the Committee on which that member held a seat.

6. Every two (2) years, typically early in the calendar year, M&G will initiate an evaluation process of community members to assess their eligibility for continued participation on a Hospital Board Committee. The process will also include a survey of the interest of the community members in continuing to sit on a Hospital Board Committee and which committees the community member is most interested. As part of this process the Chair will review with each Committee Chair each member's adherence to

policy number 010-012 Code of Conduct for Members of Board of Trustees and Members of Board Committees.

7. The Chair of M&G will seek the support of the Committee Chairs in providing a mentor to new community members of the respective board committees and in providing transitional support to the new community member in understanding the role of the committee and issues that come before the committee.

APPROVAL:	Governance Committee - February 2004 Board of Trustees – February 2004
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEWED:	Mission and Governance Committee – November 2013; January 2017 Board of Trustees – November 2013
REVISED:	Governance Committee – January 2006, November 2008 Board of Trustees - May 2006, November 2008; April 2017

ST. MARY'S GENERAL HOSPITAL
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Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-012

SECTION TITLE: Governance Process

TOPIC: Code of Conduct for Members of the Board of Trustees and Members of Board Committees

POLICY STATEMENT

Members of the Board of Trustees (the 'Board') and non-members of the Board shall fulfill their responsibilities in a professional manner appropriate to the nature and mission of the Hospital.

Every Trustee and non-Trustee who has been appointed to a Board Committee shall:

a) be loyal to the St. Joseph's Health System (SJHS) and the Hospital;
b) sign a "Declaration of Commitment to Mission for the Board of Trustees and Board Committees of Member Organizations of St. Joseph's Health System";
c) abide by the By-laws of the Hospital, the policies of the Hospital and the SJHS Roles and Responsibilities booklet. Particular concern should be given to those By-laws relating to Confidentiality and Conflict of Interest. Members of the Board will also respect the Hospital's By-law outlining the Duties and Responsibilities of Every Trustee (Article 4);
d) exercise the powers and discharge the duties of appointment in good faith and in the best interest of the Hospital;
e) exercise the degree of care, diligence, and skill that a reasonably prudent person would exercise in comparable circumstances;
f) be present for at least 70% of regularly-scheduled meetings during an annual appointment cycle;
g) conscientiously prepare for and participate in the meetings at which the member holds a seat;
h) exercise one's responsibilities honestly and forthrightly while maintaining at all times a sense of appropriate decorum and taking care to perform one's duties as a member of a team dedicated to the pursuit of a common interest.

BREACHES OF THE CODE OF CONDUCT

In the instance of a perceived conflict of interest the Hospital's By-law on Conflict of Interest (Article 5) shall apply *mutatis mutandis*, whether the

individual is a member of the Board or of a Board Committee.

In any other matter, a member deemed to be potentially in breach of conduct either through commission or omission shall be approached by the Chair of the body on which the member holds a seat and on which the breach of the Code of Conduct is deemed to have occurred. Ideally, the matter should be resolved informally if that is at all possible; if a formal process is required and the matter is sufficiently serious, the Chair shall take the matter to the Board for confidential consideration. Any member deemed to be in serious breach of the Code of Conduct is entitled to be present for the Board discussion and to provide a statement of defence. The Board's final determination shall be taken without the member's being present; a decision to recommend the removal of a member from an appointed seat will follow a course of natural justice and the individual will receive a written statement specifying the Board's final determination.

Since a final decision to remove an individual from a duly-appointed seat resides with SJHS, the Hospital Board's written recommendation will be forwarded to the President of SJHS and copied to the member under consideration after which the Board of SJHS will conclude the matter according to its own procedures.

APPROVAL:	Governance Committee - March 2006 Board of Trustees - March 2006
DISTRIBUTION:	Master Manual, Board of Trustees
REVISED:	Governance Committee - November 2008 Board of Trustees - November 2008
REVIEWED:	Mission and Governance Committee - November 2013; January 2017 Board of Trustees - November 2013; April 2017

ST. MARY'S GENERAL HOSPITAL
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POLICY ORIGIN: Board of Trustees POLICY NO: 010-013

SECTION TITLE: Governance Process

TOPIC: Access to Information

POLICY STATEMENT

Under Ontario's Freedom of Information and Protection of Privacy Act (FIPPA), any member of the public may request access to records held by St. Mary's General Hospital on or after January 1, 2007. St. Mary's General Hospital is an advocate for openness and transparency. We are committed to providing access to our records and to protecting the privacy of individuals whose personal information is held by the hospital. In some cases, we will not be able to provide access to certain records, or parts of records, because the Act includes limited protections for information holdings. For example, St. Mary's may be required to protect the rights of another person or organization.

While generally you have a right to access to your own personal information contained in the hospital's records, some records may contain other types of information that may be excluded or exempted from disclosure under FIPPA. For example, some information related to research, teaching, quality of care, labour relations and employment may not be accessible under the act. We will make every effort possible to provide appropriate access to our records. Many records are already made available to the public via our website, or will be made available upon request without a formal request for access under FIPPA.

To make a Formal Freedom of Information (FOI) Request, please use the Information Access Form. Once complete, please mail the form, and the required application fee of $5.00 (in the form of a cheque payable to St. Mary's General Hospital) to:

Freedom of Information Office
St. Mary's General Hospital
911 Queen's Blvd., Kitchener, ON N2M 1B2
Electronic requests will not be accepted.

Note that FIPPA does not apply to (for example):

1. Records in the Hospital's custody or control prior to January 1, 2007;
2. Foundation operations and donor records;
3. Labour relations and employment-related records leading to agreements;
4. Research and teaching materials;
5. Patient records/personal health information.

Approval:	Resource Planning & Utilization – June 1, 2016 Mission & Governance –June 1, 2016
Distribution:	Master Manuals, Board of Trustees
Review:	Resource Planning & Utilization – December 11, 1997, October 2002 Audit – April 2015 Board of Trustees – January 1998
Revision:	Governance – January 2003, January 2006, May 2006, April 2012 Mission and Governance – May 2015, November 2016 Board of Trustees – May 2003. May 2006, April 2012, May 2015, November 2016

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POLICY ORIGIN: Board of Trustees POLICY NO: 010-014

SECTION TITLE: Governance Process

TOPIC: Medical Staff Credentialing

POLICY STATEMENT

Pursuant to the Corporations Act and the Public Hospitals Act, the Board of Trustees (the 'Board') is responsible for the governance of the Hospital, including the management of risk and the quality of care. The implementation of a system to ensure and monitor the quality of care provided by the physicians, dentists, midwives and extended class nursing staff in the hospital is one of the primary responsibilities of the Board. In exercising this responsibility, the Trustees must:

(a) act honestly and in good faith with a view to the best interests of the Hospital; and

(b) exercise the care, diligence and skill that a reasonably prudent director would exercise in comparable circumstances.

Together with the Medical Advisory Committee (MAC) there must be a clear and reasonable system that will allow the Board to consider an application by physicians and other professionals for appointment to the Medical or Professional Staff of the Hospital in a manner that ensures that the Board is capable of managing the quality of care offered in the Hospital and minimizing the attendant risks to patients. The credentialing system further recognizes the Board's responsibility to efficiently and effectively utilize the resources of the hospital in the provision of patient care.

Responsibilities of the Board in the credentialing process include:

1. Approve the by-laws that establish the criteria for appointment and reappointment, and creates the process for appointment, re-appointment and changes in privileges.
2. Approve the form of application or, if not the form then, the required content of the application – in effect approving the scope of the due diligence that must be undertaken in respect of each applicant for appointment and re-appointment.
3. Ensure that reviews are undertaken as part of the re-appointment process for more robust, periodic reviews.

4. Appoint the senior officers and medical staff leaders who are responsible for the process (i.e., chief of staff/chair of the Medical Advisory Committee, department chiefs).
5. Receive reports and briefings from the chief staff/chair of the Medical Advisory Committee on the overall credentialing process to satisfy itself that the process is fair, thorough, etc.
6. Review the performance of the chief of staff.
7. Establish the medical advisory committee and may establish a credentials committee.
8. Make decisions on the strategic directions of the Hospital that will impact professional staff resource plans.
9. Exercise oversight to ensure the established process is followed.
10. Make decisions on appointments, re-appointments and changes in privileges.
11. Hold hearings and decides on contested matters involving professional staff appointments, where required.

APPROVAL: Mission and Governance Committee – January 2017
Board of Trustees – April 2017

DISTRIBUTION: Master Manuals, Board of Trustees

REVIEWED:

REVISED:

ST. MARY'S GENERAL HOSPITAL
(the 'Hospital')
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POLICY ORIGIN: Board of Trustees POLICY NO: 010-015

SECTION TITLE: Governance Process

TOPIC: Risk Management

PURPOSE

To outline parameters for risk identification and oversight at all levels of the Hospital.

The Ontario Hospital Association (OHA) Guide to Good Governance states that the sources of risk fall into three categories*:

1. Liabilities and losses: a health care organization has direct liability for its equipment, premises, and facilities, patient safety and protection, processes and protocols, staff appointments, and monitoring staff competence. In addition, the organization also has a vicarious responsibility for its employees.

2. Business viability risks: a fundamental business risk is sustainability. This concerns the ability of the organization to fund its commitments, ongoing services and programs.

3. Mission and intangible risks: Mission risks are clearly about reputation support in the community, as well as the ability of SMGH to meet aspirations in terms of service to patients and the community being served.

PROCEDURE

1. The Board of Trustees (the 'Board') will ensure that a formal risk management plan is developed, monitored, and evaluated.

2. The components of the risk management plan will include the following:

    2.1 Preparation: preparation involves identifying and assessing potential risks, as well as determining how to respond to each risk. Preparation includes the following:

        2.1.1 Identification of risks: conducting a comprehensive risk identification process on a regular basis.

2.1.2 Assessment of risks: considering the likelihood and potential impact of risks and the ways to address or respond to each.

2.1.3 Selecting appropriate responses to risks: that is, avoiding, accepting, reducing, or sharing a risk.

2.2 Prevention: prevention includes ensuring at both the St. Joseph's Health System and member organization levels that the operating plan is achieved, as well as preventing failures in executing the plan. Strategies for prevention of loss or risk include:

2.2.1 Adopting policies and processes that ensure risks are avoided, where possible, and that performance is monitored so management can take corrective action.

2.2.2 Ensuring the competence of staff.

2.2.3 Building an organizational culture that promotes the achieving of results, ensures seamless, transparent communication, and identifies and addresses risks expeditiously and effectively.

2.3 Protection: protection includes mitigating the effects of risks on the organization through various measures:

2.3.1 The traditional risk management strategy of insurance.

2.3.2 Establishing contractual protections against contingencies or risks.

2.3.3 Contingency planning to diminish the impacts of potential risks and surprise events. This includes emergency preparedness for disasters and infection outbreaks.

INDICATORS

1. Risk reports, inclusive of the risk management processes, will be provided to the Board annually.

* Excerpts from OHA Guide to Good Governance served as a principal resource

ST. MARY'S GENERAL HOSPITAL
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APPROVAL:	Mission and Governance Committee – January 2017 Board of Trustees – April 2017
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEWED:	
REVISED:	

ST. MARY'S GENERAL HOSPITAL
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Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-016

SECTION TITLE: Governance Process

TOPIC: External Partnerships

POLICY STATEMENT

The Hospital is strongly committed to improving the quality and safety of health care in the Waterloo Wellington Region in partnership with all health care providers.

This is a commitment that is shared among our partner organizations and continues to be fostered through open, honest communications and by focusing on the needs of our patients and their experience within the overall health care system.

To this end the Hospital will initiate, collaborate and coordinate efforts with all community partners involved in patient care in order to enhance and add value to outcomes for patients.

This horizontal integration will include working to break down internal organizational and professional boundaries and applying these same principles across organizational jurisdictions in order to deliver a seamless patient experience across the continuum of care.

We will work to ensure that decisions for system integration will be based on known best practices with a strong business case and we will be open to new and innovative ideas that add value for patients. We will work to eliminate unnecessary duplication and inefficiencies.

As a part of the St. Josephs Health Care System (SJHS), the Hospital will seek to leverage the strengths of this relationship to the benefit of our patients and healthcare partners in accordance with the By-laws.

<u>The St. Mary's Commitment</u>

As we make this commitment we do so within the following context:

1. We believe the culture of the Hospital is derived from the legacy of the Sisters of St. Joseph and continues today through the foundational

values of our Hospital. Such a culture and focus on values, while not exclusive to faith-based providers, is an integral component of all that we do and has a direct positive impact on patient care. We are committed to maintaining its positive impact.

2. We are a part of the larger SJHS and as such bring additional resources to all partnerships (e.g., added expertise with certain patient populations, models of care, finances, accountability systems, etc.) which will enhance our collective abilities to provide high quality patient care.
3. We believe that integration of services must also be balanced with a certain level of organizational autonomy to ensure the ability of an organization to innovate and develop models that enhance patient care.
4. We believe efforts for system integration must revolve around enhancing the patient experience across the care continuum for equal to or less cost.
5. We recognize and support that in order for system integration to occur, flexibility to allocate funding differently across organizational entities will be necessary.
6. We embrace the values and contributions of each of our partners and will work together collaboratively in an environment of trust and transparency to improve our service to those we are privileged to serve.

PROCEDURE

While this relationship with SJHS fully supports our integrating and partnering on behalf of improving patient care, it places certain parameters on our independence to explore merging with our partners. These discussions, should they be deemed to be in the interest of enhancing patient care, would be subject to approvals from not only the Board of Directors of SJHS but also a variety of ecclesiastical authorities. These required approvals are outlined in an existing SJHS policy on "Partnerships and Alliances".

APPROVAL: Mission and Governance Committee – January 2017
Board of Trustees – April 2017

DISTRIBUTION: Master Manuals, Board of Trustees

REVIEWED:

REVISED:

ST. MARY'S GENERAL HOSPITAL
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Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-017

SECTION TITLE: Governance Process

TOPIC: Board of Trustees Exit Interview

POLICY STATEMENT

1.0 Purpose

In keeping with a commitment to continuous improvement, the Board of Trustees (the 'Board') will conduct exit interviews with all outgoing elected Trustees.

2.0 Procedure

2.1 Interviews with all exiting elected Trustees will be initiated and led by the Mission and Governance Committee (M&G) Chair as soon as possible following departure. If an individual Trustee so chooses, the interview may be led by a representative of the St. Joseph's Health System.

2.2 The exit interview will explore the following areas:
a) Expectations
b) Relationship with peers
c) General advice
d) Other comments and suggestions

Sample questions are included in Appendix 1.

2.3 Questions will be pre-circulated and the interviews will ideally be conducted face-to-face or where necessary, by telephone. If so requested, an on-line survey option can be created.

2.4 The results of the interview will be collated and summarized for discussion at the Mission and Governance Committee (M&G). Any associated action plans or follow-up will also be discussed at this time.

2.5 Exit checklist:
- Parking/ID badge returned

- Delete/shred all files: for paper files, Trustees are to either confidentially shred or bring into the President's Office
- Return borrowed electronic devices

APPENDIX 1 – EXIT INTERVIEW QUESTIONS

The following questions will be used to guide the exit interview:

1. What do you think are the top three (3) ways to improve the culture of good governance on the Board of the Hospital?

2. What were the most rewarding aspects of being a Board member at the Hospital?

3. What were the most frustrating aspects of being a Board member at the Hospital?

4. Did your experience meet your expectations when you joined the Board? If not, why not?

5. How would you assess the culture of the Hospital as it relates to the performance of the management/staff support to the Board?

6. Would you recommend serving on the Board to another leader in your community?

7. What would you like to comment on that has not been asked?

8. Have you deleted and/or made arrangements to shred all Board materials?

POLICY ORIGIN: Board of Trustees POLICY NO: 010-101

SECTION TITLE: Finance

TOPIC: Financial Oversight and Accountability

POLICY STATEMENT

The Board of Trustees' objective is to oversee that St. Mary's General Hospital is operating in a financially sustainable manner within its resources and must efficiently and effectively use those resources to fulfil the hospital's mission of patient and family-centered care, quality and safety, and development of the health care workers so that they can continue to provide programs and services to its patients and community.

- Annually, a long range financial operating plan to support the priorities of the Strategic Plan including programs, education and research is shared with the Resource Planning and Utilization Committee and the Board. The plan identifies planned expenditures, funding requirements and sources of funding.
- Annually, in consultation with the St. Mary's General Hospital Foundation (the Foundation), a five (5) year capital plan, consistent with the needs outlined in the Strategic Plan is developed.
- Annually, within the context of the five (5) year long range financial operating plan, the Board reviews, revises if required, and approves the one (1) year operating plan.
- Annually, within the context of the five (5) year capital plan, the Board reviews, revises if required, and approves a one (1) year capital plan and ensures that the Foundation is informed of the plan.

PROCEDURES

Long Range Financial Operating and Capital Plan

The Senior Management Team, for the Resource, Planning and Utilization (RPU) Committee, develops a long range financial operating plan which identifies projected expenditures, funding requirements and timing of these requirements over a five (5) year period. The RPU Committee, in collaboration with the St. Mary's General Hospital Foundation (Foundation) completes the plan for program, education and research by reviewing and identifying sources of funds to meet projected requirements.

If necessary, existing funds are segregated internally to comply with the plans.

The plan is updated and presented on a regular basis to the RPU Committee and the Board.

Annual Operating and Capital Plan

The annual operating plan reflects the mission, vision and values, the approved strategies and annual goals and objectives of the hospital. The plans identify any changes in programs and service and the impact on level or type of service and on the quality and patient safety.

The operating and capital budgets comply with the reporting requirements of the Ministry of Health and Long-Term Care (MOHLTC), and is included in the Hospital Annual Planning Submission (HAPS) submitted to the Waterloo Wellington Local Health Integration Network (WW LHIN).

The Hospital Annual Planning Submission (HAPS) and operating plan will be aligned with the Board's established priorities, and will not place the organization at financial risk. The Board will require that the operating plan and annual budget include adequate working capital to meet the needs of the hospital. To this end, the board expects the hospital to strive towards funding all of its operating and capital needs (including building amortization and building grants received) each year using current year resources. The Board will not approve an annual operating plan that projects a deficit position, unless explicitly directed or permitted to do so by the MOHLTC or the WW LHIN. Should the annual operating budget show a deficit, a recovery plan is to be put into place to span no more than twenty-four (24) months.

The CFO is responsible for preparing a draft HAPS and a draft annual operating plan, capital plan and budgets each fiscal year with the executive team of the Hospital (Senior Team). The President in collaboration with the CFO will set the overriding parameters and objectives for hospital operations, including establishing the time frame for planning; including desired operating bottom-line; capital financing directions; desired cash flow position.

Prior to the Board granting its approval, the CFO and President will present the draft operating plan to the Resource Planning and Utilization Committee (RPU).

Risks associated with changing funding levels, change in patient care demands for service or any of the operating plan assumptions are discussed and risk mitigation strategies developed.

RPU will review and approve the documents for presentation to the Board. The RPU, on behalf of the Board will:

- Review and approve the draft detailed operating plan and budget assumptions including, but not limited to the following:

- Projected broad service distribution and volume targets;
- Projected occupancy rates including length of stay;
- Projected compensation costs;
- Projected supply costs;
- Projected MOHLTC /LHIN and other funding assumptions;
- Ranking of new or planned programs or enhancements;
- Impact of any service changes.

- Review and approve the final operating plan on a timely basis, ensuring broad planning parameters and detailed budget assumptions have been utilized.
- The operating plan and annual budget are also approved by the Advisory (Staff) Committee (when requested).

The Board will review and approve the HAPS including the operating and capital budget, and to approve the Hospital Services Accountability Agreement for submission to the Local Health Integration Network (LHIN) by a date in compliance with its requirements.

The Chair of the Board along with the President, or other authorized signing officers will sign the HAPS and the Hospital Services Accountability Agreement (HSAA).

Approval:	Resource Planning & Utilization – June 1, 2016 Mission & Governance –June 1, 2016
Distribution:	Master Manuals, Board of Trustees, Senior Team, M.A.C., Middle Managers
Review:	Resource Planning & Utilization – Dec. 11, 1997, October 2002, March 2015, November 2016 Board of Trustees – January 1998, May 2003, May 2015, November 2016
Revision:	Governance – May 2006; Mission and Governance – September 2013, May 2015 Resource Planning & Utilization – March 2015

ST. MARY'S GENERAL HOSPITAL
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-103

SECTION TITLE: Finance

TOPIC: Disbursement of Monetary Funds

POLICY STATEMENT

St. Mary's General Hospital will ensure appropriate authorization of all monetary disbursements within predefined limits. This policy applies all methods of payments, including cheques, Electronic Funds Transfer (EFT), procurement card, money order/bank draft requests, and preauthorized payments.

PROCEDURES

Cheque Amount	**Signature 1**	**Signature 2**
<= $10,000	Electronic Signature of either Director of Financial Services	Electronic Signature of President
>$10,000 and <=$1,000,000	Written signature of either 1. Director of Financial Services 2. Vice President, Corporate Services and CFO	Electronic signature of President
> $1,000,000 and <= $1,500,000	Written signature of either 1. Director of Financial Services 2. Vice President, Corporate Services and CFO	Written signature of either 1. President 2. Vice President (other than CFO)

> $1,500,000	Written signature of either 1. Vice President, Corporate Services and CFO 2. President	Written signature of either 1. Board Chair 2. Board Vice Chair 3. Treasurer

Approval:	Senior Team – October 1980
Distribution:	Master Manuals, Board of Trustees, Administration, Finance
Review:	Resource Planning and Utilization – November 2002 Board of Trustees – November 2002
Revision:	Senior Team – March 1989 Resource Planning and Utilization – Dec 1997, Nov 2007, June 2013, March 2015 Governance – March 2003, May 2006, January 2008; Mission and Governance – September 2013, May 2015, November 2016 Board of Trustees – Jan 1998, May 2003, May 2006, October 2013, May 2015, November 2016

ST. MARY'S GENERAL HOSPITAL
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POLICY ORIGIN: Board of Trustees POLICY NO: 010-104

SECTION TITLE: Finance

TOPIC: Capital Assets Acquisition

POLICY STATEMENT

This policy governs the capital assets acquired directly at St. Mary's General Hospital (see Procedures below). All capital expenditures will abide by the Broader Public Sector Procurement Directives and Guidelines.

Capital Assets have three broad categories

1. **Capital equipment and building service equipment** – defined as all equipment, computer software and building service equipment with a unit cost greater than $2,000 where the benefit continues over a period longer than one year.
2. **Land and Buildings** – defined as property consisting of land and the buildings on it. It also includes any betterment to the building that contributes towards improving the asset's performance and/or increasing its value.
3. **Hospital Infrastructure under Health Infrastructure Renewal Funds (HIRF)** – is defined as approved minor capital projects that extend the useful life, or result in an improvement in the quality or functionality of hospital facilities but that will not result in an increase in operating funding. These projects are separately funded by the Ministry of Health and Long Term Care (Ministry of Health).

PROCEDURES

1. **Capital equipment and building service equipment** acquisitions by the hospital
    a. Cannot exceed the hospital's annual depreciation if the hospital is using its own funds; and
    b. Cannot exceed cannot exceed funding provided by Ministry Grants or Foundation donations
    c. Any contemplated purchase beyond the approved capital plan will be brought to RPU and the Board for approval unless of urgent and immediate need, where the purchase may be approved by the President in consultation with the Board Treasurer.

The capital equipment and business service equipment acquisitions, business cases and financing are first considered by the Internal Capital Committee. All items recommended are then brought in summary to the Resource, Planning and Utilization Committee (RPU) for recommendation for Board approval.

2. Land and Building

a. Cannot exceed hospital annual depreciation

The land and building acquisitions business cases and financing are first considered by the Internal Capital Committee. All items recommended are then brought in summary to the RPU Committee for recommendation for Board approval. As per by-laws, the acquisition of land and buildings requires the approval of the St. Joseph's Health System Board of Directors.

3. Hospital Infrastructure Projects under Health Infrastructure Renewal Funds (HIRF)

The business cases and financing are first considered by the Internal Capital Committee and all items recommended are then brought in summary to the RPU Committee for approval. Applications to the Ministry are then completed and once we are awarded the capital for the project, funds are received by the Ministry and St. Mary's General Hospital must procure and manage the project until it is complete. Reporting to the Ministry is required.

Approval:	Finance Committee – September 22, 1992 Board of Trustees – September 30, 1992
Distribution:	Master Manuals, Board of Trustees, Senior Team, M.A.C., Middle Managers
Review:	Governance Committee – May 2006 Board of Trustees – May 2006, October 2013
Revision:	Resource Planning & Utilization – June 2013, March 2015 Mission and Governance – September 2013, May 2015, November 2016 Board of Trustees – May 2015, November 2016

POLICY ORIGIN: Board of Trustees POLICY NO: 010-106

SECTION TITLE: Finance

TOPIC: Investment Policy

POLICY STATEMENT

According to Article 29 of the Administrative By-Laws the Board may allow the hospital to invest surplus hospital funds. This policy governs the manner in which hospital funds may be invested and is intended to provide specific guidelines with respect to approved financial institutions (borrowers) and investment brokers, approved forms of investments, investment limits, terms and collateral requirements. This policy is to be reviewed by the Resource Planning and Utilization Committee (RPU) bi-annually or more frequently if required.

INVESTMENT OBJECTIVES

The objectives of the investment are to:

- Preservation of capital. Priority will be given to securing the principle value in all investment considerations.
- Maintain liquidity. A cash balance should be maintained for working capital and to meet other cash requirements as forecasted at least one year in advance by the Hospital. In addition, as a general guideline, the entire investment portfolio should be convertible into cash with minimum risk of capital loss within a period of one year. It is understood such a conversion to cash will be an extreme and rare occurrence.
- All investments will be limited to banks or governments that exhibit a moral, ethical, social and environmental responsibility and are adopted by the hospital as a definition of its own guidelines.
- To diversify the risk and enhance expected returns, investments will be allocated between the following major asset classes and maintained within the corresponding ranges expressed as a percentage of the fund's market value.

	Min.	Max.
Cash and Cash Equivalents	5%	100%
Debt Securities and GIC	0%	100%

Investment decisions should be made with consideration to appropriately diversifying the portfolio.

INVESTMENT CATEGORIES

Cash and Cash Equivalents

- Short-term investments with a term to maturity of up to one year - Treasury Bills issued by the Government of Canada or a Province of Canada or Bankers Acceptances issued by CIBC, Royal Bank, Bank of Montreal, Scotia Bank, TD Canada Trust, National Bank or Schedule "B" Banks with a rating not less than R1 MID. (Nov/01 rating for HSBC)
- Deposits with CIBC, Royal Bank, Bank of Montreal, Scotia Bank, TD Canada Trust, National Bank or Schedule "B" Banks with a rating not less than R1 MID. (Nov/01 rating for HSBC) and any other bank that is eligible to have their deposits insured up to the limit eligible with Canadian Deposit Insurance Corporation.

Debt Securities and GIC

- Guaranteed Investment Certificates and Term Deposits with a maturity of less than one year issued by CIBC, Royal Bank, Bank of Montreal, Scotia Bank, TD Canada Trust, National Bank or Schedule "B" Banks with a rating not less than R1 MID. (Nov/01 rating for HSBC)
- Canada Bonds – those guaranteed by the Government of Canada or a Province of Canada with a maturity of less than 5 years

PROCEDURES

RESPONSIBILITIES

The Board ensures that its fiduciary responsibility for the invested assets of the hospital is fulfilled through appropriate investment structure, internal and external management consistent with all policies. Although the Board is not involved in day-to-day investment decisions, based on the advice and recommendations of the RPU Committee, the Board shall:

- Approve investment policies, guidelines, and objectives that reflect the long-term goals of the hospital.
- Oversee activities related to compliance, decision-making and structure within the Hospital.
- Review and accept the Minutes of the RPU Committee

The RPU Committee of the Board is responsible for the development, recommendation, implementation and maintenance of all policies. The Committee shall:

- Recommend and set long-term investment policies and objectives. This includes studying and selecting asset classes, determining asset allocation ranges, and setting performance objectives.
- Determine that assets are prudently and effectively managed.

- Monitor and evaluate the performance of all service providers by regular review of reports provided to the Committee and by meetings with the service providers.
- Retain or dismiss outside professionals such as custodian banks, investment managers, and investment consultant.
- Receive and review reports from staff, investment consultant, and investment managers regarding the status of assets.
- Meet periodically to evaluate whether this policy, the investment activities, the risk management controls and processes continue to be consistent with meeting the goals and objectives set for the hospital.

The Vice President, Corporate Services / CFO or designate will be responsible for the day-to-day administration and implementation of the policies set for the hospital. The Vice President, Corporate Services / CFO shall also be the primary liaison between all service providers. Specifically, the Vice President, Corporate Services / CFO shall:

- Oversee the day-to-day operational investment activities of the Portfolio subject to policies established by the Board and Committee.
- Assist in establishing long-term investment policies and objectives for the hospital. This includes studying and selecting asset classes, determining asset allocation ranges, and setting performance objectives for the hospital and investment managers.
- Communicate the Statement of Investment Policy to outside professionals such as the custodian, investment managers, and investment consultant.
- Work with investment managers, investment consultant, and other outside professionals to meet the overall goals and objectives set for the hospital.
- Rebalance assets among asset classes, investment styles, and investment management firms within allocation ranges previously approved.
- Receive and review reports from outside professionals managing the investments.
- Issue status reports to the Board and Committee on a periodic basis.

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Approval: Finance Committee – Prior to mid 1980s
Board of Trustees – Prior to mid 1980s

Distribution: Master Manuals, Board of Trustees, Resource Planning & Utilization

Review: Resource Planning & Utilization – Nov 2001, Oct 2002, March 2015
Mission and Governance Committee – May 2015, November 2016

Board of Trustees – Nov 2001, May 2003, October 2013, November 2016

Revision: Resource Planning & Utilization – Nov 2001, June 2013
Governance Committee – May 2006
Mission and Governance Committee – September 2013
Board of Trustees – May 2006

POLICY ORIGIN: Board of Trustees POLICY NO: 010-108

SECTION TITLE: Finance

TOPIC: Borrowing Limits and Repayment

POLICY STATEMENT

The Board of Trustees must approve any limits on borrowing assumed by the hospital. The hospital may from time to time be required to borrow funds in order to carry out its business. The purpose of this policy is to set out the policy and procedure for approval of debt assumption (Operating or Capital).

SECURITY

In general, St. Joseph's Health System requires all loans and/or debt agreements of member organizations to be unsecured.

In the event that security is requested by the lender, the mortgaging or pledging as security any assets of the member organization requires the explicit approval of the System Board of Directors, such approval may be subject to applicable canonical and civil legislation.

LIMITED RECOURSE

St. Joseph's Health System requires all debt agreements to include appropriate Limited Recourse Language. Limited Recourse language is incorporated into any debt agreement such that the lender agrees to recover payment, including all claims and damages from the Limited Recourse assets of the individual member organization only. This is intended to ensure the assets of the other member organizations are not at risk in the event that one member organization is in default.

PROCEDURES

The President in consultation with the CFO shall ensure that appropriate and effective processes exist to identify short-term and long-term cash flow requirements.

The hospital may borrow funds for the following purposes only:

1. Operating financing (line of credit) – to fund normal operating requirements where operating expenses must be paid prior to receipt of revenues;

2. Capital purchases – to lease or finance capital equipment in the Board-approved annual capital budget as part of the hospital's long-term capital plan;

3. Land or property - to support the acquisition of land or property required by the hospital, subject to approval of St. Joseph's Health System (System); and

4. Special projects – to support a hospital expenditure justified by a business case demonstrating a reasonable financial return.

The executive team of the Hospital (Senior Team) will identify the nature, amount and purpose of the proposed borrowings. Such requests must be made with an adequate in-year and multi-year forecasting and repayment mechanism with cash flows:

- Senior Team will prepare a formal business plan identifying adequate incremental revenue, efficiencies or cost savings to fund repayment (principal + interest) over the life of the loan.
- CFO will present the plan, with an appropriate risk assessment, sensitivity analysis and contingency plans, to the local Board of Trustees through the RPU for initial approval.
- Once initial review and approval has been obtained, the CFO will present the plan to the System Finance and Audit Committee for review and consideration.
- St. Mary's General Hospital Board of Trustees must then approve the plan.
- The System Finance and Audit Committee will recommend to the System Board of Directors the appropriate course of action in response to the plan.
- Once approved by the System Board of Directors, the System Board will delegate responsibility to execute the plan including execution of the specific debt agreements to St. Mary's General Hospital Board of Trustees and Senior Team by way of a formal resolution.
- The President and Vice President, Corporate Services & CFO will execute the transaction under the direction of the Chairperson of the Board of Trustees and or Chair of the Resource, Planning and Utilization Committee.

ST. MARY'S GENERAL HOSPITAL
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	Mission and Governance Committee – November 2011, May 2015 Board of Trustees – November 2011
Revision:	Mission and Governance Committee – November 2016 Board of Trustees – November 2016

ST. MARY'S GENERAL HOSPITAL
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-109

SECTION TITLE: Finance

TOPIC: Expenditures of Board of Trustees

POLICY STATEMENT

A Board of trustee may receive reimbursement of expenses in discharging their duties of their office. Board members are included in the guidelines that specify expense reimbursement, "The Broader Public Sector Expenses Directive".

PROCEDURE

Board members are to follow the Business Travel and Expense Reimbursement Policy. This policy outlines eligible expenses and procedures.

Expenses of Board members will be disclosed per the BPSA directives and posted on the SMGH website.

Approval:	Audit Committee – February 2012 Mission and Governance Committee – April 2012 Board of Trustees – April 2012
Distribution:	Board of Trustees
Review:	Audit Committee – April 2015 Mission and Governance Committee – May 2015
Revision:	Mission and Governance Committee – November 2016 Board of Trustees – November 2016

POLICY ORIGIN: Board of Trustees POLICY NO: 010-111

SECTION TITLE: Finance

TOPIC: Financial Reporting

POLICY STATEMENT

The Board of Trustees, in dispensing of its fiduciary responsibilities, shall receive period information for review to ensure that the hospital is tracking to its annual operating plan and approve such periodic financial statements. Such information will include review of financial statements including variances from budget and any other material financial matters.

PROCEDURE

The Senior Team regularly prepares financial information reports on variance from budget are highlighted. All significant information and any other material financial matters are also prepared.

Other material financial matters include, but are not limited to:

1) Significant long-term commitments, including new leases and contracts in excess of 2 years and greater than $200,000
2) Potential significant liabilities that arise from operations
3) Changes in funding sources (MOHLTC/LHIN, Cardiac Care Network of Ontario and others)
4) Comparison of actual to budget and cost/benefit analysis of new programs
5) Comparison of actual to budget for capital assets acquisitions
6) Full-time equivalent (FTE) staffing data
7) Clinical services and workload data
8) Labour contracts, negotiations
9) Any other matters with significant financial implications

The Resource Planning and Utilization (RPU) Committee of St. Mary's General Hospital reviews and approves the periodic financial statements. Significant changes to the Capital Budget are reviewed and approved at the RPU Committee. The RPU Committee reviews capital spending on major projects regularly.

Management reports regularly to the RPU Committee on significant information and any other material financial matters.

The RPU Committee reports on the Financial Statements, Capital Budget and other material matters on a minimum quarterly basis to the Board of Trustees. The Board then formally approves the financial information.

Approval:	Resource Planning & Utilization – June 2013 Board of Trustees – October 2013
Distribution:	Master Manuals, Board of Trustees, Senior Team, M.A.C., Middle Managers
Review:	Resource Planning & Utilization – March 2015 Mission and Governance Committee – May 2015; November 2016 Board of Trustees – November 2016
Revisions:	Mission and Governance Committee – September 2013 Board of Trustees - October 2013

POLICY ORIGIN: Board of Trustees POLICY NO: 010-112

SECTION TITLE: Finance

TOPIC: Enterprise Risk Management

POLICY STATEMENT

1. The Board of Trustees will ensure that a formal risk management plan is developed, monitored, and evaluated periodically.

2. The components of the risk management plan will include the following:

   2.1. *Preparation*: preparation involves identifying and assessing potential risks, as well as determining how to respond to each risk. Preparation includes the following:
      2.1.1. Identification of risks: conducting a comprehensive risk identification process on a regular basis.
      2.1.2. Assessment of risks: considering the likelihood and potential impact of risks and the ways to address or respond to each.
      2.1.3. Selecting appropriate responses to risks: that is, avoiding, accepting, reducing, or sharing a risk.

   2.2. *Prevention*: prevention includes ensuring that the operating plan is achieved, as well as preventing failures in executing the plan. Strategies for prevention of loss or risk include:
      2.2.1. Adopting policies and processes that ensure risks are avoided, where possible and that performance is monitored so management can take corrective action.
      2.2.2. Ensuring the competence of staff.
      2.2.3. Building an organizational culture that promotes the achieving of results, ensures seamless, transparent communications and identifies and addresses risks expeditiously and effectively.

   2.3. *Protection*: Protection includes mitigating the effects of risks on the organization through various measures:
      2.3.1. The traditional risk management strategy of insurance including insurance for liabilities, malpractice suits, assets and trustee responsibilities.
      2.3.2. Establishing contractual protections against contingencies or risks.

2.3.3. Contingencies planning to diminish the impacts of potential risks and surprise events. This includes emergency preparedness for disasters and infectious outbreaks

PROCEDURES

The risk management plan and practices are reviewed with the Audit, Resources Planning and Utilization, Quality and Mission and Governance Committees as related to their terms of reference and to the Board of Trustees annually.

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Approval: Resource Planning and Utilization Committee – June 2013
Board of Trustees – September 2013

Distribution: Master Manuals, Board of Trustees, Senior Team, M.A.C., Middle Managers

Review: Audit Committee – April 2015
Mission and Governance Committee – May 2015; November 2016
Board of Trustees – November 2016

Revision:

POLICY ORIGIN: Board of Trustees POLICY NO: 010-113

SECTION TITLE: Finance

TOPIC: Donations and Receipting

POLICY STATEMENT

All donations in the name of St. Mary's General Hospital will be deposited, receipted and tracked by the St. Mary's General Hospital Foundation for the explicit use of the organization, provided that any amounts directed toward a designated purpose in the organization will be transferred promptly to the Hospital.

Approval:	Resource Planning and Utilization Committee – March 2015 Board of Trustees – May 2015
Distribution:	Master Manuals, Board of Trustees, Senior Team, M.A.C., Middle Managers
Review:	Mission and Governance Committee – November 2016 Board of Trustees – November 2016
Revision:	

ST. MARY'S GENERAL HOSPITAL
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-114

SECTION TITLE: Finance

TOPIC: Segregation of Funds

POLICY STATEMENT

St. Mary's General Hospital segregates trust funds from non-trust funds. Trust funds include externally restricted grants (including building and capital funds), endowment funds, and grants for research and other purposes.

Non-trust funds include operating funding form the LHIN (Local Health Integration Network), Ministry of Health and Long Term Care (the Ministry of Health), accumulated surpluses on self-funded programs, and any internally restricted funds.

PROCEDURE

Separate ledger accounts are maintained for each trust account.
Financial statements reflect funds held in trust.
Trust funds are not co-mingled with non-trust funds for investment purposes.

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Approval: Resource Planning and Utilization Committee – March 2015
Board of Trustees – May 2015

Distribution: Master Manuals, Board of Trustees, Senior Team, M.A.C., Middle Managers

Review: Mission and Governance Committee – November 2016
Board of Trustees – November 2016

Revision:

POLICY ORIGIN: Board of Trustees POLICY NO: 010-116

SECTION TITLE: Finance

TOPIC: Regulatory Filing, Payments and Compliance

POLICY STATEMENT

St. Mary's General Hospital will be compliant with all regulatory bodies and funding sources in regards to financial reporting and activities for the hospital.

PROCEDURE

Management attests and reports to the Audit Committee on a periodic basis regarding compliance with regulatory filings.

Examples include, but are not limited to:

- Payment are current for all salaries and benefits; including
  - Gross wages
  - Income taxes
  - Employer health tax
  - Employment insurance
  - Canada Pension Plan
- Remittances of all indirect taxes including sales tax
- Filing of Audited Financial Statements on a timely basis
- Banking covenants (if applicable)
- Insurance limit coverage reviews and renewals
- Workers Safety and Insurance Board
- Ministry of Health and Long Term Care and LHIN quarterly and annual filings
- Other non-financial and financial filings and attestations

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Approval: Audit Committee – April 2015
Board of Trustees – May 2015

Distribution: Master Manuals, Board of Trustees

Review: Mission and Governance Committee – November 2016
Board of Trustees – November 2016

Revision:

ST. MARY'S GENERAL HOSPITAL
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-201

SECTION TITLE: Human Resources

TOPIC: Performance Evaluation – Joint Chief of Staff

POLICY STATEMENT

In accordance with the By-laws, the performance of the Joint Chief of Staff will be evaluated annually.

Procedures

Since the Chief of Staff position is a shared position common to St. Mary's and Grand River Hospitals, the evaluation process will be undertaken jointly by the two Boards.

Within two months of the anniversary date of the appointment of the Joint Chief of Staff, the Chairs of St. Mary's General Hospital and Grand River Hospital will confer to establish a joint Evaluation Committee to conduct an annual evaluation of the the Joint Chief of Staff's performance over the previous year.

The evaluation will review the extent to which the Joint Chief of Staff has met the pre-approved goals and objectives for the previous year and will address other issues, concerns, successes, and development opportunities that the Joint Chief of Staff or Committee members wish to raise; the evaluation will also review and endorse the goals and objectives of the Joint Chief of Staff for the forthcoming year and review the compensation levels for the position.

The joint Evaluation Committee will be chaired by the Chairperson of St. Mary's General Hospital or Grand River Hospital board (responsibility rotates each year) and will consist of the Chairs, Vice Chairs, and Presidents of both hospitals who shall serve in that capacity for annual evaluations in accordance with the principles established in the "Common Chief of Staff Performance Appraisal".

The Chair of each Hospital will advise the Board of Trustees, in camera and as a matter of information, concerning the results of the Chief of Staff Evaluation Committee's deliberations providing as much detail as the Chair of the Board thinks both necessary and appropriate. Members of the Board

may request any additional information they deem necessary for a full appreciation of the results of the committee's deliberations.

APPROVAL:	Governance Committee - March 2006 Board of Trustees - March 2006
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEWED:	Mission and Governance Committee – November 2013 Board of Trustees – November 2013
REVISED:	Mission and Governance Committee – March 2016; January 2019 Board of Trustees – November 2016; January 2019

POLICY ORIGIN: Board of Trustees POLICY NO: 010-202

SECTION TITLE: Human Resources

TOPIC: Executive Compensation

POLICY STATEMENT

1.0 INTRODUCTION

Bill 46 – *Excellent Care for All Act* (ECFAA) was passed on June 3, 2010 in Ontario and contains a number of provisions, one of which is a performance based compensation requirement for executives. This document intends to provide a plan to meet the requirements for performance related pay.

The Act requires the compensation of CEOs and other executives to be linked to the achievement of performance improvement targets laid out in the Quality Improvement Plan (QIP) every fiscal year. In the case of St. Mary's General Hospital (SMGH) where the existing compensation plan does not provide for a bonus based on performance, the compensation plan is to be modified to ensure that a portion of the existing compensation is linked to the achievement of the Quality Improvement targets laid out in the QIP.

The Act does not specify what portion of executives' salaries must be tied to QIP. The focus is on accountability rather than any specific change to the overall level of compensation.

Due to provincial legislation (Bill 55), executive compensation has been frozen since 2010. This legislation superseded ECFAA. Therefore, the executive compensation that is linked to the QIP is a claw back or "Pay at Risk" rather than a bonus structure.

Effective, September 6, 2016 additional changes to Executive Compensation were announced, resulting in salary and performance-related pay caps. Once the Ministry of Health and Long-Term Care approve St. Mary's "Executive Compensation Framework" submission, actual compensation adjustments will be governed by a new "salary and performance-related pay envelope". The pay envelope is composed of the actual amount of salary and performance-related pay that was paid to the entire group of designated Executives (defined in Section 1.1) at the organization in the previous year. An approved maximum rate of increase will be applied to the salary and performance-related pay envelope in a given year with the resulting dollar figure representing the additional compensation "budget" that can be

distributed "in amounts determined at the discretion of the designated employer" provided it does not exceed the applicable pay cap for a role or a class of positions.

Other elements of compensation may be provided to designated executives in the same manner and relative amount as what is generally provided to non-executive managers. For any element of compensation provided only to executives, the executive compensation program must include a job requirement or business need rationale, with the submission of the Executive Framework.

An annual Executive Compensation compliance submission is required, by May 1st each year.

1.1 Who Does the Legislation Apply to?

- The President and anyone who holds an equivalent position, regardless of title,
- Members of senior executive management
- The Chief of Staff.

Therefore it does not apply to:

- Trade unions,
- Employees that report to the President that are not in senior management,
- Employees or physicians that report to the Chief of Staff,
- Consultants or others that may be providing senior management services that are not employees or deemed employees,

1.2 How is Compensation Defined?

ECFAA defines "compensation" as any form of payment, benefits, and perquisites paid or provided, including discretionary payments.

1.3 What is the Quality Improvement Plan (QIP)?

Health care organizations are to develop an annual Quality Improvement Plan for the next fiscal year and make that plan available to the public. In developing the annual Quality Improvement Plan, regard is to be had to:

- Results of annual patient and caregiver satisfaction and employee and service provider satisfaction surveys,
- Data relating to patient relations processes,
- In the case of a public hospital, its aggregate critical incident data compiled based on disclosures of critical incidents pursuant to

regulations under the *Public Hospitals Act* and information concerning indicators of quality of health care provided by the Hospital disclosed pursuant to regulations under the *Public Hospitals Act*.

- Additional factors as may be provided for by regulation.

The annual QIP is to contain annual performance improvement targets and a justification for those targets and information concerning the manner and the extent to which executive compensation is linked to achievement of those targets.

The Local Health Integration Network (LHIN) *may* request a draft of the annual QIP before it is made available to the public. Every health care organization shall provide a copy of its annual QIP to the Health Quality Ontario (HQO) in a format established by the HQO to allow for province-wide comparisons.

2.0 EVALUATION/COMPENSATION INTEGRATION

If there is no current performance based pay (PBP), a Hospital must create one. For example, 5% removed from base salary and considered "pay at risk" or performance based pay (PBP).

The Board has the discretion to set performance targets and determine how the designated Executives will be evaluated and earn their "performance based pay at risk", which is outlined in the Quality Improvement Plan. In using its discretion, the Board may:

ii) Focus only on QIP indicators for PBP and leave other areas of performance required for "evaluation and feedback" only
iii) President/Board work to identify those metrics most influenced by different senior team members and weigh accordingly – or team has a common plan with common weightings leading to a similar outcome
iv) Evaluate and may add to the PBP program based on feedback and outcomes expected, annually.

APPROVAL:	Board of Trustees, March 2013
DISTRIBUTION:	Master Manual, Board of Trustees
REVIEWED:	
REVISED:	Audit Committee – April 2015 Mission and Governance Committee – May 2015; March 2016; January 2019 Board of Trustees – May 2015; November 2016; January 2019

ST. MARY'S GENERAL HOSPITAL
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-203

SECTION TITLE: Human Resources

TOPIC: Executive Succession Planning

POLICY STATEMENT

The departure of one or more members of the senior team from the hospital represents a significant business risk. To mitigate this risk the Board of Trustees require that the President maintain a written succession plan that contains the following:

- An interim action plan for use by the President given the unexpected loss of a member of the senior (executive) team and
- A recommended action plan for use by the Board in the event of the loss of the President in cooperation with the St. Joseph's policy for system executive succession planning. This is to include appointment of an acting President and reassignment of duties within the senior team.
- Assessment of the availability of permanent internal replacements for members of the senior team and development plans for these successors.
- A proposed action plan for consideration by the Board should it be required to initiate President recruitment.

The succession plan will be presented and held by the President with access to the Chair of the Board.

APPROVAL: Audit Committee – April 2015
Board of Trustees – May 2015

DISTRIBUTION: Master Manual, Board of Trustees

REVIEWED:

REVISED: Mission and Governance Committee – May 2015; March 2016; January 2019
Board of Trustees – May 2015; November 2016; January 2019

ST. MARY'S GENERAL HOSPITAL
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-204

SECTION TITLE: Human Resources

TOPIC: Nepotism

POLICY STATEMENT

Purpose

Decisions about hiring, promoting, evaluating or terminating employees should be based on qualifications, ability and performance. Accordingly, relatives/family members of any staff member of SMGH should be given the same opportunity for employment with the Hospital as the general public. However, every attempt should be made to avoid favouritism or potential conflicts of interest.

Policy

The Hospital may hire and subsequently transfer and/or promote relatives/family members of all staff provided they are separated by at least two (2) levels of management thereby avoiding a direct or indirect supervisory relationship.

For the purpose of this policy, relative/family member shall refer to spouse including common-law spouse, children or step children, parents or step-parents, siblings or step-siblings, grandparents and grandchildren.

Procedure

Hospital recruitment policies for posting and/or advertising position vacancies will be followed with the following additions:followed with the following additions:

- Should a position arise that a relative/family member of the President, Chief of Staff or Senior Team intends to apply for, the Chair of the Board of Directors and the Director of Human Resources shall be advised in writing. During the course of the recruitment process, the Director of Human Resources will manage the process and ensure that the President, Chief of Staff or Senior Team of a relative/family member applying for a position are not involved in any steps of the recruitment process up to and including the hiring decision.

- Should a staff member including the President, Chief of Staff or Senior Team be aware that a relative/family member is applying for a position, the Director of Human Resources will be notified.
- During the course of the recruitment process, the Director of Human Resources will take all measures to ensure that no staff member of a relative/family member applying for a position are involved in any steps of the recruitment process up to and including the hiring decision.
- Upon hiring by the Hospital, the relative/family member will receive, in writing, a document stating the Hospital's expectations regarding real or perceived conflict of interest and as such will be a condition of employment documented in employment contracts or letters of employment.
- Should a relative/family member subsequently be hired by the Hospital, no staff member including the President , Chief of Staff or Senior Team will be involved in any performance management matters that they might otherwise have been consulted on and all such matters will be referred to the Director of Human Resources.

APPROVAL:	Audit Committee – April 2015 Board of Trustees – May 2015
DISTRIBUTION:	Master Manual, Board of Trustees
REVIEWED:	
REVISED:	Mission and Governance Committee – March 2016; January 2019 Board of Trustees – November 2016; January 2019

ST. MARY'S GENERAL HOSPITAL
(the 'Hospital')
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-400

SECTION TITLE: Customer Relations

TOPIC: Open, Closed and In-Camera Meetings of the Board and Board Committees

1.0 PURPOSE

1.1 The Board of Trustees (the 'Board') conducts its meetings in open, closed and in-camera sessions. The public and staff are welcome to observe the open session of a meeting to:

- Facilitate the conduct of the Board's business in an open and transparent manner;
- Ensure the Board maintains a close relationship with the public, i.e., the community, media and stakeholder groups;
- Generate trust, openness and accountability.

Open meetings also provide a forum for members of the public to address the Board concerning matters relevant to the organization.

2.0 POLICY STATEMENT

Members of the public are invited to attend the meetings of the Board in accordance with the following policy:

2.1 Notice of meeting

2.1.1 A schedule of the date, location and time of the Board's regular meetings will be available from the Board Secretary's office and will be posted on the Board's website. Changes in the schedule will be posted on the website.

2.2 Agendas, minutes and Board material

2.2.1 The Board's open meeting agenda may be obtained from the Board Secretary or delegate prior to the meeting and will be posted on the Hospital's website. Supporting materials will be distributed only to the Board.

2.2.2 Where a closed session of a Board meeting is required, a separate agenda from the open agenda shall be prepared, indicating the items to be dealt with during the closed session, and the agenda and any material in support of the agenda items

will be distributed only to the Board.

2.2.3 Definitions

- Open – is defined as the portion of the meeting and information that is open to pubic/media;
- Closed – is defined as the portion of the meeting that is confidential to members of the Board and designated resource staff.
- In-camera – is defined as the portion of the meeting which includes Board members only and all resource staff and designated ex-officio Board members will be excused, unless requested by the Chair to remain.

2.3 Attendance

2.3.1 Individuals wishing to attend shall provide at least 24 hours' notice to the Board Secretary or delegate. The Board may limit the number of attendees if space is insufficient.

2.4 Conduct during the Meeting

2.4.1 Members of the public and/or delegation may be asked to identify themselves. Recording devices, videotaping and photography are prohibited. The Chair may require anyone who displays disruptive conduct to leave.

2.5 Guidelines for Delegation Wishing to Address the Board

2.5.1 Delegation wishing to address the Board concerning matters relevant to the organization must do so according to: Policy 010-401 Delegation to the Board of Trustees. A copy of the Policy 010-401 may be requested from the Secretary to the Board (President)

2.6 Closed Session

2.6.1 The Board may move to closed session or hold special meetings that are not open to the public where it determines it is in the best interest of the Board to do so. The Chair may order the meeting to move to a closed session at any time at the Chair's discretion or any Trustee may request a matter be dealt with in closed session in which case a vote will be taken and if a majority of the Board agrees, the matter shall be dealt with in closed session.

2.6.2 Minutes of the closed session of the Board meeting shall be

recorded. The minutes of the closed session of a Board meeting shall be handled and secured in a manner which respects the nature of the material. Minutes of a closed session of a Board meeting shall be presented for approval at a closed session of a subsequent Board meeting.

2.6.3 The following matters shall be dealt with in closed session:

(a) the assessment, rewarding and disciplining of individuals;
(b) discussions and dealing with other entities or persons where the information being discussed may compromise the relationship of the Board with them or its relationship with its stakeholders;
(c) discussions on governance matters including by-laws, nominating reports, audit reports, etc.;
(d) labour relations or human resources issues;
(e) financial, personnel, contractual (including Accountability Agreements) and any other matters for which a decision must be made in which premature disclosure would be prejudicial;
(f) discussions regarding property matters;
(g) discussions that may prejudice a person or entity involved in a criminal proceeding or a civil suit proceeding, including matters before administrative tribunals;
(h) instructions given to, or opinions received from a solicitor(s) or consultants(s);
(i) personal health information related to an individual;
(j) discussions to ensure the development of plans to deal with emergency situations, failure to provide services and the disclosure of critical incidents;
(k) discussions related to appointment and determination of privileges for professional staff;
(l) deliberations that may be necessary to decide whether the matter warrants being dealt with in a closed session of the Board;
(m) other matters the Board deems appropriate.

2.6.4 All matters before a closed session of the Board are confidential until such time that any of the matters may be moved by the Board to the open session of the Board. To that end, the Board shall pass a resolution with respect to those items that are to be moved from a closed session of the Board to an open session of the Board.

2.6.5 During the closed session of the Board, all persons who are not members of the Board of Trustees shall be excluded, save and except members of the senior management team and the recording secretary, unless specifically asked to be excused. The Board may approve by resolution of the Board that individuals such as legal counsel, consultants, presenters, and hospital staff may be permitted to attend the meeting, but be asked to leave before a vote is taken.

2.7 Requests for Interviews

2.7.1 Members of the public and/or delegations may not address the Board or ask questions of the Board without the permission of the Chair.

2.8 In-Camera Sessions

2.8.1 In-camera sessions will take place following every Board meeting.

2.9 Minutes

2.9.1 Minutes of the open and closed sessions are producible under the Freedom of Information and Protection of Personal Privacy Act (FIPPA) with the following exceptions:

- Personal health information (under the *Personal Health Information Protection Act*)
- Quality of care information (under the *Quality of Care Information Protection Act*)
- Ecclesiastical records of an affiliated church or religious organization
- Records re: operations of the Foundation
- Administrative records of regulated health professionals, re: personal practice
- Records re: charitable donations made to the Hospital
- Records re: provision of abortion services
- Records re: certain labour relations, employment matters
- Records re: certain appointment, privileging matters
- Certain records respecting or associated with research (including clinical trials)
- Records containing third-party information

2.10 Meetings of Board Committee

Meetings of Board committees are not open to the public.

Contact Information:

Secretary to the Board of Trustees

ST. MARY'S GENERAL HOSPITAL
(the 'Hospital')
Kitchener, Ontario

St. Mary's General Hospital
911 Queen's Blvd.
Kitchener ON N2M 1B2
519-749-6544

APPROVAL:	Customer Relations Committee, 1988 Board of Trustees - 1988
DISTRIBUTION:	Master Manuals, Board of Trustees
REVIEW:	Customer Relations - June 1997 MEQC - May 2003 Mission and Governance - November 2013 Board of Trustees - May 2003; November 2013
REVISED:	Governance Committee - October 2004, September 2006 Mission and Governance Committee - March 2017; January 2019 Board of Trustees - November 2004, September 2006; April 2017; January 2019

ST. MARY'S GENERAL HOSPITAL
(the 'Hospital')
Kitchener, Ontario

POLICY ORIGIN: Board of Trustees POLICY NO: 010-401

SECTION TITLE: Customer Relations

TOPIC: Delegation to the Board of Trustees

POLICY STATEMENT

A Delegation (one or more individuals or an organization)who wish to address the Board of Trustees (the "Board") of the Hospital are able to do so in an open or closed session, depending on which is appropriate, provided they follow the guidelines outlined below.

GUIDELINES FOR PROSPECTIVE DELEGATION

A Delegation will be invited to make a presentation to the Board about governance and policy matters in relation to hospital mission, vision, values and strategic/directional plan. To protect confidentiality, presentations and questions about an individual's care will not be permitted.

A written request from a prospective delegation must be presented to the Secretary to the Board (President) at least ten (10) calendar days prior to the date of the meeting of the Board at which the prospective delegation wishes to make a presentation.

The written request must include:

1. The name of the individual(s) or organization seeking status as a delegation;
2. The name of the spokeperson proposed to speak on behalf of the delegation;
3. A detailed statement concerning the matter the delegation wishes to address and which:
    - must constitute the basis of the presentation, and
    - must include a detailed report on the executive team member(s) of the Hospital whom the proposed delegation has approached in advance of the current request to meet with the Board;
4. Any relevant supporting documentation.

DELEGATION APPROVAL PROCESS

The Chair of the Board will review the request and respond to it on behalf of the Board.

The Chair of the Board reserves the right to schedule presentations by a proposed delegation or, conversely, to refuse any request that a delegation appear before the Board. The Board Chair is not obligated to grant a request to address the Board, and the Board is not obligated to take any action on the presentation it receives.

The Chair's decision in this respect shall be taken in consultation with the Executive Committee of the Board; in all such cases, the Board shall be fully apprised both of the decisions taken and of the reasoning behind such decisions and with respect to decisions to refuse it is the prerogative of the Board either to affirm the consultative decision or to request a reconsideration.

With respect to all references to the Chair herein, it is understood that if the Chair is absent or has declared a conflict of interest, the Vice-Chair shall assume the role of the Chair, or in the absence of the Vice-Chair the role of the Chair shall be assumed by a member of the Board of Trustees determined by selection among the members of the Board.

The appropriate venue at which a delegation may address the Board of Trustees will be consistent with the Hospital's policy on "Open/Closed/In-Camera Sessions of the Board" (Policy 010-400).

GUIDELINES FOR APPROVED DELEGATION

Seven days prior to the scheduled Board Meeting, a delegation must submit 25 copies of the written material or an electronic copy to the Secretary the Board (President) for distribution to each member of the Board.

The Delegation will specify the spokesperson who will address the Board on behalf of the larger group and only that delegate will have the privilege of addressing the Board.

Subsequent to the delegation's presentation, the Chair will invite questions from members of the Board, but such questions will address points of clarification only.

Delegations invited to attend a closed or in-camera session may be in attendance only for their presentation.

Any individual whose presence is judged by the Chair to be a disruptive influence will be required to leave the meeting, at the discretion of the Chair.

The Board of Trustees may choose to act upon issues raised by such delegations at a time and in a manner that the Board deems to be appropriate.

APPROVAL:	Governance Committee – October 2004 Board of Trustees - November 2004
DISTRIBUTION:	Master Manuals, Board of Trustees
REVISED:	Governance Committee - January 2006 Mission and Governance Committee – March 2017; January 2019 Board of Trustees – April 2017; January 2019
REVIEWED:	Mission and Governance Committee – November 2013 Board of Trustees – November 2013