BLUEWATER HEALTH

BOARD POLICY MANUAL

No.	Policy Name	Responsible Committee	Review/ Approval Date
A.	**Establish Strategic Direction**		
1.	Purpose Statement and Values	Governance and Nominating	September 2023
2.	Strategic Planning	Governance and Nominating	September 2023
3.	Performance Monitoring	Governance and Nominating	September 2023
B.	**Provide for Excellent Management**		
1.	Chief Executive Officer and Chief of Staff Selection and Succession Planning	Governance and Nominating	September 2023
2.	Chief Executive Officer Direction & Delegation of Authority	Governance and Nominating	September 2023
3.	Chief Executive Officer and Chief of Staff Performance Management and Evaluation	Governance and Nominating	September 2023
4	Chief Executive Officer and Chief of Staff Compensation	Governance and Nominating	September 2023
5	Chief of Staff Direction & Delegation of Authority	Governance and Nominating	September 2023
C.	**Ensure Program Quality and Effectiveness**		
1.	Quality	Quality	November 2022
2.	Risk Management	Quality	November 2022
3.	Research Projects	Quality	November 2022
4.	Ethics	Quality	November 2022
5.	Patient and Family Complaints and Concerns	Quality	November 2022
6.	Freedom of Information Delegation of Authority and Oversight	Quality	November 2022

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No.	Policy Name	Responsible Committee	Review/ Approval Date
7.	Whistleblower	Resource Utilization & Audit	November 2022
8.	Occupational Health and Safety Accountability Framework	Resource Utilization & Audit	November 2022
9	Environmental Stewardship	Resource Utilization & Audit	November 2022
D.	**Ensure Financial Viability**		
1.	Resource Planning	Resource Utilization & Audit	November 2022
2.	Financial Condition	Resource Utilization & Audit	November 2022
3.	Asset Protection	Resource Utilization & Audit	November 2022
4.	Investments	Resource Utilization & Audit	November 2022
5.	Procurement and Spending Authority	Resource Utilization & Audit	November 2022
6.	Expense Reimbursement	Resource Utilization & Audit	November 2022
7.	Perquisites	Resource Utilization & Audit	November 2022
8.	Hospital Borrowing	Resource Utilization & Audit	November 2022
9.	Naming of Assets	Resource Utilization & Audit	November 2022
E.	**Ensure Board Effectiveness**		
1.	By-Laws and Board Policies	Governance and Nominating	September 2023
2.	Principles of Governance and Board Accountability	Governance and Nominating	September 2023
3.	Roles and Responsibilities of the Board of Directors	Governance and Nominating	September 2023
4.	Roles and Responsibilities as an Elected and Ex-Officio Director	Governance and Nominating	September 2023
5.	Non-Director Committee Member	Governance and Nominating	September 2023
6.	Annual Declaration of Consent	Governance and Nominating	September 2023

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No.	Policy Name	Responsible Committee	Review/ Approval Date
7.	Code of Conduct	Governance and Nominating	September 2023
8.	Nominations Process	Governance and Nominating	September 2023
9.	Board Orientation and Ongoing Development	Governance and Nominating	September 2023
10. i	Board Standing and Ad Hoc Committees Terms of Reference	Governance and Nominating	September 2023
10. ii	Board Standing and Ad Hoc Committees Terms of Reference	Executive Governance and Nominating	September 2023
10. iii	Board Standing and Ad Hoc Committees Terms of Reference	Joint Conference Governance and Nominating	September 2023
10. iv	Board Standing and Ad Hoc Committees Terms of Reference	Quality	November 2022
10. v	Board Standing and Ad Hoc Committees Terms of Reference	Resource Utilization & Audit	November 2022
11.	Board Chair Position Description	Governance and Nominating	September 2023
12.	Board Vice-Chair Position Description	Governance and Nominating	September 2023
13.	Board Treasurer Position Description	Governance and Nominating	September 2023
14.	Board Committee Chair Position Description	Governance and Nominating	September 2023
15.	Board Work Plan and Priorities	Governance and Nominating	September 2023
16.	Board and Committee Meetings	Governance and Nominating	September 2023
17.	Meetings without Management	Governance and Nominating	September 2023
18.	Director and Non-Director Committee Member Expense Reimbursement	Governance and Nominating	September 2023
19.	Board Evaluation	Governance and Nominating	September 2023
20.	Removal of a Director/Non-Director Committee Member	Governance and Nominating	September 2023

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BLUEWATER HEALTH

BOARD POLICY MANUAL

No.	Policy Name	Responsible Committee	Review/ Approval Date
21.	Conflict of Interest	Governance and Nominating	September 2023
22.	Diversity and Inclusion	Governance and Nomination	September 2023
F.	**Foster Relationships**		
1.	Community Engagement & Communications	Governance and Nominating	November 2022
2.	Service Integration Planning	Governance and Nominating	September 2023
3.	Community Advisory Panels	Governance and Nominating	November 2022
4.	Support and Relationships with Foundations	Governance and Nominating	September 2023
5.	Political Activity	Governance and Nominating	September 2023

PURPOSE STATEMENT AND VALUES: A-1

BOARD RESPONSIBILITY:	Establish Strategic Direction
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2003
REVIEWED/REVISED DATE:	September 2023 – Version 7

Purpose

As part of its responsibility for establishing strategic direction, the Board of Bluewater Health (BWH) will establish, approve and periodically review the hospital's Purpose Statement and Values and will ensure that Board decisions are consistent with these. This policy sets out the Purpose Statement and Values of BWH as developed and approved during the 2021-2026 strategic planning process.

Policy

The Board hereby adopts the following Purpose Statement and Values for BWH:

Purpose Statement: Health through Partnership
Caring with Kindness

Values: Excellence - Innovation – Compassion – Teamwork – Inclusivity

1. Each person who works, learns, or volunteers at BWH is responsible for living the Purpose Statement and Values of the Hospital.

2. The Hospital's Purpose Statement and Values are shared with all who seek care or visit our sites and the public as appropriate. This occurs regularly in a variety of ways, including but not limited to:

    a) Posted on the Hospital's website and corporate publications, including for example the strategic plan, patient materials, and recruitment materials.
    b) Through discussion and inclusion in orientation for all new employees, volunteers, and Board members.
    c) Through visible display in the organization (e.g. on posters, as signage, and through visible symbols.
    d) Through philosophy, Purpose Statement and Values-focused activities on each site.
    e) Through regular discussion and reflection by leaders at committees and hospital events.

Monitoring

The Board will generally monitor and evaluate the hospital's implementation of the Purpose Statement and Values through the strategic plan monitoring process.

Method and Frequency:

1. Strategic Plan implementation monitoring (through indicator reports and annually through report from CEO)
2. Strategic Plan review (every 3-5 years)

The Board will monitor and evaluate this policy in accordance with its normal process.

Method and Frequency:

1. Review of policy (annually)
2. Board Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

STRATEGIC PLANNING: A-2

BOARD RESPONSIBILITY:	Establish Strategic Direction
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2014
REVIEWED/REVISED DATE:	September 2023 – Version 5

Purpose

As part of its responsibility for establishing strategic direction, the Board of Bluewater Health (BWH) will establish, approve and periodically review the Hospital's Strategic Plan. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Strategic planning is a systematic process for assessing a changing environment and creating a plan of action that will position the Hospital to be successful in the environment, consistent with its Purpose Statement and Values. The Board, in collaboration with the CEO and Executive Council, is responsible for establishing the Hospital's strategic priorities. The strategic plan will incorporate specific, focused and measurable corporate goals to be pursued over the course of the plan, aligned with the approved strategic priorities.

The Board is responsible for:

- Considering key health care needs and stakeholder groups, and engaging the community of diverse persons and entities when developing plans and setting priorities.
- Establishing, and periodically reviewing BWH's Purpose Statement and Values.
- Contributing to the development of and approving the strategic plan of BWH.
- Ensuring the strategic plan is aligned with the Ministry of Health and Ontario Health's priorities.
- Conducting a review of the strategic plan as part of a regular annual planning cycle.
- Ensuring Board decisions are consistent with BWH's Purpose Statement, Values and strategic plan.
- Ensuring the Hospital's annual operating plan enables the attainment of the strategic priorities and corporate goals.
- Monitoring corporate performance regularly against the strategic plan and performance indicators.

Strategic Planning Process

1. The CEO is responsible to the Board for establishing the strategic planning process for Board approval.

2. The Board will engage with the CEO and Executive Council in the strategic plan development and monitoring. The Governance and Nominating Committee will provide guidance to management and support the Board in the development and periodic monitoring of the strategic plan, consistent with the Board and Committee

work plans.

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

4. The strategic plan will include key strategic priorities which reflect the Board's accountability to the Ministry of Health and Ontario Health.

5. The Hospital's annual operating plan will ensure the advancement of the strategic plan by addressing the approved corporate goals and initiatives.

6. Annually, the Board will identify key priorities in the coming year consistent with the purpose statement, values and the strategic plan.

7. Annually, the Board will review the strategic plan and the progress being made to advance its achievement. As necessary, the Board may request that the strategic plan be revised or updated to ensure it continues to support the achievement of the Hospital's Purpose Statement and Values.

8. Regular indicator monitoring and progress reports to assess strategic plan implementation and corporate performance will be provided to the Board.

Monitoring

Method and Frequency:

1. Review of policy (annually)
2. Review of indicator monitoring reports
3. Review of annual Strategic Plan Report implementation/achievement
4. Strategic Plan review (every 3-5 years)
5. Board Evaluation
6. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

PERFORMANCE MONITORING: A-3

BOARD RESPONSIBILITY:	Establish Strategic Direction
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	October 2017
REVIEWED/REVISED DATE:	September 2023 – Version 3

Purpose

There are three main roles for the Board with respect to performance monitoring and assessment:

1. Ensuring that management has identified appropriate performance metrics (measures of performance)
2. Monitoring hospital and board performance against Board approved performance targets and performance metrics; and
3. Ensuring that management has plans in place to address variances from performance targets and overseeing implementation of remediation plans.

Policy

The Board will ensure that the Chief Executive Officer (CEO) implements an effective performance management system, based on performance metrics for measuring and continuously improving the hospital's performance. The Board will approve the targets and performance metrics for monitoring organization performance in achieving financial, quality, safety, and human resource targets using best practices and benchmarks.

The CEO will establish an annual schedule of specific performance reports to the Board of Directors and appropriate Board Standing Committees. These performance reports are intended to support the Board in its responsibility to monitor and assess the organization's performance related to the established targets and performance metrics.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Review of indicator monitoring reports
3. Review of strategic plan implementation/achievement (annually)
4. Review of the Quality Improvement Plan (annually)
5. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

CHIEF EXECUTIVE OFFICER & CHIEF OF STAFF SELECTION AND SUCCESSION PLANNING: B-1

BOARD RESPONSIBILITY:	Provide for Excellent Management
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2009
REVIEWED/REVISED DATE:	September 2023– Version 6

Purpose

As part of its responsibility for providing for excellent management, the Board of Bluewater Health (BWH) is responsible for selecting and appointing the Chief Executive Officer (CEO) and Chief of Staff (COS), and providing for succession planning for these positions. This policy sets out the processes to support the Board in fulfilling this responsibility.

Process

The Board shall provide for continuity of leadership for the hospital by having in place a documented process for succession should the CEO or COS position become vacant due to sudden vacancy (e.g. death, resignation, termination, extended leave) or planned vacancy (e.g. retirement). For relatively short durations of absence (e.g. holidays, conferences), the CEO or COS will appoint an Acting CEO or COS and advise the Board Chair.

As part of this process, the CEO and COS are expected to cultivate potential successors through internal succession planning and executive development and to report on this to the Executive Committee during the annual performance evaluation process. This report will include a review of internal candidates who have the potential to assume the CEO or COS position at the hospital and development plans to enhance the capabilities of the internal candidates.

1. Sudden Vacancy (Interim appointment)

- The CEO will designate to the Board Chair in writing at the beginning of each fiscal year which member of the hospital's senior leadership team is recommended to fill the role of interim CEO in the event of sudden or unexpected loss of the CEO. The CEO shall update such designation from time to time as circumstances warrant. The appointment of an interim CEO will be subject to approval by the Board.
- The COS will identify to the Chair and the CEO in writing at the beginning of each fiscal year which member of the Medical Advisory Committee is recommended to fill the role of interim COS in the event of sudden or unexpected loss of the COS. The COS shall update such designation from time to time as circumstances warrant. The appointment of an interim COS will be subject to approval by the Board.

2. Planned Vacancy (Long-term appointment)

- For a CEO search, the Executive Committee shall establish a selection committee consisting of the COS, the President of the Professional Staff Association, three or more elected Directors and such other persons, if any, as it may designate.
- For a COS search, the Board shall establish a selection committee in accordance with the By-laws.
- In either case, the selection committee:
  - will be chaired by the Board Chair or their delegate.
  - will establish and clarify criteria to be used in the selection, oversee the process to obtain and interview candidates and agree on a process by which to make a final recommendation.
  - may, at its discretion, retain a search firm to assist the selection committee in its work.
  - Will conduct interviews and make a recommendation to the Board of a preferred candidate.
- In the event that a new CEO or COS has not been appointed prior to the departure of the incumbent, the Board will make an interim appointment in accordance with section 1 of this policy.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. Confirmation by Chair that the designations for interim appointments have been made as set out in section 1 of this policy (annually)
3. CEO/COS performance evaluation (annually)
4. Board Evaluation
5. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

CHIEF EXECUTIVE OFFICER DIRECTION AND DELEGATION OF AUTHORITY: B-2

BOARD RESPONSIBILITY:	Provide for Excellent Management
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	April 2005
REVIEWED/REVISED DATE:	September 2023 – Version 5

Purpose

As part of its responsibility for providing for excellent management, the Board of Bluewater Health (BWH) selects and appoints the Chief Executive Officer (CEO) and delegates responsibility and authority to the CEO for the management and operation of BWH. This policy sets out key parameters of that authority.

Policy

The CEO is accountable to the Board and the Board's sole official connection to the operations of the organization will be through the CEO.

The Board provides direction to the CEO in accordance with policies established by the Board. The Board hereby delegates to the CEO authority to manage and direct the business and affairs of the hospital, except such matters and duties as must be transacted or performed by the Board as per law or by the provisions of the hospital's By-laws, and further to employ and discharge such agents and employees of BWH as the CEO may from time to time decide.

The CEO is required to follow directions of the Board as received through the Chair. Only decisions of the Board acting as a body are binding on the CEO. When Directors or Committees make requests without Board authorization, such requests can be declined when in the CEO's opinion a material amount of staff time or funds are required to carry out the requests. The CEO may refer the matter, if appropriate, through the Chair to the Board for discussion.

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

Specifically, the CEO shall:

- ensure BWH's operations are conducted and that care to patients is provided in the hospital, in accordance with the hospital's By-laws, policies established by the Board and all applicable legislation.
- ensure BWH's practices, activities and decisions are undertaken prudently, lawfully, and in an equitable and reasonable manner congruent with commonly accepted business practices and professional ethics.
- ensure BWH's assets are protected, adequately maintained and not unnecessarily placed at risk.
- ensure Board-approved priorities are reflected in the allocation of resources.

- ensure that budgeting is based on generally accepted financial planning practices that balance expenditures in any fiscal year against expected revenues.
- promote a healthy work environment for staff and volunteers that is consistent with the hospital's values.
- represent the hospital externally to the community, government and media and other organizations and agencies in ways that enhance the public image and credibility of BWH.
- perform such other duties as outlined in the CEO Position Description.

The CEO shall provide leadership support to the Board in the discharge of its responsibilities and ensure that the Board is informed and supported in its work.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. CEO Performance Evaluation (annually)
3. Board Evaluation
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

CHIEF EXECUTIVE OFFICER AND CHIEF OF STAFF PERFORMANCE MANAGEMENT AND EVALUATION: B-3

BOARD RESPONSIBILITY:	Provide for Excellent Management
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	April 2005
REVIEWED/REVISED DATE:	September 2023– Version 5

Purpose

As part of its responsibility for providing for excellent management, the Board of Bluewater Health (BWH) is responsible for establishing measurable annual performance expectations in collaboration with the Chief Executive Officer (CEO) and the Chief of Staff (COS) and evaluating the performance of the CEO and COS annually. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Performance evaluation of the CEO and COS is the process of reviewing and evaluating performance based on progress towards achieving mutually agreed upon goals and objectives. It provides an opportunity to recognize the CEO's and COS's level of performance, to collaboratively develop the priorities for the next year and to plan strategies to support the CEO, COS and the hospital's operations as outlined in its operational plan. It also provides an opportunity for the Board to discuss expectations with the CEO and COS and address core competencies and personal development goals.

The Board will annually evaluate the performance of the CEO and COS and delegates responsibility to the Executive Committee to oversee the performance evaluation process and report the results to the Board.

In the case of a new CEO or COS, an interim performance evaluation will be completed after 6 months, unless determined otherwise by the Board.

Process

Chief Executive Officer - Self-Evaluation

Annually, the CEO will submit a written self-evaluation to the Executive Committee, assessing performance with respect to the following:

1. The organization's performance with respect to achievement of the Strategic Plan.

2. Personal performance with respect to achievement of goals/objectives.

3. Personal accomplishment of the skills and competencies as outlined in the current position description.

The self-evaluation will include relevant supporting information such as:

- Results of patient and employee surveys
- Accreditation reports
- Reports to the Board
- Reports to/from external bodies
- Financial reports
- Quality reports

Chief of Staff - Self-Evaluation

Annually, the COS will submit a written self-evaluation to the Executive Committee, assessing performance with respect to the following:

1. Professional Staff Organization's performance with respect to the achievement of the Strategic Plan.

2. Professional Staff Organization's performance with respect to operation within the boundaries established in the By-laws and Board policies.

3. Personal performance with respect to achievement of goals/objectives.

4. Personal accomplishment of the skills and competencies as outlined in the current position description.

The self-evaluation will include relevant supporting information such as:

- Results of Professional Staff surveys
- Professional Staff Resource Plan
- Reports to the Board
- Reports to/from external bodies
- Utilization reports
- Quality reports

360 Feedback Assessment Survey

The Executive Committee will seek feedback from key internal and external assessors through the use of a survey instrument. The survey will seek the opinion of individuals concerning the competencies demonstrated by the CEO and the COS during the review period. The following individuals will be requested to complete the survey:

- Board members
- Direct reports
- Key external work colleagues, as agreed upon between the CEO/COS and the Executive Committee.

The Director of Human Resources will be appointed to coordinate the survey. All surveys will be returned confidentially to the Director of Human Resources who will collate the information and prepare a summary for the Executive Committee.

Reporting

The Executive Committee will prepare a draft report of the results of the performance evaluation.

The Executive Committee will meet separately with the CEO and the COS to review the draft report. Based on the outcome of the meetings, the Executive Committee will prepare a final report for presentation to an *in camera* meeting of the Board.

The CEO and the COS will have an opportunity to provide comments on their own final report and shall then sign the report. A copy will be placed in their respective confidential personnel files.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. Completion of CEO and COS Performance Evaluation (annually)
3. Board Evaluation
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

CHIEF EXECUTIVE OFFICER AND CHIEF OF STAFF COMPENSATION: B-4

BOARD RESPONSIBILITY:	Provide for Excellent Management
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2014
REVIEWED/REVISED DATE:	September 2023– Version 3

Purpose

As part of its responsibility for providing for excellent management, the Board is responsible for establishing an appropriate and competitive compensation package for the positions of the Chief Executive Officer (CEO) and the Chief of Staff (COS). This policy sets out the process to support the Board in fulfilling this responsibility.

Policy

The Board will establish an appropriate and competitive compensation package for the position of the CEO and the COS in order to:

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

The compensation packages provided to the CEO and the COS will be set out in properly prepared Board-approved employment contracts between the hospital, and the CEO and the COS.

The total compensation packages will be aligned with applicable legislation pertaining to executive compensation. The total compensation package for the CEO and the COS will include the sum of base salary, vacation, incentive compensation, benefits, and perquisites allowable according to Broader Public Sector directives and guidelines. In keeping with applicable legislation, CEO and COS compensation will be linked to achieving performance improvement targets set out in the annual Quality Improvement Plan.

The Executive Committee of the Board will annually review the CEO and the COS compensation for possible adjustments, subject to the CEO and the COS meeting performance expectations as determined through the performance evaluation process, and within the limits of the overall salary budget set by the Board, and in keeping with all applicable legislation. The Executive Committee of the Board will bring forward a recommendation to the Board for consideration of any compensation changes for the CEO or COS.

Monitoring

Method and Frequency:

1. Review of CEO and COS compensation packages (annually)
2. Board Evaluation
3. Review of the policy (annually)
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

CHIEF OF STAFF DIRECTION AND DELEGATION OF AUTHORITY: B-5

BOARD RESPONSIBILITY:	Provide for Excellent Management
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	June 2009
REVIEWED/REVISED DATE:	September 2023 – Version 4

Purpose

As part of its responsibility for providing for excellent management, the Board of Bluewater Health (BWH) selects and appoints the Chief of Staff (COS) and delegates responsibility and authority to the COS for (a) the supervision of the practice of medicine, dentistry, midwifery and privileged extended class nursing at BWH, and (b) through and with the Chief Executive Officer (CEO), for the appropriate resource utilization of the clinical programs. This policy sets out key parameters of that authority.

Policy

The COS is accountable to the Board. The Board provides direction to the COS in accordance with policies established by the Board. The Board hereby delegates to the COS authority:

(a) to supervise the practice of medicine, dentistry, midwifery and privileged extended class nursing at BWH; and

(b) along with the CEO, to ensure appropriate resource utilization within the clinical programs,

except for such matters and duties as must be transacted or performed by the Board by law or by the provisions of the Hospital's by-laws.

Specifically, the COS shall:

- organize the Professional Staff to ensure that the medical, dental, midwifery and privileged extended class nursing care given to all patients of the hospital is in accordance with policies established by the Board and report to the Board with respect to the quality of such care.
- ensure that methodologies are in place to regularly evaluate the quality of care at the hospital and, in collaboration with hospital management, ensure that, all hospital services are regularly evaluated in relation to generally accepted standards.
- ensure that a clear and accessible process for registering and resolving patient/family complaints or concerns is provided, in collaboration with hospital management.
- work with the Medical Advisory Committee to plan the clinical human resource needs of the hospital in accordance with the hospital's strategic plan, and consult with the CEO to develop a Clinical Human Resources Plan for the hospital.
- supervise the professional care provided in the hospital by all members of the Professional Staff.
- be responsible to the Board, through and with the CEO, for the appropriate utilization of resources by all clinical programs.

- ensure that fair and effective credentialing processes for the Professional Staff are in place and regularly reviewed by the Board.
- report regularly to the Board on the activities, recommendations and actions of the Medical Advisory Committee and any other matters about which the Board should be aware.
- perform such other duties as outlined in the COS Position Description.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. COS Performance Evaluation (annually)
3. Board Evaluation
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

QUALITY: C-1

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Quality
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2006
REVIEWED/REVISED DATE:	November 2022 – Version 7

Purpose

As part of its responsibility for ensuring program quality and effectiveness, the Board recognizes the importance of monitoring, trending, reporting, evaluating, and continuously improving the quality and safety of patient care and services. The Board is committed to addressing quality issues and acting upon opportunities for improvement. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board will:

- ensure that the Hospital establishes adequate systems to identify and manage quality and patient safety issues
- ensure that the Hospital fosters a quality improvement and patient safety culture
- establish a Quality Committee whose mandate includes monitoring the delivery of health care and services at Bluewater Health and ensuring that quality improvement is an integral component of the hospital's governance and management processes
- determine key indicators of quality, goals and appropriate benchmarks to evaluate and trend the Hospital's performance

The Board delegates responsibility and authority to the Chief Executive Officer and the Chief of Staff to develop, implement, monitor, and evaluate a quality improvement plan and program consistent with the strategic plan goals and objectives which shall include a quality indicator dashboard, annual quality reports, quality and utilization committees (Quality Interprofessional Practice Patient Experience Committee, Medical Quality Committee, Performance and Utilization Committee), and quality performance support structures consistent with this policy.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. Review of the quality improvement program and its outcomes (quarterly)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

RISK MANAGEMENT: C-2

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Quality
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2006
REVIEWED/REVISED DATE:	November 2022 – Version 7

Purpose

As part of its responsibility for ensuring program quality and effectiveness, the Board recognizes the importance of mitigating the potential for risk to patients, visitors, Hospital personnel and to Hospital assets. The Board will provide Integrated Risk governance by ensuring that management has an effective risk management cycle process that is implemented, monitored, reported and regularly evaluated.

The Board delegates responsibility and authority to the Chief Executive Officer to develop, implement, support, and evaluate a risk management program consistent with this policy. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board will ensure that the Hospital has in place an integrated risk management program, which addresses the risks faced by the organization. Such a system for management will include:

1. **Identification of risks**: identify risks through an organization-wide assessment of risks that threaten the hospital's achievement of its objectives.
2. **Assess and quantify risks**: understand the context of identified risks and assess the likelihood of the risk happening and the severity of the risk, if it happens.
3. **Integrate the risks**: aggregate all risks that reflect correlations, and effects on the hospital and express the results in terms of the impact on the hospital's key strategic and operational priorities.
4. **Prioritize risks**: determine the contribution of each risk to the aggregate risk profile identified and then prioritize accordingly for mitigation.
5. **Mitigate/control risks**: employ strategies/actions including decisions to avoid, reduce, eliminate or transfer risk.
6. **Monitor and review**: continually gauge the risk environment and performance of the risk management strategies

The Quality Committee of the Board has the accountability, on behalf of the Board, to ensure that management has an adequate process in place for integrated risk management. The Quality Committee of the Board will ensure that management has processes and tools in place that effectively identify:

- Risks to the organization
- Mechanisms and plans to monitor, prevent and manage such risks

The Quality Committee of the Board has the accountability, on behalf of the Board, to oversee the Bluewater Health integrated risk management program (provide oversight of the process and ensure that the identified risks are being addressed the by appropriate Board committee and management. The Quality Committee of the Board will ensure that there is appropriate progress and completion of plans to mitigate risks identified through the risk management program.

Monitoring/Reporting

Method and Frequency:

1. Review of the policy (annually)
2. Review of the risk management program (annually)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

References

Healthcare Insurance Reciprocal of Canada (HIROC) 2017. IRM (Integrated Risk Management) Policy Template. Spring. Toronto, ON.

Southlake Regional Health Centre. 2015. *Risk Management Policy* (Board of Directors). Newmarket, ON.

Windsor Regional Hospital, *Enterprise Risk Management* Policy. Windsor, ON.

RESEARCH PROJECTS: C-3

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Quality
APPROVED BY:	Board of Directors
ISSUE DATE:	October 2009
REVIEWED/REVISED DATE:	November 2022 – Version 4

Purpose

As part of its responsibility for ensuring program quality and effectiveness, the Board of Bluewater Health (BWH) recognizes that research is an essential component in advancing evidenced based care, but that research is not its core function and that there are special considerations that exist when conducting research in a community hospital setting. The hospital therefore supports research subject to certain considerations.

Policy

1. The Board will ensure that the Hospital has an operational process in place for managing research projects undertaken within the organization.

2. Such process will include provisions to ensure that:

   a) All research carried out at Bluewater Health
   - Is consistent with the hospital's purpose statement and values
   - Does not negatively impact the Hospital's resources
   - Is conducted in a scientifically sound and ethical manner
   - Complies with Accreditation Canada governance standards
   - Complies with the *Personal Health Information Protection Act*

   b) Only a member of the Professional Staff or an employee of Bluewater Health with actual responsibility (principal investigator or site liaison with principal investigator) for a proposed research project is eligible to apply to conduct clinical research within the Hospital.

   c) Unless the Hospital's role is limited to facilitating chart reviews or other passive involvement, all applications for clinical research projects have been:
   - Approved by a Research Ethics review board which is located at a recognized institution of post-secondary education; or
   - Initiated through government agencies such as the Institute for Clinical and Evaluative Sciences, Cancer Care Ontario, Clinical Trials Ontario, or similar entity; or
   - Approved by a Canadian or a reputable international teaching hospital/centre.

   d) All clinical research involving human subjects adheres to the principles of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.

e) All medical research complies with the research ethics guidelines established by the Canadian Medical Association (CMA).

f) A process is in place to evaluate other ethical consideration relevant to the study.

3. The Quality Committee shall monitor the types of research being undertaken within the organization and provide a report back to the Board on an annual basis.

The Board hereby delegates responsibility and authority to the Chief Executive Officer and the Chief of Staff to develop, implement, monitor, and evaluate processes to manage research projects within the organization consistent with this policy.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. Review of report on research projects undertaken within the organization (annually).
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

ETHICS: C-4

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Quality
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2010
REVIEWED/REVISED DATE:	November 2022 – Version 5

Purpose

As part of its responsibility for establishing strategic direction and ensuring program quality and effectiveness, the Board of Directors of Bluewater Health (BWH) recognizes the importance of ensuring that the organization delivers services and makes decisions consistent with its values and code of ethics. This policy sets out the process to support the Board in fulfilling this responsibility.

Policy

The Board of BWH expects all employees, Professional Staff and volunteers to perform their duties with integrity, honesty, fairness, and diligence; and to be guided by ethical considerations when acting and making decisions in the course of performing those duties.

The sources of these ethical considerations include, but are not limited to:

- The Hospital's Purpose Statement and Values
- Applicable legislation, regulations and professional codes
- Hospital policies
- Accreditation Canada standards
- BWH Ethical Framework

The Board hereby delegates responsibility and authority to the Chief Executive Officer (CEO) and the Chief of Staff to develop and implement a comprehensive ethics framework to guide ethical behavior throughout BWH, consistent with the above policy statement. The CEO is also responsible for working with the Board of Directors to ensure the ethical framework/principle based decision making approach is applied in board decision making processes.

Monitoring

Method and Frequency:

1. Review of policy (annually)
2. Board Evaluation
3. Report to the Quality Committee on Ethics Framework implementation (annually)
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

Reference: BWH Ethical Framework Pocket Tool

PATIENT AND FAMILY COMPLAINTS AND CONCERNS: C-5

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Quality
APPROVED BY:	Board of Directors
ISSUE DATE:	September 2009
REVIEWED/REVISED DATE:	November 2022 – Version 6

Purpose

As part of its responsibility for ensuring program quality and effectiveness, the Board is committed to ensuring hospital staff address patient and family complaints and concerns and act upon opportunities to improve patient care, processes and service delivery.

Policy

1. The Board will ensure that the Hospital has a process in place for managing patient and family complaints and concerns that is consistent with *Excellent Care for All Act* (ECFAA) legislation and supports Bluewater Health's commitment to a philosophy of patient and family-centred care, including our culture of kindness

2. To optimize the usefulness of feedback provided to Board members, members will refer such feedback to the Manager, Patient Experience.

3. The process will include:
   - Monitoring patient experience ratings
   - Tracking and monitoring response and resolution times related to complaints
   - Tracking and monitoring overall complaint rate, complaints per visit, and complaints by category.

4. The Quality Committee will monitor trends in patient and family complaints and will provide a report back to the Board on at least an annual basis.

The Board delegates responsibility and authority to the Chief Executive Officer and the Chief of Staff to develop, implement, monitor, and evaluate a complaints and concerns response program consistent with this policy.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Review of the complaints and concerns monitoring reports (at least quarterly)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

FREEDOM OF INFORMATION – DELEGATION OF AUTHORITY & OVERSIGHT: C-6

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Quality
APPROVED BY:	Board of Directors
ISSUE DATE:	November 2011
REVIEWED/REVISED DATE:	November 2022 – Version 5

Purpose

As part of its responsibility for fostering relationships and pursuant to the requirements of the *Freedom of Information and Protection of Privacy Act* ("FIPPA"), the Board of Bluewater Health is responsible for ensuring that the Hospital's policies and processes comply with FIPPA. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board hereby authorizes and directs the Chief Executive Officer (CEO) to implement appropriate and effective processes to ensure that the Hospital is in compliance with FIPPA. In particular, the Board directs adequate personnel and resources to permit the Hospital to fulfill its obligations in respect of access to information and protection of privacy. The Quality Committee monitors the Board's obligation for FIPPA compliance.

FIPPA designates the Chair of the Board as the "Head" of the Hospital. The Board hereby directs the Chair to consult with the CEO to identify appropriate Hospital personnel to whom the Head's powers and duties should be delegated, and to take all necessary steps to effect such delegation.

The CEO shall:

- annually report to the Board, through the Quality Committee,on FIPPA compliance
- advise the Board of FIPPA-related activities which are particularly significant
- ensure that the Hospital meets its reporting obligations to the Information and Privacy Commission (IPC)

Monitoring

Method and Frequency:

1. Review of policy (annually)
2. Review of Delegation of Authority of 'Head' (annually)
3. CEO Performance Evaluation (annually)
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

References:

Freedom of Information and Protection of Privacy Act: https://www.ontario.ca/laws/statute/90f31

WHISTLEBLOWER: C-7

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2007
REVIEWED/REVISED DATE:	November 2022 – Version 6

Purpose

As part of its responsibility for ensuring program quality and effectiveness, the Board of Bluewater Health (BWH) is committed to maintaining a safe, fair and productive environment in which all those receiving healthcare services, working at or visiting the Hospital behave in a professional manner that respects the rights of others and contributes to an environment that is free from verbal or physical abuse, abuse of authority, unlawful harassment, retaliation or discrimination. This policy sets out the process to support the Board in fulfilling this responsibility.

Policy

The Board will ensure the Hospital provides a process for any person associated with the Hospital to communicate any legitimate and genuine concerns in relation to:

- Criminal activity, breach of legal or regulatory obligations, financial malpractice, fraud, unethical conduct, falsification of records or any attempt to conceal information relating to the above, including information that is considered confidential
- Harassment or discrimination of anyone receiving healthcare services, working or visiting the Hospital
- An abuse of authority
- Patient, visitor, staff, physician, volunteer, students or contractors, including sub-contractors, suppliers, safety within Hospital premises

This policy does not apply to:

- Personal complaints concerning an employee's terms and conditions of employment
- Professional Staff agreements with the Hospital
- Volunteer and student arrangements with the Hospital
- Clinical or harassment concerns that fall under the *Quality of Care Information and Protection Act, Schedule B* unless confidentiality is a major concern in the given situation
- Any aspects of the working relationship in the Hospital, or
- Disciplinary matters

Such issues are dealt with under the provisions of duly negotiated agreements (including collective agreements), applicable current Hospital policies and procedures which may be accessed through the Hospital Administration and Human Resource Policy and Procedures Manual, BWH's Code of Conduct policy, and federal or provincial laws as appropriate. If confidentially is a concern, then such complaints may be addressed by this policy.

Individuals in registered professions are governed by the *Regulated Health Professions Act, 1991* and must abide by the Code of Ethics, which includes obligation of all registered personnel to report any unethical behaviours.

General Procedure

a) Disclosure regarding concerns within this policy may be made, in confidence in writing (by mail/email) or by phone and/or in-person, to an external firm. This firm will review the information provided and determine, in consultation with the Hospital, whether an investigation should be conducted and what form it should take. The external firm shall retain a confidential record of any information and documentation pertaining to such complaints or concerns for a period of no less than seven (7) years. A detailed process will be made available through the selected firm.

b) The investigation, depending on the nature of the matter raised may be –
- Investigated internally by the Hospital
- Referred to the Hospital's external auditors
- Investigated externally by an independent organization
- Referred to the police

c) A general update on the investigation will be communicated to the person making the disclosure by the external firm.

d) The external firm will provide regular reports to the Chief Executive Officer (CEO) regarding disclosures received pursuant to this policy as well as the outcome of any investigative process.

e) Notwithstanding section 2 d) any disclosure regarding concerns related to the CEO will be reported to the Board Chair by the selected external firm.

Guiding Principles

The guiding principles related to this policy are:

- Confidentiality for the person(s) making disclosure. (The external firm will ensure the privacy rights of parties, the person(s) making the disclosure and the person(s) implicated or alleged to be responsible for the wrongdoing are respected. In the case of legal proceedings disclosure to the police and/or courts may be required). The external firm will establish adequate procedures to ensure the protection of the information and the treatment of files are in accordance with the *Personal Health Information Protection Act, 2004* and the *Freedom of Information and Protection of Privacy Act.*
- Anonymous complaints will not be accepted.
- The Hospital will treat reprisals towards the person making disclosure seriously and take appropriate disciplinary or other action.
- Allegations which are determined to be false or malicious after investigation will be considered to be mischief and treated seriously and appropriate disciplinary or other action will be taken.
- All employees, physicians, students, contractors and volunteers who know or ought to know a violation has occurred and do not report it will be subject to disciplinary action up

to and including termination. Individuals involved in a violation will be subject to disciplinary action, up to and including termination of employment of service.

- The Hospital will not condone any attempt to conceal evidence and/or information relating to matters covered under this policy.

The Board hereby delegates responsibility and authority to the CEO to implement and monitor the effectiveness of this policy.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Report to the Board by the CEO of Bluewater Health related to the Third party Whistleblower services (annually)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

OCCUPATIONAL HEALTH AND SAFETY ACCOUNTABILITY FRAMEWORK: C-8

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	October 2005
REVIEWED/REVISED DATE:	November 2022 – Version 7

Purpose

As part of its responsibility for ensuring program quality and effectiveness, the Board of Bluewater Health (BWH) recognizes the importance of taking reasonable steps to prevent harm to employees and Professional Staff of BWH arising from the fulfillment of their responsibilities at the Hospital. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

As a part of its commitment to developing a healthy work environment and in accordance with the Hospital by-laws, the Board will ensure the Hospital has established an Occupational Health and Safety Program and a Health Surveillance Program (including a Communicable Diseases Surveillance Program). These programs will include procedures with respect to:

(i) the safe use of substances, equipment and medical devices in the Hospital
(ii) safe and healthy work practices in the Hospital, including without limitation, the prevention of disruptive behaviour
(iii) the prevention of accidents to persons on the premises of the Hospital
(iv) the elimination of undue risks and the minimization of hazards inherent in the Hospital environment, including the risks to staff relating to the patient safety indicators

The Board delegates responsibility and authority to the Chief Executive Officer (CEO) (or designate) to develop, implement, and evaluate the Occupational Health and Safety Program, which shall include:

- supporting the Joint Health and Safety Committees and ensuring that each Committee is provided with adequate resources to fulfill its mandate
- providing such training to all workers with respect to the Occupational Health and Safety Program and safe work practices as may be necessary for the safe performance of their duties
- ensuring that all workers are provided with the equipment and medical devices necessary for the safe performance of their duties. Such equipment and devices shall be reasonably suited for their intended use and adequately maintained
- ensuring that contractors, sub-contractors and their workers meet or exceed these requirements
- fostering a culture in which all workers take responsibility for protecting their own health and safety and that of their co-workers by:
    - working in compliance with the safe work practices and procedures established by BWH
    - using or wearing the equipment, protective devices or clothing that BWH requires to be used or worn

- o taking such steps as are reasonable to prevent unsafe or unhealthy conditions from occurring
- o reporting all unsafe or unhealthy working conditions of which they are aware to their supervisor or manager
- o reporting all accidents, occupational injuries and illnesses of which they are aware of in accordance with Hospital procedures

The CEO (or designate) will regularly consult with all levels of the organization to regularly identify the areas of greatest risk to health and safety and will develop an action plan to address these high risk areas. The CEO (or designate) will monitor the effectiveness of the Health and Safety Program and ensure BWH is in compliance with the relevant legislation - *Occupational Health and Safety and Health Protection and Promotion Act* for communicable diseases.

The Board will receive annual reports from the CEO (or designate) on the Hospital's Occupational Health and Safety Program to include information about the ability of the organization to meet occupational health and safety requirements, risk issues, statistical data on incidents and program outcomes.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Receive an annual report on the Occupational Health and Safety Program and outcomes (annually)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

ENVIRONMENTAL STEWARDSHIP: C-9

BOARD RESPONSIBILITY:	Ensure Program Quality and Effectiveness
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	October 2002
REVIEWED/REVISED DATE:	November 2022 – Version 6

Purpose

As part of its responsibility for ensuring program quality and effectiveness, the Board of Bluewater Health (BWH) recognizes the importance of delivering its services in an environmentally responsible manner. This policy sets out the principles and processes to support the Board in fulfilling this responsibility.

Policy

The Board is committed to the delivery of health care services in a manner that minimizes undue risk and adverse effect on the natural environment. The Board hereby delegates responsibility and authority to the Chief Executive Officer to develop and implement programs that will ensure that BWH maintains a progressive focus on environmental stewardship and sustainable development and complies with applicable legal and regulatory requirements with respect to the protection of the natural environment. BWH will review the environmental management programs and outcomes, and report the outcomes in the energy conservation and demand management plans annually. BWH will report incidents to the Board.

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Post the Energy Consumption and Greenhouse Gas Emissions annual report on the hospital website and intranet (annually)
3. Review of the environmental management programs and outcomes
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle

RESOURCE PLANNING: D-1

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	June 2005
REVIEWED/REVISED DATE:	November 2022 – Version 7

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health (BWH) wishes to ensure that the organization undertakes appropriate financial planning, optimizes the use of and operates within its resources and adheres to its Service Accountability Agreement (SAA). This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

As set out in the Principles of Governance & Board Accountability policy, BWH is accountable to work within its resources and according to legislative and other binding directives of the Ministry of Health (Ministry) and Ontario Health.

The Hospital's funding and service obligations are set out in the HSAA which is based on the Hospital Accountability Planning Submission (HAPS). In particular, the Hospital is expected to achieve a balanced budget in each fiscal year.

The Board hereby delegates responsibility and authority to the Chief Executive Officer (CEO) to develop an annual operating plan and capital plan which:

1. is consistent with the Board's strategic priorities in the allocation of resources among competing program and service needs
2. contains sufficient information to support projections of revenues, expenditures, cash flow, and service levels with clear distinction of capital and operational items, and disclosure of planning assumptions and restrictions related to program/service volumes, borrowing requirements, cash flow, significant changes in financial position and material changes to accounting procedures
3. is consistent with the HAPS and is premised on achieving or surpassing the patient service targets established in the HSAA
4. incorporates the following at a minimum:

    a. program and service plans
    b. a financial plan, including operating and capital budget
    c. human resource plans for hospital employees and Professional Staff

The CEO shall ensure that:

1. reasonable opportunities exist for stakeholder engagement in the development of the operating plan and capital plan

2. any material deviation(s) between actual revenues, expenses, staffing and service volumes from the operating plan approved by the Board and any significant reallocations of resources between programs are promptly brought to the Board's attention
3. ensuring the fiscal position of the BWH is not placed at risk and that adequate internal controls and process are in place

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

FINANCIAL CONDITION: D-2

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	December 2010
REVIEWED/REVISED DATE:	November 2022 – Version 5

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health (BWH) wishes to ensure that the financial condition and operations of the Hospital are consistent with the Board-approved Operating Plan and Capital Plan. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Chief Executive Officer (CEO) shall ensure that appropriate and effective processes exist to achieve a balanced budget each fiscal year and manage the operating and capital expenses within the Board-approved operating and capital budgets.

These processes exist to minimize the opportunity for expenditures to occur which may jeopardize the Hospital's financial standing.

The CEO shall ensure that any material reallocation of funds between programs and projects will be promptly brought to the Board's attention. Accordingly, the CEO is responsible for ensuring the financial position of the Hospital is not placed at risk and that sufficient internal controls and reporting structures are in place and are followed so that:

- Revenue is only expended for its intended purpose
- More funds are not expended than have been budgeted or reasonably forecast to be received
- Debt, whether capital or operating, is only incurred in accordance with the Board's direction
- The Hospital's cash balance is maintained at a sufficient level to meet the Hospital's obligations in a timely manner
- Governmental, regulatory and agency filings and payments thereon are made in a timely and accurate manner

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Review of regular monitoring reports (per financial statements, balanced scorecard (monthly) and work plan
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

ASSET PROTECTION: D-3

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2005
REVIEWED/REVISED DATE:	November 2022 – Version 6

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health (BWH) wishes to ensure that the assets of the Hospital are reasonably protected, adequately maintained, and not placed at unnecessary risk. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board hereby delegates responsibility and authority to the Chief Executive Officer (CEO) to implement appropriate and effective processes to safeguard Hospital assets and not unnecessarily expose the Hospital or its Board, staff or volunteers to claims of liability. Accordingly, the CEO shall ensure that:

1. appropriate liability, property and fidelity insurance coverage is obtained and maintained in force for the protection of BWH, its Directors, Officers, Non-Director Committee Members, employees, volunteers and such other persons whom the CEO deems appropriate
2. adequate control processes are in place, both internally and through Hospital agents, for the receipt, processing and disbursement of funds in compliance with Canadian generally accepted accounting standards and applicable internal control practices
3. adequate control process are in place, both internally and through Hospital agents, for the retirement of tangible capital assets including post-retirement operation, maintenance, and monitoring costs
4. financial reporting is consistent with Canadian generally accepted accounting principles
5. Hospital funds are invested in accordance with the Hospital's Investment Policy
6. real property is not acquired, disposed of or encumbered without the prior approval of the Board
7. plant and equipment are adequately maintained and not subjected to unreasonable wear and tear

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Annual External Review of Financial Processes and Internal Controls
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

INVESTMENTS: D-4

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2005
REVIEWED/REVISED DATE:	November 2022 – Version 6

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health (BWH) wishes to ensure that investment activities are undertaken in a manner designed primarily to preserve and safeguard capital, and secondarily to optimize investment return. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Preservation of both the operating and capital funds are of paramount importance in the administration of the investment policy. The mix of investments must adhere with current legislated requirements and be within the powers of the Hospital Board as set out in the By-Laws.

The investment mix should generate a steady, dependable and predictable flow of revenue from year to year. In all cases, maturity dates of investments shall recognize the forecasted cash flow requirements for operating and capital expenses.

The Board hereby delegates responsibility and authority to the Chief Executive Officer to invest surplus-to-need funds in order to optimize investment return while minimizing the risk of loss. Investments may take two forms:

1. Long-term (greater than 12 months) investments shall be limited to:

    a) Debt obligations issued or guaranteed by the Government of Canada
    b) Debt obligations issued or guaranteed by a Province of Canada provided the instruments are rated, and continue to be rated, at least AA or equivalent, by a recognized rating agency
    c) Debt obligations issued or guaranteed by a Canadian municipal government provided the instruments are rated, and continue to be rated, at least AA or equivalent, by a recognized rating agency
    d) Debt obligations issued or guaranteed by a corporation, incorporated under the laws of Canada or a province thereof, provided the instruments are rated, and continue to be rated, at least A-1 or equivalent, by a recognized rating agency;
    e) Bankers' acceptances, bonds or term deposit receipts of a Canadian chartered bank which are rated, and continue to be rated at least A-1 or equivalent, by a recognized rating agency
    f) Equity-based instruments of a corporation, incorporated under the laws of Canada or a province thereof, with the approval of the Board

2. Short-term (12 months or less) investments shall be limited to:

   a) Cash or cash equivalents held on deposit at the Hospital's chartered bank, other Canadian chartered bank or regulated investment agency
   b) Short-term instruments such as Treasury Bills or Guaranteed Investment Certificates when the rate of return is superior to cash or cash equivalents

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Investment Review (quarterly)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

PROCUREMENT AND SPENDING AUTHORITY: D-5

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	March 2011
REVIEWED/REVISED DATE:	November 2022 - Version 5

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health (BWH) is required to ensure that the Hospital's procurement principles and processes comply with the Ontario Broader Public Sector ("BPS") Procurement Directive. This Directive:

- ensures that publicly funded goods and services, including construction, consulting services, and information technology are acquired by BPS organizations through a process that is open, fair, and transparent
- outlines responsibilities of BPS organizations throughout each stage of the procurement process
- ensures that procurement processes are managed consistently throughout the BPS.

This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board hereby authorizes and directs the Chief Executive Officer (CEO) to ensure that appropriate and effective processes exist to ensure that decisions related to planning, acquisition and management of goods and services for use by the Hospital will comply with the BPS Procurement Directive including the Supply Chain Code of Ethics.

The hospital's procurement processes will be guided by the following principles:

- **Accountability** - BWH will be accountable for appropriateness of the procurement processes and the results of its procurement decisions.
- **Transparency -** BWH's procurement processes will be transparent to all stakeholders and, wherever possible, will provide stakeholders with equal access to information on procurement opportunities, processes and results.
- **Value for Money** - BWH will maximize the value received from the use of public funds by adopting a value-for-money approach which aims to deliver goods and services at the optimum total lifecycle cost.
- **Quality Service Delivery** - BWH will endeavour to ensure that the programs and services it provides receive the right product, at the right time, in the right place.
- **Process Standardization** - BWH will endeavour to standardize processes in order to improve efficiency of program and service delivery.
- **Risk Management** - BWH will ensure all Health and Safety legislation, regulations and standards are addressed during the procurement process so that potential hazards are controlled in design and purchasing stages.

The Board hereby approves the signing authority framework for the Hospital attached hereto as Schedule “A” and the procurement framework attached hereto as Schedule “B”. The link to the BPS Directive is attached hereto as Schedule “C”.

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Certificate from the CEO or designate of Bluewater Health’s compliance with the Directive (quarterly)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle

Schedule A
Signing Authority Framework

Unless otherwise approved by the Board of Directors, all purchases of goods and services must be approved in the annual budget. Formal approval of the budget constitutes financial approval to proceed with the procurement process. The ability to incur the actual expenditures is delegated to the Hospital staff based on the following approval limits:

Type of Expenditure	Maximum	Position
Goods and Service Contracts (Non-Consulting) Examples include: · Supplies · Non-Consulting Services · Minor Equipment · Board Approved Capital Equipment	 Up to $5,000 Up to $20,000 Up to $100,000 Up to $1,000,000 > $1,000,000	 Managers and Designated Staff Director VP/CFO CEO Board of Directors
Consulting Services	Up to $20,000 Up to $100,000 Up to $500,000 > $500,000	Director VP/CFO CEO Board of Directors
Contractual and Financial Obligations	Up to $20,000 Up to $100,000 Up to $500,000 > $500,000	Director VP/CFO CEO Board of Directors

For clarity in application of the authority approval limits:

- The dollar limits noted above refer to invoice costs before taxes.
- No requisition, purchase, or contract shall be divided in order to circumvent the requirements of the spending limits of this section.
- The Executive Committee (EC) is responsible for the review and evaluation of all capital expenditure proposals for furnishings, equipment, and facilities. Vice-President endorsement of any capital expenditure that is not on the approved capital budget list is required prior to approval as indicated in the table above.

If a capital item is specifically listed in the capital budget that the Board of Directors has approved, it need not go back for approval unless the dollar amount exceeds the amount so budgeted.

Schedule B

Procurement Framework

Unless otherwise approved by the Board of Directors, all purchases of goods and services must be approved in the annual budget. Formal approval of the budget constitutes financial approval to proceed with the procurement process. The procurement process for goods, consulting & non-consulting services, and construction should align with the below means of procurement to be compliant with the BPS Procurement Guidelines:

Goods, Non-Consulting Services and Construction		
Total Procurement	**Means of Procurement**	**Recommended/Required**
$0 up to but not including $25,000	Informal procurement (one or more quotes) or Invitational Procurement	Recommended
$25,000 up to but not including $100,000	Invitational competitive procurement (minimum of three suppliers are invited to submit a bid) or Open competitive process	Required
$100,000 or more	Open competitive process	Required
Consulting Services		
Total Procurement	**Means of Procurement**	**Recommended/Required**
$0 up to but not including $100,000	Invitational or Open competitive process	Required
$100,000 or more	Open competitive process	Required

To achieve optimum value for money, a competitive procurement process should be employed as per the above recommendations. It is recognized, however, special circumstances may require the organization to use non-competitive procurement.

Prior to commencement of non-competitive procurement, a Non-Competitive Procurement Exemption form must be completed and approved by an appropriate authority within the organization. Goods and non-consulting services that go through a non-competitive process from $25,000 up to but not including $100,000 must be approved by the CEO. Goods and non-consulting services that go through a non-competitive process of $100,000 or greater must have Board of Directors or equivalent approval. Consulting services obtained through a non-competitive process must be signed by one level higher than the Procurement Approval Authority Schedule and services over $100,000 require Board approval.

Where Board of Directors approval is required, the Board Chair will be asked to review the Non-Competitive Procurement Exemption form to confirm all guidelines have been

followed and sign-off on behalf of the Board. The Board Chair would provide an update to the Board at the next scheduled Board meeting on all exemptions completed.

Schedule C

Broader Public Sector (BPS) Procurement Directive

EXPENSE REIMBURSEMENT: D-6

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	April 2011
REVIEWED/REVISED DATE:	November 2022 – Version 3

Purpose

As part of its fiduciary responsibility, the Board of Bluewater Health (BWH) is required to ensure that the Hospital's policies and processes regarding reimbursement of expenses comply with the Ontario Broader Public Sector ("BPS") Expenses Directive.

This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board hereby authorizes and directs the Chief Executive Officer (CEO) to ensure that appropriate and effective processes exist to ensure that reimbursement of business expenses by the Hospital complies with the BPS Expenses Directive.

These processes will be guided by the following principles:

- **Accountability** – BWH will be accountable for the appropriateness of expenses reimbursed by the organization.
- **Transparency** – BWH's expense reimbursement processes will be transparent to all stakeholders. The rules for incurring and reimbursing expenses will be clear, easily understood and available to the public.
- **Value for Money** – BWH will use public funds prudently and responsibly to ensure that any expenses reimbursed by the Hospital are necessary and reasonable.
- **Fairness** - Legitimate authorized expenses incurred by individuals for the benefit of the organization will be reimbursed in a timely manner.

The BPS Expenses Directive is attached hereto as Schedule "A".

Approval Process

Reimbursement requests shall be submitted on the form provided for that purpose and shall be accompanied by original receipts where available and by a detailed description of the expense (to whom paid, amount, date and purpose) if no receipt for a specific item is available.

Individuals' expenses shall be approved by their immediate supervisor prior to reimbursement. The CEO's expenses shall be approved by the Chair.

With respect to the Board, Directors' expenses shall be approved by the Chair. The Chair's expenses shall be approved by the Vice-Chair.

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Expenses are posted to the BWH website by November 30 and May 31
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle (annually)

Schedule A

Broader Public Sector (BPS) Expenses Directive

PERQUISITES: D-7

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	October 2011
REVIEWED/REVISED DATE:	November 2022 – Version 3

Purpose

As part of its fiduciary responsibility, the Board of Bluewater Health (BWH) is required to ensure that the Hospital's policies and processes regarding the provision of perquisites for Board members and Hospital employees comply with the Ontario Broader Public Sector ("BPS") Perquisites Directive. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board hereby authorizes and directs the Chief Executive Officer (CEO) to ensure that appropriate and effective processes exist to ensure that provision and reimbursement of perquisites by the Hospital complies with the BPS Perquisites Directive. In this policy, a perquisite is a privilege that is provided to an individual or to a group of individuals, provides a personal benefit, and is not generally available to others employed by or associated with the Hospital.

These processes will be guided by the following three (3) key principles:

- **Accountability** - The Hospital is accountable for its use of public funds. All expenditures must support the Hospital's objectives.
- **Transparency** - The Hospital's processes must be transparent to all stakeholders. The rules for perquisites must therefore be clear and easily understood.
- **Value for Money -** Taxpayer dollars must be used prudently and responsibly.

To be allowable, a perquisite must be a business-related requirement for the effective performance of an individual's duties. Authorized perquisites will be reimbursed in a timely manner according to Hospital policies and procedures.

The BPS Perquisites Directive is attached hereto as Schedule "A".

Summary information about allowable perquisites at the Hospital will be made publicly available on an annual basis, in accordance with the BPS Perquisites Directive.

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

Schedule A

BPS Perquisites Directive

HOSPITAL BORROWING: D-8

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2012
REVIEWED/REVISED DATE:	November 2022 – Version 3

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health (BWH) wishes to ensure the Hospital borrows money only where necessary and uses the proceeds of borrowing in accordance with the Hospital's financial planning process to achieve the strategic goals of the organization. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Board approval is required for the Hospital to borrow money.

The Chief Executive Officer 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. Bridge financing – to secure funds to meet the timing difference between payment of a one-time expense and the receipt of funds to pay the expense;
2. Operating financing (line of credit) – to fund normal operating requirements where operating expenses must be paid prior to receipt of revenues;
3. 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;
4. Capital projects – to support Hospital capital projects approved by the Board;
5. Land or property - to support the acquisition of land or property required by the Hospital; and
6. Special projects – to support a Hospital expenditure justified by a business case demonstrating a reasonable financial return.

These activities must also comply with the Board's Procurement and Spending Authority Policy.

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Review of Loan portfolio (quarterly)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

NAMING OF ASSETS: D-9

BOARD RESPONSIBILITY:	Ensure Financial Viability
COMMITTEE:	Resource Utilization and Audit
APPROVED BY:	Board of Directors
ISSUE DATE:	November 2018
REVIEWED/REVISED DATE:	November 2022 - Version 2

Purpose

The purpose of Bluewater Health is fulfilled, in part, by the support it receives from society, volunteers and financial donors. The Hospital welcomes the opportunity to recognize such support through the naming of buildings, facilities, programs and other components of its operation.

The philanthropic services and programs provided to the Hospital are the responsibility of the Bluewater Health Foundation and the Charlotte Eleanor Englehart Hospital Foundation.

This policy sets out guidelines for the granting of the honour of naming hospital assets for both philanthropic and other distinguished support. It sets out a consistent approach to the naming of facilities, major equipment, programs and research/academic positions entrusted to and operated by the Hospital and referred to herein as “assets”.

Definitions

Assets: The term “Assets” includes and is limited to, Facilities, Programs, Major Equipment, and Research/Academic Positions, each of which is defined as follows:

- Facilities: The term “Facilities” includes, but is not limited to all buildings, internal building spaces, exterior grounds, landscaping materials and finishes.

- Major Equipment: The term “Major Equipment” includes, but is not limited to single items with a unit value of $50,000 or more or multiple units of a single item with a combined cost of $50,000 or more.

- Programs: The term “Programs” includes, but is not limited to, all programs, services, and areas of care to patients.

- Research/Academic Positions: The term “Research/Academic Positions” include, but is not limited to, lead research positions, chairs, department heads, etc.

Authority

The Board of Directors of Bluewater Health exercises the sole approval authority for naming - in honour of philanthropic gifts or distinguished service - any assets entrusted to the Hospital subject to applicable federal and/or provincial laws. The Board may delegate to the President and Chief Executive Officer (CEO) authority to approve naming of assets carrying a naming

value of under $100,000. In such cases the CEO shall report these to the Board at the next regular meeting. The CEO shall use their discretion in placing before the Board any namings in this category that may be considered sensitive or controversial.

Policy

1. Bluewater Health retains the sole right to name its assets and will name assets only as it deems appropriate.

2. In the process of naming assets, Bluewater Health shall consider factors which may affect the Hospital's reputation and reserves the right to withdraw naming rights at its sole discretion.

3. Naming shall not be bestowed in honour of any individual, group or organization linked to causes that could compromise health, the purpose statement or values of Bluewater Health or the well-being of its staff, physicians, volunteers or patients it serves.

4. Prior to naming an asset, consideration shall be given to its full potential to generate revenue as donor naming opportunity while balancing other benefits and the current philanthropic environment.

5. Permanent named recognition will be provided only in circumstances where gift size and/or contribution to the organization are exceptional. When permanent named recognition has been extended for a gift received, it will be honoured in perpetuity. (This does not negate the Hospital's authority as noted under item 2.) In the event of changed circumstances, e.g. a facility no longer exists or has been radically renovated, the Hospital reserves the right to determine the form which the permanence will take.

6. Bluewater Health will not name minor items that are replaced on a regular or scheduled basis such as minor equipment, furnishings or individual trees/shrubs.

7. Only in exceptional circumstances will assets be named to honour outstanding service of members of staff, the Board of Directors of the Hospital, the foundations, any elected or appointed official concerned with the functions or control of the corporation so long as their official relationship continues. However, such individuals making philanthropic donations remain eligible for naming recognition.

8. For safety reasons, such as denoting the location of emergency codes, where naming rights bestowed to donors are not permanent, the Hospital will continue to use an appropriate permanent wayfinding system to reference the specific geographic area. Naming signage will be designed in consultation with the Communications and Public Affairs Office in keeping with the wayfinding signage.

9. The Hospital reserves the right to decide on the nature of physical displays which may accompany named recognition while recognizing the value of donor or honouree input.

10. No name will be approved that will imply the Hospital's endorsement of a partisan political or ideological position or of a commercial product. This does not preclude naming with the name of an individual or company that manufactures or distributes commercial products.

11. Provisions in this policy that refer to naming for a benefactor also in general apply to naming for a third party at the wish of a benefactor.

12. The proposed name of an asset shall comply with the corporate policies and procedures of Bluewater Health and with all applicable federal and provincial laws.

Procedure

1. Bluewater Health Foundation, shall, as appropriate, entertain proposals from and in consultation with Bluewater Health, medical staff, management and staff, major corporate partners and other interest groups.

2. Recommendations are to be directed to the CEO of the Hospital.

3. At the discretion of the Board Chair and CEO a group will be selected or delegated to review naming proposals according to this policy.

4. The Office of the Chair of the Board of Directors shall keep a permanent record of all approved naming of hospital assets.

Monitoring

Method & Frequency:

1. Review of the Policy (annually)
2. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

BY-LAWS AND BOARD POLICIES: E-1

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	November 2018
REVIEWED/REVISED DATE:	September 2023 - Version 1

Purpose

To ensure governance best practice, BWH will review its Corporate and Professional Staff By-Laws and Board Policies annually, to ensure compliance with applicable legislation and Accreditation Standards, and will make recommendations to the Board for revisions as required. Revisions to the By-laws and policies will also be considered with the introduction or changes to any relevant legislation.

Policy

1. Directors are encouraged to question the clarity and relevance of existing policies and identify the need for additional policies as issues arise.

2. Directors perceiving a need for policy development or revision should advise the Chair, who shall refer the issue to the Board. The Board shall determine if and when a policy will be developed or revised.

3. Policy development and revision work will be led and coordinated by the Governance and Nominating Committee.

4. Policy development and revision work will be assigned to Board committees based on the fit with the committee mandate and responsibilities, with final draft reviews completed by the Governance and Nominating Committee prior to submission to the Board for review/approval. This work will form part of each Committee's work plan.

5. The Governance and Nominating Committee will monitor policy review completion regularly through the year, and provide the Board with an annual monitoring report on policy review completion.

Monitoring

Method and Frequency:

1. Review of the By-laws and policies (annually)
2. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

PRINCIPLES OF GOVERNANCE AND BOARD ACCOUNTABILITY: E-2

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2009
REVIEWED/REVISED DATE:	September 2023 – Version 5

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) will establish, approve and periodically review a statement of *Principles of Governance and Board Accountability.* This statement is an important requirement of effective governance and addresses the Board's overarching philosophy and approach to its governance responsibilities, including its model of governance and accountabilities. This policy sets out the *Principles of Governance and Board Accountability* as developed and approved by the Board of BWH.

Policy

1. The Board of Directors governs BWH through the direction and supervision of the business and affairs of the corporation in accordance with its articles of incorporation, its by-laws, purpose statement and values, governance policies and other laws and regulations.

2. The Board adheres to the *Modified Pointer and Orlikoff Governance Model,* (as referenced in the Roles and Responsibilities of the Board of Directors policy) a model of governance through which it provides strategic leadership and direction.

3. The Board acts at all times in the best interests of BWH, having regard for its accountabilities to its patients and the communities served, the Ministry of Health, Ontario Health, the Sarnia-Lambton Ontario Health Team, and its relationship with other service providers.

4. The Board maintains a culture of honesty and integrity, open debate, ethical decision making, forthright examination of all issues and strives for decision-making based on evidence-informed, best practice.

5. The Board, through the strategic planning process, defines values for BWH which will be reflected in the Board's decision making processes, recognizing that decisions and actions taken must be consistent with the approved values.

6. The Board maintains at all times a clear distinction between Board and management roles, while recognizing the interdependencies between them.

7. The Board is accountable to:

A. BWH's patients and its communities served to:

- engage the communities served when developing plans and setting priorities for the delivery of health care
- advocate for and seek resources to provide appropriate health care
- utilize its resources effectively to fulfill BWH's purpose statement and mandate
- ensure the quality and safety of patient care and service delivery
- ensure the appropriate use of community contributions and resources
- consider the diversity of needs and interests in its policy formulation and decision-making
- work within its resources, monitoring their efficient and effective use consistent with BWH's purpose statement and mandate
- measure and report on BWH performance against accepted standards and best practices in comparable hospitals and in accordance with requirements of all applicable legislation
- inform the Ministry of Health/Ontario Health of any gaps between needs of the communities served and scope of services provided, based on resources allocated by the Ministry of Health/Ontario Health to fulfill the BWH's purpose statement and mandate
- apprise the Ministry of Health/Ontario Health and the communities served of Board policies and decisions related to the BWH's mandate that might be required to operate within its resources
- identify and undertake integration opportunities (separately and in conjunction with the Ministry of Health/Ontario Health/Sarnia-Lambton Ontario Health Team) and other health service providers to provide appropriate, co-ordinated, effective and efficient services and that are consistent with the purpose statement, values and strategic plan of BWH and in the best interests of the community
- disclose information about BWH's governance processes, decision-making and performance in an open and transparent manner

B. the Ministry of Health and/or Ontario Health to:

- comply with applicable government legislation, regulations, directives policies and directions
- operate within service accountability agreements
- work within its resources, monitoring their efficient and effective use consistent with BWH's purpose statement and mandate
- measure and report on BWH performance against accepted standards and best practices in comparable hospitals

8. Consistent with the Board's commitment to good governance practices, timely access to information, appropriate protection of personal privacy, and appropriate protection of other information that is exempt or excluded from disclosure under the *Freedom of Information and Protection of Privacy Act*, the Board will make available to the public information about its governance processes, decision making and organizational performance including, but not limited to:

- the statement of Board and Director roles, responsibilities and accountabilities
- a list and biographies of elected and ex-officio Directors and their participation on Board committees
- the Board policies addressing governance structures and processes, including those which address how the Board functions independently of management
- the terms of reference governing Board standing committees
- the results of BWH's participation in the voluntary national accreditation process through Accreditation Canada
- the Hospital and Multi-Sectoral Service Accountability Agreements with the Ministry of Health and Ontario Health
- the Open Board meeting information package with the CEO report
- an annual report, including audited financial statements, outlining BWH's accomplishments and performance
- performance reporting information in compliance with applicable government legislation or directives
- a summary of the processes through which BWH demonstrates accountability, transparency and engagement

Monitoring

Method and Frequency:

1) Review of the Policy (annually)
2) Board Evaluation
3) Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

ROLES AND RESPONSIBILITIES OF THE BOARD OF DIRECTORS: E-3

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2009
REVIEWED/REVISED DATE:	September 2023 – Version 6

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) will establish, approve and periodically review a description of the *Roles and Responsibilities of the Board of Directors.* This description is an important requirement of effective governance. It addresses the Board's expectations for itself and provides the foundation upon which the Board's performance can be evaluated. This policy sets out the *Roles and Responsibilities of the Board of Directors* as developed and approved by the Board of BWH.

Policy

The Board adheres to the *Modified Pointer and Orlikoff Governance Model* and governs by fulfilling the following roles:

1.0 Policy Formulation
Establish policies to provide guidance to those empowered with the responsibility to lead and manage BWH operations.

2.0 Decision-Making
Directors will ensure the ethical framework/principle based decision-making approach is applied in Board decision-making processes.

3.0 Oversight
Monitor and assess organizational processes and outcomes.

Responsibilities of the Board

A) Establish Strategic Direction

- Consider key healthcare needs and stakeholders, and engage the community of diverse persons and entities when developing plans and setting priorities for the delivery of healthcare
- Establish and periodically review BWH's purpose statement and values
- Contribute to the development of and approve the strategic plan of BWH, ensuring alignment with the provincial priorities. Conduct a review of the strategic plan as part of a regular annual planning cycle
- Ensure Board decisions are consistent with BWH's purpose statement, values and strategic plan

- Monitor corporate performance regularly against the strategic plan and performance indicators

B) Provide for Excellent Management

- Select and appoint the President and Chief Executive Officer (CEO)
- Establish measurable annual performance expectations in co-operation with the President/CEO, assess the President/CEO performance annually and determine compensation
- Delegate responsibility and authority to the President/CEO for the management and operation of BWH and require accountability to the Board
- Select and appoint the Chief of Staff (COS)
- Establish measurable annual performance expectations in co-operation with the COS, assess COS performance annually and determine compensation
- Delegate responsibility and authority to the COS for the supervision of the practice of medicine, dentistry and midwifery, and extended class nurses with privileges, within BWH and require accountability to the Board
- Provide for President/CEO and COS succession
- Ensure the President/CEO and the COS establish an appropriate succession plan for senior management and Professional Staff and a human resource plan, with review of such plans annually
- Appoint Medical Directors and other medical leadership positions, on the recommendation of the COS, as required under Bluewater Health's by-laws and the *Public Hospitals Act*
- Establish and monitor implementation of policies to provide the framework for the management and operation of BWH, in compliance with applicable laws and regulations

C) Ensure Program Quality and Effectiveness

- Ensure the effectiveness and fairness of the annual credentialing process for the Professional Staff
- Review and approve appointments, reappointments and privileges for Professional Staff as recommended by the Medical Advisory Committee, in consideration of BWH's resources and the community's needs
- Provide oversight of the credentialed Professional Staff through the COS and the Medical Advisory Committee and, if necessary or advisable, effect the restriction, suspension or revocation of privileges of any credentialed professional staff member as provided under the *Public Hospitals Act*, following recommendation by the Medical Advisory Committee
- Review and approve the Quality Improvement Plan, quality goals and performance indicators (using best practices and benchmarks) and monitor indicators of clinical outcomes, quality of care and service delivery, patient safety, satisfaction and organizational risk
- Ensure the development of a process for identifying, managing and monitoring organizational risks
- Ensure that policies and processes to manage resource utilization and patient safety are in place and operating effectively
- Ensure policies are in place to provide a framework for addressing ethical issues arising from clinical care, education and research
- Ensure management has plans in place to address variances from performance standards, including management of critical incidents, systemic or recurring

quality of care issues, and complaints and concerns, and oversee implementation of the remediation plans

D) Ensure Financial Viability

- Approve the annual operating and capital budget, and monitor financial performance periodically against the budget and agreed-upon indicators
- Ensure management undertakes multi-year financial planning, optimizes the use of resources, operates within the resource envelope, adheres to the Hospital (H-SAA) and Multi-Sectoral (M-SAA) Service Accountability Agreements and manages to acceptable levels of risk
- Ensure policies are in place on asset protection, procurement, borrowing, signing authority, resource planning, financial condition, expense reimbursement and perquisites
- Approve an investment policy and monitor compliance
- Ensure management has measures in place to ensure the integrity of internal accounting controls and reporting processes and the effectiveness of management information systems
- Ensure the Members appoint qualified auditors, and examine, consider and approve the Corporation's financial statements and the report of the auditors at least annually

E) Ensure Board Effectiveness

- Recruit Directors who are skilled, experienced and committed to BWH, and plan for the succession of Directors and Officers
- Establish comprehensive Board orientation and ongoing Board development and education programs
- Establish and monitor implementation of Board priorities and annual work plans for the Board and its standing committees
- Ensure the Board receives timely, appropriate information to support informed policy formulation, decision-making and oversight
- Establish and periodically review policies concerning governance structures and processes to maximize the effective functioning of the Board
- Establish a policy and process for evaluating the performance of the Board as a whole and individual Directors that fosters continuous improvement
- Ensure decision-making processes are transparent
- Ensure effective mechanisms are in place for reporting on BWH performance
- Ensure the Board adheres to the Principles of Governance and Accountability statement and demonstrates accountability to its stakeholders
- Ensure the Board fulfills all of its responsibilities as set forth by applicable legislation.

F) Foster Relationships

- Ensure BWH builds and maintains positive relationships with Ontario Health in fulfilling BWH's service accountability agreements with Ontario Health and its obligations under provincial policies established by the Ministry of Health
- Ensure BWH is fulfilling its role within Sarnia-Lambton and the Erie St. Clair regions by fostering effective coordination and integration of patient care and health service delivery and positive working relationships with other community health service providers
- Ensure mechanisms are in place to build and maintain positive relationships and effective two-way communication within BWH with Professional Staff, staff, volunteers, the Foundations and with the community served.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Board Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

ROLES AND RESPONSIBILITIES AS AN ELECTED AND EX-OFFICIO DIRECTOR: E-4

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2009
REVIEWED/REVISED DATE:	September 2023 – Version 9

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) will establish, approve and periodically review a description of the *Roles and Responsibilities as an Elected and Ex-Officio Director.* This description is an important requirement of effective governance as it provides Directors with a clear understanding of what is expected of them and serves as a benchmark against which individual director performance can be assessed. This policy sets out the *Roles and Responsibilities as an Elected and Ex-Officio Director* as developed and approved by the Board of BWH.

Policy

1.0 Accountability and Fiduciary Duties

A Director acts ethically, honestly, in good faith and in the best interests of BWH and in so doing, supports BWH in fulfilling its mandate, and discharging its accountabilities. A Director exercises the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. Directors with special skill and knowledge are expected to apply that skill and knowledge to matters that come before the Board.

A Director does not represent the specific interests of any constituency. A Director acts and makes decisions that are in the best interest of BWH as a whole. A Director adheres to the purpose statement and values of BWH and complies with the by-laws, applicable laws and regulations, and Board policies. A Director adheres to the Principles of Governance and Board Accountabilities policy.

2.0 Exercise of Authority

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

3.0 Conflict of Interest

A Director shall avoid positions where their personal interests conflict with those of BWH. A Director complies with the Conflict of Interest provisions in the by-laws and Board approved policy.

4.0 Team Work

A Director works positively, cooperatively and respectfully with others in the performance of their duties while exercising independence in decision-making.

5.0 Participation

A Director reviews pre-circulated material and comes prepared to Board and committee meetings and educational activities, asks informed questions, and makes a constructive contribution to discussions. A Director considers the need for independent advice to the Board on major corporate actions.

6.0 Formal Dissent

A Director reviews the minutes of the previous meeting on receipt and insists that they record any Director's disclosure of an actual or potential conflict of interest or dissent. A Director who is absent from a Board meeting is deemed to have supported the decisions/actions taken in their absence unless within seven (7) days after becoming aware of the decisions/actions, they cause their written dissent to be placed within the meeting minutes, or submit their written dissent to the secretary.

7.0 Board Solidarity

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

8.0 Confidentiality

A Director respects the confidentiality of *in camera* Board discussions and information and such other Board discussions as deemed to be confidential by the Board. Directors will respect the confidentiality of any Informal Meetings.

9.0 Time and Commitment

A Director is expected to commit the time required to fulfill Board and committee responsibilities. A Director is expected to attend a minimum of 70% of Board/ committee meetings. Directors who fail to meet the attendance requirements are subject to review by the Chair and may be asked to step down from the Board. All Directors are expected to serve on the Quality Committee at least once over their first term, and serve on at least two (2) different Board Standing Committees over the course of any subsequent term as a Director. Directors are also expected to represent the Board and BWH in the community and to participate on ad hoc committees and panels or in other forums, when reasonably requested by the Board Chair.

10.0 Competencies

A Director actively contributes specific expertise, skills and other attributes that are needed on the Board.

11.0 Education

A Director seeks opportunities to be educated and informed about the Board and the key issues at BWH and in the broader health care system through participation in Board and Committee orientation and education programs, maximizing use of information and resources on the Board website, participation in strategic planning processes, Board retreats and other mechanisms, as appropriate.

12.0 Self-Evaluation and Continuous Improvement

A Director is committed to a process of continuous self-improvement as a Board member. All Directors participate in processes for the evaluation of the Board and in the Individual Director/Peer evaluation and act upon results in a positive and constructive manner.

13.0 Fundraising Activity

A Director supports the efforts of the BWH Foundation and Charlotte Eleanor Englehart Hospital Foundation.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Board Evaluation
3. Individual Director Evaluation
4. Accreditation Canada Survey and report (timing aligned with survey)

NON-DIRECTOR COMMITTEE MEMBERS: E-5

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2006
REVIEWED/REVISED DATE:	September 2023 – Version 8

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) has determined the participation of Non-Directors from the community as members of certain Board Committees is beneficial to obtain a broad range of perspectives, to provide additional expertise and to identify and assess individuals' interest and aptitude to be Directors in the future. This policy sets out selection process and responsibilities of Non-Director Committee Members (NDCMs).

Policy

Selection

The Governance & Nominating Committee is responsible for recommending individuals to the Board to serve as NDCMs in accordance with the Nominations Process Policy. NDCMs shall meet the qualifications for Directors as set out in this Policy and in the Corporate By-laws of BWH. NDCMs shall have one (1) year renewable terms. No individual shall serve more than five (5) consecutive one-year terms as a NDCM, except as otherwise permitted from time to time by resolution of the Board.

Professional Staff Association (PSA)

The PSA annually elects Professional Staff members to its Executive Committee. These PSA members are then appointed to Board Standing Committees through processes established by the Chief Executive Officer (CEO) and Chief of Staff (COS). For the purposes of role clarity at Board Standing Committee meetings, the Vice-President Sarnia and Secretary/Treasurer should be considered NDCMs once appointed.

Other NDCM Positions

The Quality Committee of the Board membership includes two Patient Experience Partners (PEPs), one Professional Staff Association member (non-executive) and one hospital employee member other than a physician or nurse. The PEPs are selected by the BWH Patient Experience Partner Council. The Professional Staff and hospital employee positions are selected through processes established by the CEO and COS respectively. For the purposes of role clarity at Quality Committee of the Board meetings, these positions should be considered NDCMs once appointed.

1.0 Accountability and Fiduciary Duties

A NDCM acts ethically, honestly, in good faith and in the best interests of BWH and in so doing, supports BWH in fulfilling its purpose statement and mandate, and discharging its

accountabilities. A NDCM exercises the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. NDCMs with special skill and knowledge are expected to apply that skill and knowledge to matters that come before the Committee. A NDCM does not represent the specific interests of any constituency. A NDCM acts and makes decisions that are in the best interest of BWH as a whole. A NDCM adheres to the purpose statement and values of BWH and complies with by-laws, applicable laws and regulations and Board policies. A NDCM adheres to the Principles of Governance and Board Accountabilities Policy.

2.0 Exercise of Authority

A NDCM carries out the powers of office only when acting as a voting member during a duly constituted meeting of the Committee. A NDCM respects the responsibilities delegated by the Board to the President/Chief Executive Officer and Chief of Staff, avoiding interference with their duties but insisting upon accountability to the Committee and reporting mechanisms for assessing organizational performance.

3.0 Conflict of Interest

A NDCM shall avoid positions where their personal interests conflict with those of BWH. A NDCM complies with the Conflict of Interest provisions in the by-laws and Board policy.

4.0 Team Work

A NDCM works positively, cooperatively and respectfully with others in the performance of their duties while exercising independence in decision-making.

5.0 Participation

A NDCM reviews pre-circulated material and comes prepared to Committee meetings and educational activities, asks informed questions, and makes a constructive contribution to discussions. A NDCM considers the need for independent advice to the Committee on major corporate actions.

6.0 Formal Dissent

A NDCM reviews the minutes of the previous meeting on receipt and insists that they record any NDCMs disclosure of an actual or potential conflict of interest or dissent. A NDCM who is absent from a Committee meeting is deemed to have supported the decisions/actions taken by the Committee in their absence, unless within seven (7) days after becoming aware of such decisions/actions, they cause their written dissent to be placed with the meeting minutes or submit their written dissent to the secretary .

7.0 Board Solidarity

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

8.0 Confidentiality

A NDCM respects the confidentiality of Committee discussions and information.

9.0 Time and Commitment

A NDCM is expected to commit the time required to fulfill Committee responsibilities. A NDCM is expected to attend a minimum of 70% of the meetings of the Committees they

are appointed to.NDCMs who fail to meet the attendance requirements are subject to review by the Committee Chair and may be asked to step down from the Committee.

10.0 Competencies

A NDCM actively contributes specific expertise, skills and other attributes that are needed on the Committee.

11.0 Education

A NDCM seeks opportunities to be educated and informed about the Committee, the Board and the key issues at BWH and in the broader health care system through participation in Board and Committee orientation and education programs, maximizing use of information and resources on the Board portal, participation in strategic planning processes, Board retreats and other mechanisms, as appropriate.

12.0 Self-Evaluation and Continuous Improvement

A NDCM is committed to a process of continuous self-improvement as a Committee member. All NDCMs participate in the evaluation of the Committee and in individual NDCM evaluations and act upon results in a positive and constructive manner.

13.0 Fundraising Activity

A NDCM supports the efforts of the BWH Foundation and Charlotte Eleanor Englehart Hospital Foundation.

Monitoring

Method and Frequency:

1. Board Evaluation
2. Review of the Policy (annually)
3. Accreditation Survey and Report (timing aligned with Accreditation cycle)

ANNUAL DECLARATION AND CONSENT: E-6

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2005
REVIEWED/REVISED DATE:	September 2023 - Version 10

To: Bluewater Health and the Board of Directors of Bluewater Health

Consent

☐ I am an individual elected or appointed to the Board and hereby acknowledge and declare that I:

a) consent to act as a Director/Ex-Officio Director/Non-Director Committee Member of the Corporation;
b) am at least 18 years of age;
c) have not been found under the *Substitute Decisions Act, 1992* or under the *Mental Health Act* to be incapable of managing property;
d) have not been found to be incapable by any court in Canada or elsewhere;
e) do not have the status of an undischarged bankrupt;
f) am not an "ineligible individual" as defined in the *Income Tax Act* (Canada) or any regulations made under it; and
g) have provided Bluewater Health with a criminal record check, including vulnerable sector screen, and confirm there have been no changes since I filed this information.

Meeting Participation Consent

☐ I consent to the holding of Board and Board Committee meetings by telephonic or electronic means that permit all persons participating in the meeting to communicate adequately with each other during the meeting. I also consent to the participation by any Director or Board Committee Member at a Board or Board Committee meeting by such telephonic or electronic means.

Compliance with Policies

☐ I confirm that I have read and understand all of the Board-approved policies and any other applicable policies of the Corporation, as amended or supplemented from time to time (the "**Policies**"), including but not limited to:

a) Principles of Governance and Board Accountability Policy

b) Roles and Responsibilities of the Board Policy
c) Roles and Responsibilities as an Elected and Ex-Officio Director Policy
d) Non-Director Committee Members Policy
e) Code of Conduct Policy
f) Conflict of Interest Policy
g) Corporate By-law

☐ I agree to comply with the *Not-for-Profit Corporations Act, 2010* (the "**Act**") and the Corporation's Articles, By-laws, and Policies ("**Governance Documents**").

Conflicts

In accordance with the Act and the Corporation's Governance Documents, I make the following disclosure:

I have an interest, directly or indirectly, in the following entities, persons, or matters, which includes entities in which I am a Director or Officer (please indicate *not applicable* if you have no conflicts to declare):

This disclosure is a general notice of interest pursuant to the Act and the Corporation's Governance Documents, and accordingly, I should be regarded as interested in any of the above entities, persons, or matters.

I acknowledge that this disclosure is in addition to my obligations to comply with the Act and the Corporation's Governance Documents in respect of any specific conflict that may arise.

☐ I declare the above information to be true and accurate as of the date hereof.

Notice

Notice for Board and/or Board Committee meetings may be sent to me at the address set out below:

Address	
City	
Postal Code	
E-mail	
Telephone	

Name: Signature:

Date:

CODE OF CONDUCT: E-7

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2005
REVIEWED/REVISED DATE:	September 2023– Version 7

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) is committed to ensuring that in all aspects of its affairs it maintains the highest standards of public trust and integrity.

Application

This Code of Conduct applies to all Directors, including Ex-Officio Directors, and Non-Director Committee Members (NDCM). All Directors/NDCMs will complete a declaration of commitment to, and compliance with, this Code of Conduct.

Directors and NDCMs are also required to comply with the Hospital's Code of Conduct Policy which applies to all employees and volunteers.

Policy

Fiduciary Duty and Duty of Care

As a fiduciary of the Corporation, a Director/NDCM acts honestly and in good faith with a view to the best interests of the Corporation, and exercises the care, diligence, and skill that a reasonably prudent person would exercise in comparable circumstances. In so doing, a Director/NDCM supports the Corporation in fulfilling its purpose statement and discharging its responsibilities. All Directors/NDCMs, including E*x-Officio* Directors, are held to the same duties and standard of care.

A Director/NDCM does not represent the specific interests of any constituency or group. A Director/NDCM acts and makes decisions that are in the best interests of the Corporation as a whole.

Exercise of Authority

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

A Director/NDCM adheres to the purpose statement and values of the Corporation, applicable law, the By-Laws, and Board-approved policies.

Conflict of Interest

Every Director/NDCM must comply with the conflict of interest provisions in the *Not-for-Profit Corporations Act, 2010* (the "**Act**"), the By-laws, and Board-approved policies.

Confidentiality

Every Director/NDCM must respect the confidentiality of the information of the Corporation, including matters brought before the Board and all committees, keeping in mind that unauthorized disclosure or use of information could adversely affect the interests of the Corporation. Directors/NDCMs shall not disclose or use for their own purpose confidential information concerning the activities and affairs of the Corporation unless otherwise authorized by the Board.

It is recognized that the role of a Director/NDCM may include representing the Corporation in the community. However, such representations must be respectful of and consistent with the Director's/NDCM's duty of confidentiality.

Media Relations

As outlined in the Hospital's Media Relations Policy, media requests are facilitated by Communications and Public Affairs. Any Director/NDCM who is questioned by media representatives will refer such individuals to Communications and Public Affairs to ensure that the most applicable spokesperson is speaking on behalf of the organization. A representative from Communications and Public Affairs will be at all Board meetings to facilitate media requests. The Board Chair will be the designated spokesperson for issues pertaining to the Board/governance, the CEO or Chief, Communications and Public Affairs for corporate/organizational issues and the Chief of Staff (COS) for Professional Staff issues, unless otherwise directed by Communications and Public Affairs.

Board Solidarity and Director Dissent

A Director supports the decisions of the Board in discussions with persons beyond the Board, even if the Director holds another view or voiced another view during a Board discussion or was absent from the Board or Board committee meeting. In accordance with the Act, a Director who is present at a Board or Board committee meeting is deemed to have consented to any resolution passed or action taken at the meeting, unless:

(a) the Director's dissent is entered in the meeting minutes;

(b) the Director requests that their dissent be entered in the meeting minutes;

(c) the Director gives their dissent to the secretary of the meeting before the meeting is terminated; or

(d) the Director submits their written dissent to the secretary immediately after the meeting is terminated.

A Director who votes for or consents to a resolution is not entitled to dissent.

A Director who was not present at a meeting at which a resolution was passed or action taken is deemed to have consented to the resolution or action unless within seven days after becoming aware of the resolution, the director:

(a) causes their written dissent to be placed with the meeting minutes; or

(b) submits their written dissent to the secretary.

Respectful Conduct

It is recognized that Directors and NDCMs bring to the Board and its committees diverse backgrounds, skills, experience and opinions. Directors and NDCMs will not always agree with one another on issues. All discussions and interactions will take place in an atmosphere of mutual respect and courtesy, with all striving for a consensual approach to decision-making. The authority of the Board Chair and Committee Chairs will be respected by all Directors and NDCMs.

All Directors and NDCMs must be in compliance with all municipal, provincial and federal laws and conduct themselves in a respectful, lawful manner.

Director - Management Interactions

In all interactions with the CEO and COS, Directors and NDCMs will do so within the scope of the Board's authority, recognizing the lack of authority vested in the individuals except when explicitly Board authorized. Directors and NDCMs will respect the responsibilities delegated by the Board to the CEO and COS, avoiding interference with their duties.

Time and Commitment

Directors and NDCMs are expected to commit the time required to fulfill Board and Committee responsibilities, including preparation for and attendance at meetings/Board events, as well as attendance at the Corporation's public events when possible. Those who fail to meet the attendance and participation requirements as outlined in the Roles and Responsibilities as an Elected and Ex-Officio Director Policy or the Non-Director Committee Member Policy will be subject to review by the Board Chair and may be asked to step down from the Board or Committee.

<u>Obtaining Advice of Counsel</u>

Requests to obtain outside opinions or advice regarding matters before the Board must be made through the Board Chair.

<u>Process for Breach of the Code of Conduct</u>

(a) The matter shall be referred to the Board Chair or where the issue may involve the Chair, to the Vice-Chair, with notice to the CEO.
(b) The Board Chair (or Vice-Chair, as the case may be) may either:
    (i) attempt to resolve the matter informally; or
    (ii) refer the matter to either the Executive Committee or to a special committee of the Board established by the Board Chair (or Vice-Chair, as the case may be) which shall report to the Board.

(c) If the Board Chair or Vice-Chair elects to attempt to resolve the matter informally and the matter cannot be resolved to the satisfaction of the Board Chair (or Vice-Chair as the case may be), the Director/NDCM referring the matter, and the Director/NDCM involved, then the Board Chair or Vice-Chair 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 the matter referred cannot be resolved to the satisfaction of the Board (by simple majority resolution) or if a breach of conduct has occurred, a Director/NDCM may be asked to resign or may be subject to removal pursuant to the By-laws and the Act.

All Directors have an obligation to report a breach of the code of conduct or any illegal behavior.

Monitoring

Method and Frequency:

1. Board Evaluation
2. Review of the Policy (annually)
3. Accreditation Report and Survey (timing aligned with Accreditation cycle)

NOMINATIONS PROCESS: E-8

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	March 2009
REVIEWED/REVISED DATE:	September 2023 – Version 10

Purpose

To ensure that the Board of Directors is comprised of individuals who possess the skills, qualities, experience, knowledge and diversity to collectively contribute to effective Board governance, this policy describes the process, practices and selection criteria to be applied to ensure an inclusive, systematic, transparent, accountable and equitable nominations process.

Board Composition

In accordance with the Corporation's articles, by-laws, and the *Public Hospitals Act*, the Board shall consist of seventeen directors; twelve elected directors and five *ex-officio* non-voting directors. The *ex-officio* directors shall be the President and Chief Executive Officer, Chief Nursing Executive, Chief of Staff, President of the Professional Staff and Vice-President Professional Staff, Rural Health.

Term of Office

An Elected Director is elected to the Board for a term of three years and may serve for a maximum of three terms (nine years). *Ex-officio* Directors are members of the Board by virtue of their position within the Corporation and serve on the Board according to the applicable terms of the particular office. In order to adhere to the requirements of the *Public Hospitals Act,* in which four directors must retire (subject to re-election) each year, Director appointments will be staggered and any mid-term vacancy will be filled by the Board for the balance of the vacated term.

Process

This policy sets out the process to nominate:

- Directors
- Non-Director Committee Members (NDCMs)
- Board Officers
- Board Committee Chairs/Committee Vice-Chairs

In recommending the slate of nominees for election and appointment to the Board, the Governance & Nominating Committee shall:

1. canvass all existing Directors/NDCMs to ascertain their interests in being considered for a Board Officer position, Committee Chair/Vice-Chair position, and preferred committee assignment.

2. review the current Board Matrix to identify gaps and needs in knowledge, skills, experience and diversity.

3. recruit candidates for the Board and Board Standing Committees, using means including but not limited to advertising in local media and on the hospital's website, and communication to partner organizations in the community.

4. invite formal applications by requesting that all candidates complete the required application form.

5. provide information for potential candidates through presentations, written documentation and/or the BWH website, to address an overview of BWH, the Board and individual Director and NDCM roles, responsibilities, accountabilities and expectations, and to address questions.

6. recommend membership for the Nominating Sub-Committee comprised of:
    a. The Board Chair (Chair of Nominating Committee)
    b. The President & CEO
    c. Minimum of three (3) current Directors

    An individual whose term as Director is expiring and who intends to apply to serve for a further term shall not be a member of the Nominating Sub-Committee, with the exception of the Board Chair and the Board Vice-Chair if they expect to be the Board Chair the following year. Efforts shall be made to diversify the Nominating Committee membership. In the event a member(s) is seeking election as a Board Officer or Standing Committee Chair/Vice-Chair, the Committee will exclude the member(s) from Committee deliberations in relation to these positions.

The Nominating Sub-Committee will:

7. receive a report from the Board Chair confirming the current Directors/NDCMS (incumbents) eligible for recommendation to the Board of Directors, and subsequently to the Members of the Corporation. Incumbents eligible for re- election are not automatically reappointed, and are subject to a performance-based re-election process as outlined below. Considerations include:

    a. the individual's performance during their term, while balancing the need to ensure ongoing expertise on the Board and committees and the need to plan for the succession of the Board Officer positions

    b. potential to assume a Board Officer position

    c. Board meeting and committee meeting attendance

    d. effective communication, including contributions at Board and committee meetings and on behalf of the Board where requested

    e. preparation prior to Board and committee meetings

    f. ability to express a dissenting opinion in a constructive manner

    g. support for Board decisions and policies once established

h. commitment to continuing education and development and ability to integrate continuing education and development into Board deliberations

i. compliance with the governing legislation, by-laws and policies particularly related to conduct, conflict of interest and confidentiality

j. commitment to and support for BWH's purpose statement and values

k. individual/peer evaluation results

8. Where incumbents receive a positive performance appraisal, the Nominating Committee uses its discretion in balancing the need for continuity of experienced Board members and orderly succession planning, against the need for knowledge, skills, experience and diversity on the Board in recommending the number of Director/NDCM vacancies.

9. Review the Board applications received and:

- identify a short list of candidates using the Nomination Guidelines for Selection of Directors and NDCMs (Appendix A) and the Board Skills, Knowledge and Diversity Matrix as a guide. The Nominating Committee may recommend incumbents without an interview.

- where the number and quality of applicants is insufficient to meet the Board's succession planning needs, the Committee may recommend the recruitment period be extended.

10. invite one (1) or more BWH Patient Experience Partners to join the Nominating Sub-Committee interview panel, to conduct structured interviews with selected candidates.

11. obtain a police criminal record check, including vulnerable sector screen, and a Health Clearance in accordance with BWH volunteer requirements, for the candidates considered for nomination. Communicate with all candidates selected and not selected for inclusion on the slate of nominees.

12. recommend nominees for election to the Board of Directors including rationale for selection for approval by members of the Corporation at the Annual Meeting of the Corporation. The Committee has discretion to recommend only incumbents to the Board for approval.

    If the number of candidates equals the number of vacancies, subject to the *Not-for-Profit Corporations Act, 2010,* the members may be asked to vote for or against the slate and, if such a vote does not carry, the vote shall take place for or against each nominee individually. If one or more recommended candidates are not elected, the Board shall determine an appropriate process to bring new candidates forward for election.

13. recommend the Board Officers, Standing Committee Chair/Vice-Chair positions, and assignment of Directors/NDCMs to Standing Committees to the Board of Directors for approval at its first meeting following the Annual Meeting of the Corporation. See Selection Guidelines for Board Leadership and Standing Committee Appointments (Appendix B).

Monitoring

Method and Frequency:

1. Board Evaluation
2. Individual Director/NDCM Evaluations
3. Committee Evaluation
4. Chair Evaluations
5. Review of policy (annually)
6. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

APPENDIX A

NOMINATION GUIDELINES FOR SELECTION OF DIRECTORS & NON-DIRECTOR COMMITTEE MEMBERS

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1. Balance within the Board

- The Board of Directors, as a whole, should be credible, capable, experienced and well able to govern the organization.
- The membership of the Board and its committees should be drawn widely to achieve a balance of skills and expertise needed for the Board to fulfill its governance roles and responsibilities.
- The overall composition of the elected Directors should ensure a balance of perspectives and reflect the diversity of the residents of Lambton County. For the purpose of this policy, diversity considerations include: business and other experience, gender identification, age, disability, sexual orientation, geographic representation, Indigenous status, and ethnicity.

2. Profile of a Director or Non-Director Committee Member

The generic qualities/personal attributes expected of all Directors and Non-Director Committee Members include**:**

- commitment to the Bluewater Health Purpose Statement, Values and Strategic Plan
- experience in and understanding of governance including the roles and responsibilities of the Board and individual Directors and the difference between governance and management
- enthusiasm for the role and its demands
- personal and professional integrity, wisdom, and judgement
- high ethical standards
- strong interpersonal and communication skills
- financial literacy
- understanding of fiduciary duty
- ability to exercise sound judgment
- ability to work positively, cooperatively and respectfully and communicate effectively as a member of the team with other members of the Board and senior management
- ability to provide wise counsel and ask relevant questions at a strategic level
- ability to participate assertively in deliberation and group processes
- ability and willingness to commit the necessary time to participate in Board and/or committee meetings, meeting preparation, Board orientation and continuing education, retreats, and Bluewater Health activities/events
- commitment to comply with the Bluewater Health conflict of interest policies
- ability and willingness to represent Bluewater Health as required.

3. Board Profile

Beyond the generic qualities/personal attributes expected of all Directors as outlined in the Profile of a Director, the members of the Board will collectively possess specific skills, expertise and experience including but not limited to:

- Board and Governance
- Quality and Performance
- Health Care System and Patient Care
- Finance and Accounting
- Transformation and Innovation
- Community and Government Relations
- Enterprise Risk Management
- Legal/Law
- Strategic Planning
- Business and Management
- Human Resource Management
- Information Technology
- Board Leadership/Leadership
- Equity, Diversity and Inclusion
- Construction and Project Management

APPENDIX B

SELECTION GUIDELINES FOR BOARD LEADERSHIP AND STANDING COMMITTEE APPOINTMENTS

The Board seeks to achieve and maintain diversity in the membership of its Committees and in Board leadership roles. The Nominating Committee will consider diversity when recommending Board leadership and Standing Committee assignments.

Chair Position

The incoming Chair shall:

- be a current member of the Board
- be approved by the Board at least one year prior to the conclusion of the current Board Chair's term
- serve as a Vice-Chair until the commencement of their own term
- possess the skills, attributes and experience as outlined in the Board Chair Position Description

Vice-Chair, Treasurer, Committee Chair and Vice-Chair Positions

- The nominee shall:
- be a current member of the Board
-
- possess the skills, attributes and experience as outlined in the position descriptions below:
  - Board Vice-Chair Position Description
  - Treasurer Position Description
  - Committee Chair/Committee Vice-Chair Position Description

The Committee will discuss and consider the results of Director/Peer/Chair Evaluations, input from the members of the Board of Directors and the Bluewater Health executive leadership team before making a recommendation for the positions to the Board for approval. Where there are multiple candidates for the position of the Board Vice-Chair, the Nominating Sub-Committee will consult each Board Director to determine their views on the candidates for leadership in formulating their recommendation to the Board of Directors. It is preferred that nominees serve on all Board Standing Committees prior to being recommended for a Board leadership position.

Standing Committee Assignments

In nominating Directors and NDCMs for appointment to Standing Committees, the Nominating Sub-Committee will take into account:

1) preference of Directors and NDCMs
2) balance of skills and expertise
3) prior experience and relation to matters before the Committee
4) the expectation that each Director serve on the Quality Committee at least once over their first term, and serve on at least three (3) different Board Standing Committees over the course of any subsequent term as a Director
5) that each Committee include at least three (3) elected Directors
6) that Directors should comprise a majority of all the members of the Standing Committees per the Corporate By-law of BWH

7) other criteria as determined by the Board

BOARD ORIENTATION AND ONGOING DEVELOPMENT: E-9

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2009
REVIEWED/REVISED DATE:	September 2023 – Version 7

Purpose

As part of its responsibility for ensuring board effectiveness, the Board of Bluewater Health (BWH) recognizes orientation of the Board of Directors is an important requirement of effective governance and is essential Directors and Non-Director Committee Members (NDCMs) be fully informed with respect to the background and context of the issues they are called upon to address. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board of Directors delegates responsibility to the Governance and Nominating Committee for orientation of new Directors and NDCMs and ongoing Board development. The Chair of each Board Committee is expected to take an active role in the orientation process, specifically with respect to the mandate and Terms of Reference of the Committee which they chair.

Taking into account learning needs, an orientation/education program will be established each year that is consistent with the Board's priorities and work plan for that year, and current and emerging healthcare, hospital and governance issues.

Directors are legally responsible for the discharge of their duties as soon as they are elected or appointed to the Board of Directors.

Director and NDCM Orientation

Orientation for new Directors/NDCMs will take place in a timely manner as soon as practical after the Annual Meeting. Each Director/NDCM is expected to participate in an initial orientation process and ongoing Board education events.

Directors/NDCMs have a duty to be knowledgeable about the affairs of the hospital and their obligations. The hospital requires Directors/NDCMs to demonstrate a firm commitment to continuing education by participating in Board orientation, committee orientation, and ongoing Board education. This commitment is a factor that is considered in the election or re-election of a Director/NDCM of the Board.

Orientation will include, but not be limited to:

- Tours of BWH, Sarnia and Charlotte Eleanor Englehart Hospital of BWH
- An overview of BWH within the context of the healthcare environment, including the Ministry of Health, Ontario Health, Sarnia-Lambton Ontario Health Team, and related health service providers and community partners

- An overview of BWH operations, programs, human resources and finances
- Corporate By-laws
- Board policies
- Fundamentals of hospital governance
- Governance Model and Board Roles and Responsibilities
- Responsibilities of individual Directors
- Legal duties and protection of Directors
- Hospital partnerships, stakeholders and key relationships
- Professional Staff – organization, leadership, committees, credentialing, etc.
- Strategic Planning
- Performance Measurement – quality of care, financial management, resource utilization, accreditation, performance indicators
- Patient and Family-Centred Care
- Ethics Framework
- Community engagement, communications and media relations
- Capital Planning and Projects
- the Foundations

Participants will evaluate the orientation program upon completion. Orientation evaluation results will be used to ensure that orientation is responsive to Director/NDCM needs and expectations.

Board Portal

Directors and NDCMs will be provided with access and orientation to the Board portal which has a variety of information (e.g. Board and Standing Committee information, By-laws, strategic plan, Board orientation and education materials, Accreditation reference material, Ontario Hospital Association (OHA) Governance Centre of Excellence publications and resources) to support them in fulfilling their roles effectively and maximizing their contribution to the Board. Directors and NDCMs are encouraged to make maximum use of the Board portal and to provide feedback to management on updates and improvements that may be desirable.

Committee Orientation

The Chair and management lead of each Board committee will ensure that an orientation is provided to new committee members. This orientation will include a review of the Committee's terms of reference, membership, meeting schedule, work plan, meeting agenda, committee/meeting processes, resources, meeting preparation and participation, Balanced Scorecard/performance indicators and other relevant information specific to the Committee's mandate.

Board Development

The Governance and Nominating Committee in consultation with the President and CEO (CEO) will develop an ongoing Board education program each year that is consistent with BWH's strategic priorities and the Board's priorities and work plan for that year. It is expected that each Director (including the *ex officio* Directors) and each NDCM will participate in this education program, with participation reviewed and feedback provided on an annual basis through the Governance and Nominating Committee.

Components of the ongoing development may include:

- specific information/education sessions provided at Board or Committee meetings
- relevant education offerings sponsored by organizations other than BWH with written approval of the Board Chair
- Annual Board Retreat to review the Strategic Plan to ensure progress is being made towards its achievement. Additionally, the retreat should focus on other relevant areas within the Board Roles and Responsibilities and the Board's work plan.

Ontario Hospital Association (OHA) Education Sessions & Programs

Directors and NDCMs are encouraged to participate in educational programs offered by the OHA's Governance Centre of Excellence and other similar organizations where relevant and practical. Information regarding educational offerings will be provided to Directors and NDCMs and they will be encouraged to attend programs pertinent to their individual development needs.

Specifically, new Directors are expected to complete the OHA's Essentials Certificate in Hospital Governance for New Directors within their first year on the Board..

Board Education/Development Approval Process

Requests to attend a conference should be forwarded to the Senior Executive Assistant for the approval of the Chair. In determining whether to grant such approval, the Chair shall consider:

- The individual's development needs
- The position served by the individual on the Board or its Committees
- The cost of the program in relation to the budget provided for that purpose
- The importance of ensuring reasonable equity in educational opportunities among the individual Directors and NDCMs.

Expenses

Reasonable expenses incurred attending and participating in approved educational events will be reimbursed in accordance with the Director and NDCM Reimbursement Policy.

Mentoring

The Board will support a mentoring process by ensuring that a supportive and welcoming environment for new Directors and NDCMs is in place. Through this process, more experienced Directors, depending upon their knowledge base and comfort level, will be assigned as mentors and be available to offer advice and support with respect to questions or concerns the new Director or NDCM may have with the hospital's, Board's or Committee's functioning, governance processes and external environment. The needs of each new Director and NDCM will vary and the role and time involved by the mentor(s) will vary accordingly. Resource information to support the mentoring process will be located on the Board portal.

Education Needs Assessment & Monitoring

The Governance and Nominating Committee is responsible for Board development, effectiveness and evaluation. Directors and NDCMs will be encouraged to share their

development needs and achievements on the Board, Individual Director, NDCM or Committee evaluations, as appropriate.

A request for an education session on a particular topic may be brought forward to the Chair or the administrative lead of the Governance and Nominating Committee. Reasonable efforts will be made to accommodate such requests.

Knowledge Transfer/Reporting

Directors are required to report back at the appropriate Board Committee to share information/best practice processes acquired at education session.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Evaluation of Board Orientation program (annually)
3. Board Evaluation (annually)
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

TERMS OF REFERENCE
GOVERNANCE AND NOMINATING COMMITTEE: E-10 i

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2009
REVIEWED/REVISED DATE:	September 2023 – Version 14

Role

To ensure processes and policies are in place to support effective functioning of the Board.

Responsibilities

The Governance and Nominating Committee shall ensure processes are established and monitored for:

1. **General Governance matters including**:

   A. ensuring the governance framework is in place and regularly updated to reflect the current circumstances including reviewing, guiding and/or recommending to the Board on:
      i. the establishment of the Board member nomination and selection processes in accordance with the Guidelines for Selection of Directors and Non-Director Committee Members (NDCMs)
      ii. Board and committee structure
      iii. By-laws and policies
      iv. Board orientation and continuing education program
      v. Board evaluation

   B. ensuring that strategic planning is conducted on a regular basis and monitoring the outcomes of the strategic planning process

   C. developing and monitoring a plan to achieve compliance with the governance standards of Accreditation Canada

   D. ensuring that the hospital has a communication and community engagement plan and monitors its effectiveness on a regular basis

   E. reviewing and recommending community collaborations that improve healthcare services, enhance program performance, integrate service delivery in Sarnia-Lambton and advance or support the hospital's Strategic Plan

   F. developing an annual work plan that fulfills the responsibilities of the Committee, for approval by the Board

G. performing such other tasks as outlined in the by-laws or requested by the Board

2. Board Nominations including:

A. preparing a slate of nominees for recommendation to the Board and election by the members of the Corporation of a sufficient number of individuals to fill the vacancies on the Board.

B. recommending for election by the Board:

i. a slate of officers
ii. Directors to serve as Chairs/Vice-Chairs of Board Standing Committees;
iii. Directors and NDCMs to serve as members of Board Standing Committees.

Accountability

The Governance and Nominating Committee is accountable to the Board.

Administrative Lead

Chief, Communications and Public Affairs

Committee Composition

Elected Directors (5)
Ex-Officio Directors (2)
President/CEO
President of the Professional Staff Association (PSA)

All committee members have voting privileges. The chair of the Committee does not vote unless necessary to break a tie.

Directors are appointed to committees annually, in accordance with the Board Nominations Policy. Terms of the ex-officio Directors on the committee are for the period of time they hold these positions. The Committee may designate a sub-committee for the Nominations work which may include non-Directors and need not include all of the members of the Committee.

Quorum

Quorum shall consist of a majority of the Committee members. The chair of the Committee meeting is included in computing a quorum.

Meetings

A minimum of seven (7) times per year.

Communication

Minutes will be maintained. Reports will be circulated to the committee and to the Board.

Evaluation

The Governance and Nominating Committee shall annually evaluate its effectiveness in meeting its work plan objectives and fulfilling its designated responsibilities, as set forth by the Board.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Board Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

TERMS OF REFERENCE
EXECUTIVE COMMITTEE: E - 10 ii

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2005
REVIEWED/REVISED DATE:	September 2023 – Version 11

Role

To act as a body with delegated authority to make certain decisions binding on the Corporation on matters of administrative urgency where the Board of Directors (the "Board") is unable to convene in a timely manner; provided that, in accordance with the *Not-for-Profit Corporations Act*, the Executive Committee may not exercise any of the following Board powers:

- submitting to the members any question or matter requiring the approval of the members;
- filling a vacancy among the Directors or in the position of Auditor;
- appointing additional Directors;
- issuing debt obligations, except as authorized by the Directors;
- approving the financial statements of the Corporation;
- adopting, amending, or repealing the By-laws of the Corporation; and
- establishing contributions to be made, or dues to be paid, by the members.

Responsibilities

The Executive Committee shall:

- Develop a process to oversee performance, compensation, and succession planning for the President and Chief Executive Officer (CEO) and Chief of Staff (COS) by:
  - developing a position description for the CEO/COS for Board approval;
  - overseeing CEO/COS recruitment, selection, and succession planning, including oversight of emergency and long-term term succession plans to be reported to the Board annually;
  - reviewing and recommending to the Board the CEO/COS's annual objectives;
  - developing and conducting a process to review the performance of the CEO/COS and reporting the results to the Board; and
  - recommending CEO/COS compensation for Board approval.
- Oversee CEO/COS supervision of management and management succession plans.
- Undertake such other activities as may be authorized by the Board, from time to time.

Accountability

The Executive Committee is accountable to the Board and shall report to the Board on the outcome of any decisions made, and the reason for addressing at the Executive Committee level at the earliest opportunity.

Administrative Lead

President and Chief Executive Officer

Committee Composition

Board Chair, who shall serve as the Committee Chair
Vice-Chair
Chairs of each Board Standing Committee
President and Chief Executive Officer (E*x-officio* non-voting)
Chief of Staff (E*x-officio* non-voting)
President of the Professional Staff Association (E*x-officio* non-voting)

Pursuant to Regulation 965 under the *Public Hospitals Act* as amended by O. Reg. 156/10, any member of the Executive Committee who is an employee or member of the Professional Staff of the Hospital shall not be entitled to vote at meetings of the Executive Committee.

Quorum

A quorum shall consist of a majority of the voting members. The Chair of the Committee meeting is included in computing a quorum.

Meetings

Meetings of the Committee shall be scheduled at the call of the Executive Committee Chair.

Communication

Minutes will be maintained. Reports will be circulated to the committee and to the Board.

Resources

The CEO shall provide the Executive Committee with appropriate resources to perform its mandate.

Monitoring

Method and Frequency:

1. Review of the Terms of Reference (annually)
2. Board Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

TERMS OF REFERENCE
JOINT CONFERENCE COMMITTEE: E - 10 iii

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	October 2001
REVIEWED/REVISED DATE:	September 2023 – Version 10

Role

The role of the Joint Conference Committee is to facilitate communication among the Professional Staff Association, the Board, and senior management.

Responsibilities

The Joint Conference Committee shall serve as a forum in which the members may:

i. exchange and discuss ideas, opinions and concerns of interest;
ii. explore new ideas and concepts and seek comments from other members;
iii. achieve understanding on points of interest to the Board, the Hospital's management, and the Professional Staff; and
iv. raise concerns that have not been satisfactorily addressed in other venues with a view to determining an appropriate forum for their resolution.

Accountability

The Joint Conference Committee is accountable to the Board.

Administrative Lead

Chief Executive Officer

Committee Membership

The Joint Conference Committee shall consist of the following membership groups:

i. the Chair, Vice-Chair and Treasurer of the Board,
ii. the President, both Vice-Presidents and the Secretary-Treasurer of the Professional Staff Association,
iii. the Chief Executive Officer, the Chief of Staff, the Chief Nursing Executive and the Vice-President (s).

The Chair may invite guests to attend meetings of the Committee.

Chairperson

The Chair of the Committee shall be the Chair of the Board.

Quorum

A quorum shall be a majority of the members of the Committee, including at least one member from each of the membership groups. The chair of the Committee meeting is included in computing a quorum.

Meetings

Meetings of the Committee shall be scheduled at the call of the Chair and upon request of any two members of the Committee.

Communication

As the purpose of the Committee is to facilitate communication among the parties, in order to realize this:

- any member may raise an issue for the consideration of the Committee
- there must be meaningful representation and participation among all three groups
- minutes will be maintained for follow-up purposes and circulated to Committee members and the Board; and
- the Committee shall report on the nature of the discussions to the Board, Medical Advisory Committee and the Professional Staff Association.

Monitoring

Method and Frequency:

1. Review of the Terms of Reference(annually)
2. Board Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

TERMS OF REFERENCE
QUALITY COMMITTEE: E - 10 iv

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Quality Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	April 2003
REVIEWED/REVISED DATE:	November 2022 – Version 14

Role

To monitor the delivery of health care and services at Bluewater Health (BWH) and to ensure that quality improvement is an integral component of the hospital's governance and management processes.

Responsibilities

a) monitor and report to the Board on quality issues and on the overall quality of services provided at Bluewater Health, making use of appropriate data, including the critical incident data (twice annual reporting in aggregate) and the Medical Advisory Committee's recommendations related to systemic or recurring quality of care issues at the hospital (*Public Hospital's Act Regulation 965* requirements)

b) recommend to the Board the long-term objectives for quality at Bluewater Health and annual quality goals and specific quality indicators to be monitored by the Board and the Committee

c) provide oversight for the preparation of the annual Quality Improvement Plan (QIP) for recommendation to the Board

d) receive *Quality of Care Information Protection Act* (QCIPA) and Quality Care Review recommendations in aggregate twice per year

e) review and monitor the quality and patient safety processes and indicators established by management related to programs and services provided by Bluewater Health

f) consider and make recommendations to the Board regarding quality improvement initiatives and policies

g) monitor Integrated Risk Management (IRM) annually

h) ensure that a process is in place for sharing best practices information that is scientific, evidence-based with hospital and Professional staff and for monitoring its use within Bluewater Health

i) consider the quality implications of budget proposals and make appropriate recommendations to the Board

j) receive periodic reports from the hospital's Quality Interprofessional Practice Patient Experience Committee

k) review quality reports and monitor their compliance with the requirements of internal and external standard-setting bodies, such as Accreditation Canada, the Ontario Health Quality Council and the Canadian Patient Safety Institute (CPSI)

l) monitor hospital-wide policies, processes and programs to prepare and protect Bluewater Health from foreseeable and significant risks related to the quality and safety of service delivery

m) review and report periodically to the Board on the outcomes of stakeholder satisfaction surveys and issues to be addressed

n) review, evaluate and make recommendations to the Board on litigation matters, based on appropriate input from management
o) monitor the preparation processes for Bluewater Health's accreditation survey by Accreditation Canada and monitor implementation of relevant recommendations arising from the survey
p) monitor hospital-wide policies, processes and programs for research, research ethics and clinical ethics and make recommendations to the Board, as appropriate
q) recommend to the Board recognition for quality improvement work and new quality initiatives
r) monitor compliance with Ministry of Health regulation or policy changes and make recommendations to the Board as required
s) develop an annual work plan of goals and objectives that fulfills the responsibilities of the Committee, for approval by the Board
t) perform such other tasks as outlined in the by-laws or requested by the Board

Administrative Lead

Chief Nursing Executive (CNE)

Committee Composition

Minimum of five (5) Elected Directors
Up to Two (2) Non-Director Committee Members
Two (2) Patient Experience Partners
President/Chief Executive Officer (CEO)
Chief of Staff (COS)
Chief Nursing Executive (CNE)
One (1) member of the Professional Staff Association Executive
One (1) employee of the Hospital other than a physician or a nurse
One (1) member of the Professional Staff

All committee members have voting privileges. The chair of the Committee does not vote unless necessary to break a tie.

Directors are appointed to committees annually, in accordance with the Nominations Process Policy. Non-Director Committee Members are selected through the Board nominations process and serve one year terms, renewable up to total of five years. The CEO, CNE, and COS are ex-officio Directors and, as such, their terms are for the period of time they hold these positions. Hospital employee and Professional Staff positions are selected through processes established by the CEO, CNE and the COS respectively and appointed for one year terms with possibility of renewal up to total of five years. The Patient Experience Partners (PEPs) will be selected by the Patient Experience Partner Council. The Chair is a voting member of the Board of Directors and appointed by the Board of Directors.

Quorum

Quorum shall consist of a majority of the Committee members, including at least one Committee member who is also an elected Director per the By-laws.

The chair of the Committee meeting is included in computing a quorum.

Meetings

Minimum of seven (7) times per year.

Communication

Minutes will be maintained. Reports will be circulated to the committee and to the Board.

Evaluation

The Quality Committee shall evaluate its effectiveness in meeting its work plan objectives and designated responsibilities as set forth by the Board.

Monitoring

Method and Frequency:

1. Review of the Terms of Reference (annually)
2. Board Evaluation
3. Review of Quality Program and its outcomes (quarterly)
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

TERMS OF REFERENCE
RESOURCE UTILIZATION & AUDIT COMMITTEE: E - 10 v

BOARD RESPONSIBILITY	Ensure Board Effectiveness
COMMITTEE:	Resource Utilization and Audit Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2009
REVIEWED/REVISED DATE:	November 2022 – Version 11

The Resource Utilization and Audit Committee's role is to:

- oversee the Corporation's resource planning processes
- monitor the Corporation's utilization of its financial, human, capital equipment, facility; and information system resources
- oversee the integrity of the Corporation's internal accounting controls and reporting processes
- oversee the annual planning and performance of the external audit of the Corporation's books of accounts and internal controls, and review the report of the external auditor

Responsibilities

Resource Utilization:

1. Review and recommend to the Board for approval, a detailed annual budget for capital and operating revenues and expenditures for the next fiscal year.

2. Advise the Board on the preparation and negotiation of the Hospital (HAPS) and the Community (CAPS) Accountability Planning Submissions and the Service Accountability Agreement (SAA) and Multi-Sectoral (M-SAA) Service Accountability Agreement.

3. Monitor and report to the Board on the performance and compliance with the Service Accountability Agreements.

4. Monitor and report to the Board on the performance and compliance of the applicable legislation.

5. Review and recommend to the Board for approval on an annual basis a Human Resources plan for hospital staff and Professional Staff.

6. Review Bluewater Health's quarterly operating outcomes (human resource, capital and financial) and advise the Board accordingly.

7. Review the Utilization Management process for Bluewater Health, with particular emphasis on performance indicators, ensuring the Hospital is providing its services within its available resources, considering peer group benchmarking and Ontario Health defined parameters.

8. Review, evaluate and/or make recommendations to the Board, based on appropriate input from management, on other resource issues including:
   - (i) banking arrangements
   - (ii) activities and support received from co-owned and operated, regional shared service organizations
   - (iii) types and amounts of insurance (annually)
   - (iv) physical facilities and redevelopment of the Hospital buildings and structures
   - (v) investment policy for the management of the Corporation's funds (annually, with quarterly monitoring of the control and management of investments)
   - (vi) borrowing policy for the management of the Corporation's funds (quarterly monitoring of the control and management of loans)
   - (vii) forecasting and planning
   - (viii) financial stewardship principles and protocols
   - (ix) financial risk management
   - (x) revenue generating opportunities
   - (xi) litigation

Audit:

1. Review and recommend to the Board for approval at the Annual Meeting, the annual, audited financial statements of the Corporation and report to the Board prior to the Board's approval thereof.

2. Oversee the annual planning, preparation and conduct of the external audit of the Corporation's books of accounts and internal controls; and review the report of the external auditor to include but not restricted to:
   - a) reviewing the auditor's post-audit or management letter and management's response and subsequent follow-up to any identified weaknesses
   - b) meeting privately with the external auditor (without the presence of management) with regard to the adequacy of internal accounting controls and similar matters
   - c) reviewing any problems experienced by the external auditor in performing the audit, including any restrictions imposed by management or significant accounting issues on which there was a disagreement with management, or, situations where management seeks a second opinion on a significant accounting issue

3. Oversee the annual performance of the external auditor and annually recommend to the Members the appointment of licensed public accountants as the Corporation's external auditor in compliance with the applicable legislation. This function to include but not restricted to:
   - a) reviewing the factors that might impair, or be perceived to impair, the independence of the external auditor including the external auditor's independence letter;
   - b) meeting privately with senior management (without the external auditor being

present) with regard to the performance of the external auditor;

c) regularly consider tendering the auditing service to meet statutory and other requirements or at a minimum every five years

4. Receive, review, evaluate and/or make recommendations to the Board, based on appropriate input from the external auditors, other statutory bodies and management on other audit issues including but not limited to:
   a) changing the financial systems and controls during the year
   b) reviewing the integrity and effectiveness of policies regarding financial operations, systems of internal control and reporting mechanisms and that they are in accordance with Canadian generally accepted accounting principles and practices
   c) enquiring into major financial risks and the appropriateness of related controls to minimize the potential impact(s)
   d) reviewing the procedures for establishing management's remuneration and benefits, and for approving their expense reports
   e) enquiring about changes in professional standards or regulatory requirements
   f) enquiring into any major control deviations and detection of fraud

5. Notice of the time and place of the Committee meetings shall be given to the external auditor. The external auditor shall be entitled to attend Committee meetings and to be heard, and shall attend every Committee meeting if requested to do so by a Committee member

Other:

1. Develop an annual work plan of goals and objectives that fulfills the responsibilities of the Committee, for approval by the Board.

2. Prepare an annual report to the Board of Directors detailing the activities it has taken and the assistance the Committee has had in fulfilling its duties.

3. Perform such other tasks as outlined in the By-Laws or requested by the Board.

Accountability

The Resource Utilization and Audit Committee is accountable to the Board of Directors.

Administrative Lead

Vice-President Operations

Committee Composition

Elected Directors (minimum 3, maximum 7)
Non-Director Committee Members (maximum 5)
President/CEO
Chief of Professional Staff

One (1) or two (2) members of the Professional Staff Association Executive

All Committee members have voting privileges. The Chair of the Committee does not vote unless necessary to break a tie.

Directors are appointed to committees annually, in accordance with the Board Nominations Process Policy. Non-Director Committee Members are selected through the Board nominations process and serve one-year terms, renewable up to total of five years. The terms of the ex-officio Directors who are Committee members are for the period of time they hold these positions.

The Committee when sitting as the Audit Committee shall not include members of management or the Professional Staff and need not include all members of the Committee.

At least two members of the Committee must have formal education and work experience in the professional accounting and/or finance fields.

Quorum

Quorum shall consist of a majority of the Committee members, including at least one Committee member who is also an elected Director per the By-Laws.

The Chair of the Committee meeting is included in computing a quorum.

Meetings

Resource Utilization – The Committee meets a minimum of seven (7) times annually.

With respect to the Audit function of the Committee, meeting are held at the call of the Chair. Meetings may also be held at the call of the external auditor and/or Committee member in accordance with the *Ontario Not-for-Profit Corporations Act, 2010*

Communication

Minutes will be maintained. Reports will be circulated to the Committee and to the Board.

Evaluation

The Resource Utilization and Audit Committee shall evaluate its effectiveness in meeting its work plan objectives and designated responsibilities as set forth by the Board.

Monitoring

Method and Frequency:

1. Review of the Terms of Reference (annually)
2. Board Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

BOARD CHAIR POSITION DESCRIPTION: E-11

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2005
REVIEWED/REVISED DATE:	September 2023– Version 9

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) will establish, approve and periodically review a position description for the Board Chair. This description is an important requirement of effective governance as it provides the Chair and all Directors and Non-Director Committee Members (NDCMs) with a clear understanding of what is expected of this position and serves as a benchmark against which the performance of the Chair can be assessed. This policy sets out the position description of the Board Chair as developed and approved by the Board of BWH.

Policy

Role Statement

The Board Chair, working collaboratively with the President/CEO and the Chief of Staff (COS), provides leadership to the Board, ensures the integrity and effectiveness of the Board's governance role and processes and represents the Board within the hospital and to outside parties.

The Board Chair co-ordinates the activities of the Board in fulfilling its governance responsibilities and facilitates co-operative relationships among Board and NDCMs, between the Board and President/CEO and the Board and COS and with internal and external stakeholders.

The Board Chair ensures that all matters relating to the Board's mandate are brought to the attention of, and discussed by, the Board.

Responsibilities:

Board Governance:

Through the work of the Governance and Nominating Committee, ensures the quality of the Board's governance processes including that:

- the Board's governance structures and processes are reviewed, evaluated and revised, as required
- the Board performs a governance role that respects and understands the role of management

- the Board develops and implements annual priorities and a work plan aligned with the hospital's purpose statement, values and strategic priorities and embrace continuous improvement
- the work of the Board committees is aligned with the Board's role and annual work plan and the Board respects and understands the role of Board committees
- Board succession planning through processes to recruit, select and educate Directors and NDCMs with the skills, experience, background and personal qualities required for effective governance
- Board members have access to appropriate orientation and education
- Constructive feedback is provided to Committee Chairs, Directors and NDCMs, as required, to foster continuous improvement

Board Meetings:

- Ensure a schedule of Board meetings is prepared annually and is reflective of current Board issues, needs and/or interests
- Establish agendas for Board meetings in collaboration with the President/CEO that are aligned with the Board's roles, annual priorities, work plan and current issues
- Preside over meetings of the Board and Executive Committee
- Ensure that meetings are conducted according to applicable legislation, By-laws, governance policies and Rules of Order
- Facilitate and advance the business of the Board, ensuring that meetings are effective and efficient for the performance of governance work
- Encourage input and ensure that the Board hears all sides of a debate or discussion.
- Encourage all Directors to participate in the discussions
- Ensure relevant information is made available to the Board in a timely manner, and that external advisors are available to assist the Board as required

Direction:

Serve as the Board's central point of official communication with the President/CEO and COS

- Guide and counsel the President/CEO and COS regarding the Board's expectations and concerns
- Serve as a resource to the President/CEO and COS at their request
- In collaboration with the President/CEO, develop standards for Board decision-support documents that include formats for reporting to the Board and the level of detail provided to ensure that BWH management strategies and planning and performance information are appropriately presented to the Board

Performance Evaluation:

- Lead the Board in monitoring and evaluating the performance of the President/CEO and COS through an annual process

Representation:

- Ensure the Board is appropriately represented at BWH functions, other official functions and to the community and public at large
- Serve as the Board's exclusive official spokesperson and contact with the media, unless otherwise delegated

Relationships and Mentorship:

- Facilitate relationships with, and communication among Directors and NDCMs and between Directors, NDCMs and the President/CEO and COS
- Provide assistance and advice to committee Chairs to ensure they understand Board expectations and have resources required to fulfill their Terms of Reference
- Serve as a mentor to other Directors and NDCMs to ensure that each is supported and contributes their skills and expertise effectively in the performance of their roles
- Provide feedback to individual Directors and NDCMs on performance, including addressing issues associated with underperformance, in order to facilitate continuous improvement
- Maintain a constructive working relationship with the President/CEO and COS providing advice, counsel and an understanding of Board expectations

Reporting:

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

Board Conduct:

- Set a high standard for Board conduct and enforce by-laws and policies regarding Director and NDCM conduct

Succession Planning:

- Ensure succession planning occurs for the President/CEO, COS and the Board and its Standing Committees.

Committee Membership:

- Serve as an Ex-officio member of all Board standing committees, sub-committees and special committees (but not generally be expected to participate in their work and deliberations)

Skills, Attributes and Experience

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

- All of the personal attributes required of a Director
- Substantial governance experience in the hospital, not-for profit or broader public sector, preferably as a Board Chair
- Demonstrated leadership skills
- Strategic and facilitation skills
- Tact and diplomacy skills
- Ability to effectively influence and build consensus within the Board
- Ability to establish trusted advisor relationship with the President/CEO, COS and other Directors and NDCMs
- Ability to make the necessary time commitment and required flexibility in work schedule to meet the requirements of this leadership role

- Ability to communicate effectively with the Board, Senior Management, the Ministry of Health, Ontario Health, the Sarnia-Lambton Ontario Health Team and the community
- Demonstrated commitment to continuous learning and self-development in areas of skills and expertise required by the Board and that will enhance Board effectiveness
- Demonstrated commitment to the Principles of Governance and Board Accountability

Term

The Board Chair shall be elected by the Board to serve a two-year term. Following completion of the two-year term, the individual may be re-elected for a further one-year term.

Monitoring

Method and Frequency	1. Board Evaluation 2. Review of the Policy (annually) 3. Accreditation Canada Survey and Report (timing aligned with Accreditation cycle)

BOARD VICE-CHAIR POSITION DESCRIPTION: E-12

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2009
REVIEWED/REVISED DATE:	September 2023 – Version 5

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) will establish, approve and periodically review a position description for the Board Vice-Chair. This description is an important requirement of effective governance as it provides the Vice-Chair and all Directors and Non-Director Committee Members (NDCMs) with a clear understanding of what is expected of this position and serves as a benchmark against which the performance of the Vice-Chair can be assessed. This policy sets out the position description of the Board Vice-Chair as developed and approved by the Board of BWH.

Policy

Role Statement

The Vice-Chair works collaboratively with the Board Chair and supports the Board Chair in fulfilling their responsibilities.

Responsibilities

Board Chair Substitute:

Assume the duties of the Board Chair in their absence, as requested by the Chair, including representing the Board and the Hospital at official functions and to the public at large.

Board Conduct:

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

Mentorship:

Serve as a mentor to other Directors and NDCMs.

Committee Membership:

Serve as a member of the Executive Committee and at least one additional standing committee of the Board.

Skills, Attributes and Experience

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

- Hospital Board experience
- All of the personal attributes required of a Director
- Demonstrated management skills
- Strategic and facilitation skills
- Tact and diplomacy skills
- Ability to effectively influence and build consensus within the Board
- Ability to establish trusted advisor relationship with the President/CEO, Chief of Staff, other Directors and NDCMs
- Ability to make the necessary time commitment and required flexibility in work schedule to meet the requirements of this leadership role
- Ability to communicate effectively with the Board, Senior Management, the Ministry of Health, Ontario Health, the Sarnia-Lambton Ontario Health Team and the community
- Demonstrated commitment to continuous learning and self-development in areas of skills and expertise required by the Board and that will enhance Board effectiveness
- Demonstrated commitment to the Principles of Governance and Board Accountability

Term

The Vice-Chair shall be elected annually by the Board. An individual may serve a maximum of three (3) consecutive annual terms as Vice-Chair provided that the Board may approve extensions in exceptional circumstances.

Monitoring

Method and Frequency	1. Board Evaluation 2. Review of the Policy (annually) 3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

BOARD TREASURER POSITION DESCRIPTION: E-13

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2009
REVIEWED/REVISED DATE:	September 2023 – Version 6

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) will establish, approve and periodically review a position description for Board Treasurer. This description is an important requirement of effective governance as it provides the Board Chair and all Directors and Non-Director Committee Members (NDCMs) with a clear understanding of what is expected of this position and serves as a benchmark against which the performance of the Treasurer can be assessed. This policy sets out the position description of the Board Treasurer as developed and approved by the Board.

Policy

Role Statement

The Treasurer works collaboratively with the Board Chair and President/CEO to support the Board in fulfilling its fiduciary responsibilities.

Responsibilities

Board Conduct:

Maintain a high standard for Board conduct and uphold By-laws and policies regarding Director and NDCM conduct, with particular emphasis on fiduciary responsibilities.

Mentorship:

Serve as a mentor to other Directors and NDCMs.

Committee Membership:

Serve as a member of the Executive Committee and chair the Resource Utilization and Audit Committee.

Audited Financial Statement:

Present to the Annual Meeting as part of the annual report, an audited financial statement of BWH and the report thereon of the independent auditors.

Skills, Attributes and Experience

The Treasurer will possess the following personal qualities, skills and experience:

- All of the personal attributes required of a Director
- Strong financial management literacy, preferably with education and work experience in the professional accounting and/or finance fields
- Ability to make the necessary time commitment and required flexibility in work schedule to meet the requirements of this leadership role
- Ability to communicate effectively and efficiently
- Demonstrated commitment to continuous learning and self-development in areas of skills and expertise required by the Board and that will enhance Board effectiveness
- Demonstrated commitment to the Principles of Governance and Board Accountability

Term

The Treasurer shall be elected annually by the Board. An individual may serve a maximum of three (3) consecutive annual terms as Treasurer provided that the Board may approve extensions in exceptional circumstances.

Monitoring

Method and Frequency	1. Board Evaluation 2. Review of the Policy (annually) 3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

BOARD COMMITTEE CHAIR/ COMMITTEE VICE-CHAIR POSITION DESCRIPTION: E-14

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2009
REVIEWED/REVISED DATE:	September 2023 – Version 7

Purpose

As part of its responsibility for ensuring Board effectiveness, the Board of Bluewater Health (BWH) will establish, approve and periodically review a position description for Board Committee Chair/Vice-Chair. This description is an important requirement of effective governance as it provides the Committee Chair/Vice-Chair, Directors and Non-Director Committee Members (NDCMs), with a clear understanding of what is expected of the positions and serves as a benchmark against which the performance of the Committee Chair/Vice-Chair can be assessed. This policy sets out the position description of the Committee Chair/Vice-Chair as developed and approved by the Board.

Policy

Role Statement

A **Committee Chair**, working collaboratively with assigned staff support, provides leadership to the committee. They ensure the terms of reference of the committee are followed, effectively manage issues to promote effective dialogue, and respect that the committee has no direct management role with Hospital staff.

A **Committee Vice-Chair** assumes the roles and responsibilities of the Committee Chair in their absence. The Committee Vice-Chair supports the Committee Chair and assigned staff support with facilitation, coordination and communication as required; and should seek to develop an understanding of the committee's work plan in preparation to serve in the Committee Chair role.

Responsibilities

Agendas:

Establish agendas, consistent with the Board approved committee work plan, in collaboration with staff support and preside over meetings of the committee.

Leadership:

Effectively facilitate each committee meeting in a manner that encourages thoughtful participation and promotes understanding of complex issues. Ensure a fair discussion, especially when differences and conflicting opinions arise.

Expertise:

Serve as a leader within the Board on the matters addressed in the committee's terms of reference.

Advise Board Chair:

Liaise with the Board Chair on the key issues and recommendations addressed by the committee.

Report to the Board:

After each committee meeting, with the assistance of executive staff support, prepare a report and where appropriate, decision-support recommendations for consideration by the Board.

Work Plan:

With the assistance of executive staff support, develop an annual work plan that fulfills the responsibilities of the committee and is consistent with the Board work plan.

Mentorship:

Serve as a mentor to committee members and with the Board Chair, develop a succession plan for the chair role. The Committee Chair should plan for and prepare the Committee Vice-Chair to act as their alternate during any absence.

Skills, attributes and experience:

A Committee Chair/Committee Vice-Chair will possess the following personal qualities, skills and experience:

- All of the personal attributes required of a Director
- Interest and experience related to the work of the committee
- Ability to chair a meeting such that decisions are made in a manner that is respectful and efficient
- Willingness and ability to commit time to the responsibilities of the Committee Chair/Committee Vice-Chair
- Demonstrated commitment to continuous learning and self-development in areas of skills and expertise required by the Board and that will enhance Board effectiveness
- Demonstrated commitment to the Principles of Governance and Board Accountability

Term

A Committee Chair/Committee Vice-Chair shall be elected by the Board for a one (1) year term. An individual may be re-elected to chair the same committee or may be elected to chair a different committee following completion of their term.

Monitoring

Method and Frequency:

1. Board Evaluation
2. Review of the policy (annually)
3. Accreditation Canada Survey and Report (timing aligned with Accreditation cycle)

BOARD WORK PLAN AND PRIORITIES: E-15

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	March 2005
REVIEWED/REVISED DATE:	September 2023 – Version 6

Purpose

As part of its responsibility for ensuring board effectiveness, the Board of Bluewater Health (BWH) recognizes the development of an annual work plan and setting Board priorities is an important component of effective governance in order to:

1) ensure the Board meets its roles of policy formulation, decision-making and oversight
2) ensure the Board meets its responsibilities for establishing and providing strategic direction, excellent management, program quality and effectiveness, financial viability, Board effectiveness and fostering relationships
3) anticipate priority matters for consideration during the year and monitor the status of these matters
4) articulate the Board's expectations of its own contributions to the achievement of BWH's strategic priorities and goals
5) focus the work of the Board and establish benchmarks against which the Board can evaluate its performance

This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Board Work Plan

The Board work plan will address the matters to be considered by the Board during the Board meeting cycle to ensure the Board meets its roles and responsibilities and the organization meets all legislative accountabilities. On an annual basis, the Board and Board Standing Committees will establish work plans to fulfill this purpose.

Board Priorities

On an annual basis, the Board will establish priorities that are consistent with the strategic priorities and goals of the hospital, the annual operating plan and the specific objectives the Board must address in the coming year. Board priorities will be translated into the work plan to establish direction for the Board Committees.

The Board will evaluate its success in the achievement of its priorities and work plan items at the meeting of the Board of Directors prior to the Annual Meeting.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Development and evaluation of Board Priorities and Board Work Plan (annually)
3. Board Evaluation
4. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

BOARD AND BOARD COMMITTEE MEETINGS: E-16

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	February 2005
REVIEWED/REVISED DATE:	September 2023 – Version 10

Purpose

In keeping with its responsibility for fostering relationships and ensuring Board effectiveness, the Board of Bluewater Health (BWH) is committed to conducting its business in an open and transparent manner by having open Board meetings, with the exception of *in camera* sessions and special sessions as described below. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Notice of Board Meetings

A schedule of the dates, locations and times of the Board's open meetings will be established annually. The schedule will be posted on the BWH website

Reasonable efforts will be made to post the Open Board meeting agendas to the BWH website and intranet at least two (2) business days before the meeting. Open Board meeting agenda packages will be available to members of the public and staff on the BWH website and intranet by 12:00 p.m. on the day of the meeting.

Attendance at Board Meetings

Members of the public, media and staff are welcome to attend open Board meetings to:

- facilitate the conduct of the Board's business in an open and transparent manner
- ensure the hospital maintains a close relationship with the community, the media and stakeholder groups
- generate trust and accountability

Such individuals are invited to attend open Board meetings in accordance with the following procedures:

Conduct During the Meeting

Members of the public may not address the Board or ask questions without the permission of the Chair. Individuals who wish to raise issues through presentations to the Board must contact the President & CEO (CEO) in advance, in accordance with the Guidelines for Presentations to the Board. Proper and respectful meeting decorum is expected of all attendees. The Chair may require anyone who is disruptive and interferes with the proper conduct of the meeting to leave. With the exception of any recording done by BWH, or otherwise approved by the Chair, no one

shall take or transmit any photograph or video or audio recording of any portion of the Board meeting.

Guidelines for Presentations to the Board

The Board may permit members of the public to make a presentation to the Board concerning matters relevant to the hospital. Persons wishing to address the Board will follow the guidelines listed below.

1. Written notice of the request to address the Board meeting shall be provided to the CEO at least eight (8) days prior to the meeting date for an item not related to the monthly Board agenda, and at least 48 hours notice is required for items specific to the agenda posted for that meeting. The CEO will direct these requests to the Chair, who will determine whether to include the presentation on the agenda. The request shall include the identity of the person(s) proposing to address the Board (including mailing address, email address, and telephone number) and a description of the specific nature of the matter proposed to be addressed.

2. Persons not permitted to address the Board will be so notified. The Board may limit the number of presentations at any one meeting.

3. Persons addressing the Board:
   - will be notified and receive the guidelines for presentations to the Board;
   - will be required to limit their remarks to the time allocated by the Chair;
   - will be required to speak only on the subject for which they have received approval to address the Board, unless otherwise requested by the Chair during the meeting; and
   - will maintain proper and respectful meeting decorum when addressing the Board.

4. Following the meeting, the Chair will communicate in writing to the presenter or spokesperson for the delegation, acknowledging the presentation and outlining any actions to be taken by the hospital in response.

5. The Chair is not obliged to grant a request to address the Board and the Board is not obliged to take any action on any presentation it receives.

The Board may be required to limit the number of attendees at meetings if the space is insufficient.

Participation of Invited Participants at Board Meetings

The Board of BWH consists of 17 Directors (12 elected and 5 ex-officio, non-voting) who are entitled to participate in all Board meetings. The invited participants may include the officers of the Professional Staff Association who are not Directors, senior members of the hospital's leadership team, and representatives of the hospital's Foundations. The CEO shall determine which members of the senior leadership team should be present at meetings of the Board. As participants at meetings of the Board, these individuals will be required to abide by BWH Board policies.

The invited participants referred to above will generally be welcome to participate at Board meetings to the extent it is believed their contributions would be valuable to advance the business of the meeting or the Directors' understanding of any particular item of business. It is the role of the Chair to ensure that meetings are effective and efficient for the performance of governance work, and the Chair may limit participation where necessary to achieve these objectives.

The invited participants referred to above may be invited to attend *in camera* Board meetings but may be requested to leave by the Chair when issues need to be addressed by Directors only.

Board and Board Committee Meeting Agenda Development and Management of Meetings

In collaboration with the Administrative Leads, the CEO, Chair and Committee Chairs, shall establish agendas for Board and Board Committee meetings aligned with the Board's roles and responsibilities, annual Board priorities and work plan. Directors are invited to share agenda/work plan item suggestions with the Committee Chair/Board Chair for consideration.

Board agenda packages should be accurate, timely, balanced, relevant and clear, and sufficiently detailed to ensure each meeting contributes effectively to the discharge of the Board's governance role. The Chairs may assign time allocations to each agenda item and manage the Board discussion to that time allocation, and have discretion to table items to the next regularly scheduled meeting, if time considerations unduly limit any discussion.

All Board Standing Committee meetings shall be closed to the public.

Consent Agenda

The Board elects to use a consent agenda for the passage of non-controversial or routine Board business, allowing more time for education and discussion of substantial and strategic issues. Consent items are those which usually do not require discussion or explanation prior to Board action, or are items which have already been discussed or explained and do not require further discussion.

Consent agenda items may include, but are not limited to: approval of the previous minutes, approval of routine policies and procedures, reports, and correspondence. Consent agenda items must be circulated with the agenda package. Items may be moved out of the Consent agenda at the request of any member of the Board prior to approval of the agenda. No motion or vote of the Board is required with respect to moving an item out of the Consent agenda. Where a member of the Board requests that an item be moved out of the Consent agenda section, the Chair shall decide where to place that item on the agenda.

In Camera Sessions

The Board may move to an *in camera* session that is not open to the public where it determines it is in the best of the interests of the hospital to do so. The Chair may order the meeting move *in camera* or any Director may request a matter be dealt with *in camera* in which case a vote will be taken. If a majority of the Board decides the matter should be dealt with *in camera*, members of the public will be asked to leave the meeting. A Board motion is required to move into and to rise from an *in camera* session.

Matters that may be dealt with in an *in camera* session include, but are not limited to:

- Matters involving property – security, acquisition, sale, lease, etc.
- Matters involving litigation or potential litigation
- Material contracts
- Human resource issues – labour relations concerning collective bargaining, terms of employment of individual employees or management
- Professional staff appointments, re-appointments, discipline and credentialing issues
- Patient issues
- Protected information
  - information that would reveal the confidential commercial, financial, labour relations, scientific or technical information of an individual or company
  - information that is subject to solicitor client privilege
  - personal information of individuals, including employees

In camera sessions form part of a Board meeting and, as such, agendas will be prepared and minutes recorded. The agenda, minutes and supporting documentation will be clearly marked confidential and will be handled and secured in a manner that respects the nature of the material. Minutes of *in camera* sessions will be presented for approval at subsequent *in camera* sessions of the Board.

Following the *in camera* session, the Board Chair shall report at the open meeting on the *in camera* session. This report shall include advising the public on the category(s) justifying the *in camera* session and, where appropriate, reporting on the decisions taken at the meeting.

BWH personnel and others (e.g. legal counsel, consultants) may be permitted to attend all or a portion of the *in camera* session upon invitation of the Chair.

Board Decisions

Board decisions, unless they fall within the scope of an *in camera* session, will be available on the BWH website and intranet and made available to the public upon request.

Board Retreats

The Board may periodically hold retreats for the purposes of Board education, orientation and strategic planning. These meetings are not regular Board meetings but should any formal Board business be conducted at a retreat, any decisions made will be confirmed at a duly constituted Board meeting and be reported to the public.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. Board Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

MEETINGS WITHOUT MANAGEMENT: E-17

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	April 2018
REVIEWED/REVISED DATE:	September 2023– Version 4

Purpose

Meetings without Management is one of the mechanisms of evaluation used by the Board. The purpose of this meeting is to provide the Board with an opportunity to discuss the quality of the governance they provided to the organization. This involves questions related to the level of the discussion and the engagement of Board members in the meeting.

The purpose of this meeting is to ensure the Board exercised independent oversight of management and to provide an opportunity to assess Board processes. The Board Chair can use this forum to draw attention to areas where the performance of Directors could be enhanced. It also allows for the building of relationships of confidence and cohesion among Board Directors.

Process

The independent Directors shall meet without management three times per year.

1. If a meeting without management is planned, the agenda of the Board meeting must include this information.
2. Timing of the session without management should be declared in the notice or agenda.
3. Such meeting shall not be considered to be meeting of the Board, but rather, will be for information purposes only.
4. Minutes will not be kept but the chair may keep notes of the discussion.
5. The Ex-Officio Directors of the Board may be invited by the Board Chair to participate in part of the meeting without management before being excused.
6. The chair shall immediately communicate with the Chief Executive Officer and, as appropriate, the Chief of Professional Staff on any relevant matters raised in the meeting.

Membership/Participation

A director that remains in the meeting without management is identified as an “independent director” who is described as being free of any special relationship with the corporation.

Monitoring

Method and Frequency:

1. Board Evaluation
2. Chair Evaluation
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)
4. Policy review (annually)

DIRECTOR AND NON-DIRECTOR COMMITTEE MEMBER EXPENSE REIMBURSEMENT: E-18

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2008
REVIEWED/REVISED DATE:	September 2023 – Version 5

Purpose

As set out in the by-laws, Directors and Non-Director Committee Members (NDCMs) of Bluewater Health serve as such without remuneration. A Director/ NDCM is entitled to be reimbursed for reasonable expenses incurred in the performance of their duties. The purpose of this policy is to set out the categories of eligible expenses and the process for reimbursement.

Policy

Directors and NDCMs are encouraged to attend meetings, conferences and education events as reasonably required.

Conference Registration Expenses:

Conference registration fees must be pre-approved by the Board Chair and will be paid for or reimbursed by the Hospital in accordance with the Hospital's Reimbursement of Hospital Expenses Policy.

Transportation, Accommodation and Meal Expenses:

BWH will reimburse Directors/NDCMs for pre-approved expenses incurred while attending a conference, education session or hospital-related meeting. This includes transportation (e.g. mileage, train, parking), accommodation and meals. Directors/NDCMs will be reimbursed by the hospital in accordance with the Hospital's Reimbursement of Hospital Expenses Policy which requires original itemized receipts for each expense. Local travel to BWH Board meetings and other hospital related events is not considered a reimbursable expense.

Other Expenses:

A Director/NDCM who is required to pay others to care for dependents (e.g. child care, elder care) in order to fulfill their duties as a Director/NDCM may be reimbursed the actual out-of-pocket expenses incurred for such purpose. A Director/NDCM who incurs long-distance telephone, postage, courier charges or other similar expenses may be reimbursed the actual out-of-pocket expenses incurred for such purpose.

Other categories of expenses will be considered for reimbursement if supported by a reasonable explanation.

Monitoring

Method and Frequency:

1. Review of the policy (annually)
2. Completion and public posting (BWH website) of Director and NDCM expense reports (every 6 months – Broader Public Sector Accountability Act requirement)
3. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

BOARD EVALUATION: E-19

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2009
REVIEWED/REVISED DATE:	September 2023 – Version 8

Purpose:

The Bluewater Health Board recognizes that the establishment of a process for evaluating its performance is an important component of effective governance to maintain and improve policies, practices and processes. The Board is responsible for ensuring its own effectiveness and this policy sets out processes to support the Board in fulfilling this responsibility.

Policy:

The Board evaluation process will be clearly aligned with the roles and responsibilities of the Board and individual Directors and will examine the structure, processes, performance and effectiveness of the Board as a whole, its leadership, committees, individual directors, and Non-Director Committee Members (NDCMs).

The timing of the process will be linked to the annual board cycle so as to inform the implementation of corrective action/improvements as required. The evaluation will include processes to permit the results of the evaluation to be acted upon to foster continuous improvement and mechanisms to review and adopt governance best practices and benchmark with similar organizations.

The Governance and Nominating Committee will establish an annual process for evaluation of the Board, its leadership, and individual Directors and NDCMs based on applicable Board policies setting out their roles and responsibilities. This process will include a report to the Board on the results of the evaluation and key issues to be addressed to ensure continuous improvement of the Board as a whole, its leadership, and individual Directors and NDCMs.

The Board will evaluate its performance with focus on continuous improvement through completion of a variety of evaluations on a regular basis which address the following:

1. Orientation/education - annually
2. Collective Board performance – every two years/Accreditation cycle
3. Individual Director performance - annually
4. Individual Non-Director Committee Member performance – annually
5. Board Meeting effectiveness – twice annually
6. Committee effectiveness – annually
7. Board Chair effectiveness – every two years (first year of tenure)
8. Committee Chair effectiveness – annually

Individual Director and NDCM contributions will be reviewed and feedback provided on performance as part of the individual Director and NDCM evaluation process. Specifically,

following completion of the annual Individual Director/NDCM assessment survey, Directors and NDCMs will be provided with a statement of individual results and related performance information. The Board Chair will meet with each Director and NDCM to review results and provide feedback on performance.

The Governance and Nominating Committee shall support the Board in its improvement activities by:

1. Developing strategies to address the areas for improvements identified in the evaluation processes.
2. Recommending improvement projects to the Board for inclusion in the annual Board and committee work plans.

Monitoring

Method and Frequency:

1. Review of the Policy (annually)
2. Completion of Board evaluation(s) tools and processes
3. Accreditation Canada Survey and report (timing aligned with Accreditation Cycle)

REMOVAL OF A DIRECTOR/ NON-DIRECTOR COMMITTEE MEMBER (NDCM): E-20

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Executive Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	November 2018
REVIEWED/REVISED DATE:	September 2023 - Version 2

Purpose

The Bluewater Health Board is responsible for ensuring the quality and effectiveness of its individual Directors/NDCMs in order to fulfill its roles and responsibilities. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Under extreme circumstances and in highly unusual situations, it may become necessary to remove a Director/NDCM from the Board if they fail to comply with the By-laws and policies of the Board.

Process

The Executive Committee is responsible for recommending the removal of a Director/NDCM to the Board. Prior to making a recommendation to the Board, the Executive Committee will follow the following procedures, in a fair and respectful manner:

(a) The matter shall be referred to the Board Chair or where the issue may involve the Board Chair, to the Vice Chair, with notice to the Chief Executive Officer.

(b) The Director/NDCM in question will be notified of the matter by the Board Chair (or Vice Chair)

(c) The Board Chair (or Vice Chair) may either:

  (i) attempt to resolve the matter informally with the Director/NDCM given opportunity to address it with a performance improvement plan with timelines, if appropriate (for example, attendance can improve, conflict of interest can be examined and questions of conduct can be reviewed) or

  (ii) refer the matter to the Executive Committee which shall report to the Board.

(d) If the Board Chair (or Vice Chair) elects to attempt to resolve the matter informally and the matter cannot be resolved to the satisfaction of the Board

Chair (or Vice Chair), then the Board Chair (or Vice Chair) shall refer the matter to the Executive Committee, which shall report to the Board.

(e) The Director/NDCM will be given the opportunity to respond to the recommendation of the Executive Committee to the Board.

(f) A decision of the Board by majority resolution shall be determinative of the matter.

(g) The Director/NDCM will be notified of the final consideration and action of the Board.

Member Approval

A Special Members meeting to remove a Director/NDCM is required.

Monitoring

Method and Frequency:

1. Board Evaluation
2. Accreditation Canada Survey and report (timing aligned with Accreditation)
3. Review of policy (annually)

CONFLICT OF INTEREST: E-21

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	May 2022
REVIEWED/REVISED DATE:	September 2023 - Version 1

Purpose

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

Application

This policy applies to all Board members including Directors, Ex-Officio Directors, Officers, and Non-Director Committee Members (NDCMs).

"Officers" means officers appointed by the Board under the *Not-for-Profit Corporations Act*, 2010 (the "Act") and the By-laws, including: Board Chair, Board Vice-Chair, and Treasurer.

Policy

Directors, Officers, and NDCMs shall avoid situations in which they may be in a position of a conflict of interest or perceived conflict of interest. In addition to the conflict of interest provisions in the Act and the By-laws, which must be strictly adhered to, the process set out in this policy shall be followed when a conflict or potential conflict arises.

Description of Conflict of Interest

A conflict of interest arises in any situation where a Director/NDCM's duty to act solely in the best interests of the Corporation and to adhere to their fiduciary duties is compromised or impeded by any other interest, relationship, or duty of the Director/NDCM.

A conflict of interest also includes circumstances where the Director/NDCM's duties to the Corporation are in conflict with other duties owed by the Director/NDCM such that the Director/NDCM is not able to fully discharge the fiduciary duties owed to the Corporation.

The situations in which a potential conflict of interest may arise cannot be exhaustively set out. Conflicts generally arise in the following situations:

1. *Transacting with the Corporation*

- When a Director/NDCM transacts with the Corporation directly or indirectly.

- When a Director/NDCM has a material direct or indirect interest in a transaction or contract with the Corporation.

2. *Interest of a Relative*

   When the Corporation conducts business with suppliers of goods or services or any other party of which a relative or member of the household of a Director/NDCM is a principal, Officer, or representative.

3. *Gifts*

   When a Director/NDCM or a member of their household or any other person or entity designated by the Director/NDCM, accepts gifts, payments, services, or anything else of more than a token or nominal value from a party with whom the Corporation may transact business (including a supplier of goods or services) for the purposes of (or that may be perceived to be for the purposes of) influencing an act or decision of the Board.

4. *Acting for an Improper Purpose*

   When Directors/NDCMs exercise their powers motivated by self-interest or other improper purposes. Directors/NDCMs must act solely in the best interest of the Corporation. Directors/NDCMs who are nominees of a particular group must act in the best interest of the Corporation even if this conflicts with the interests of the nominating party.

5. *Appropriation of Corporate Opportunity*

   When a Director/NDCM diverts to their own use, an opportunity or advantage that belongs to the Corporation.

6. *Duty to Disclose Information of Value to the Corporation*

   When Directors/NDCMs fail to disclose information that is relevant to a vital aspect of the Corporation's affairs.

7. *Serving on Other Corporations*

   A Director/NDCM may be in a position where there is a conflict of "duty and duty". This may arise where the Director/NDCM serves as a Director/NDCM of two corporations that are competing or transacting with one another. It may also arise where a Director/NDCM has an association or relationship with another entity. For example, if two corporations are both seeking to take advantage of the same opportunity, a Director/NDCM 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 Director/NDCM cannot discharge the duty to maintain such information in confidence while at the same time discharging the duty to make disclosure. The Director/NDCM cannot act to advance any interests other than those of the Corporation.

Process for Resolution of Conflicts and Addressing Breaches of Duty

Disclosure of Conflicts

A Director/NDCM, who is in a position of conflict or potential conflict, shall immediately disclose such conflict to the Board by notification to the Board Chair or Vice Chair. Where the Board Chair has a conflict, notice shall be given to the Vice Chair.

A NDCM, who is in a position of conflict or potential conflict, shall immediately disclose such conflict to the Board by notification to the Committee 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.

- In the case of a Director, the disclosure must be made, at a minimum:
    - at the meeting where a matter in which the Director has a conflict is first considered;
    - if the Director was not then interested in a matter, at the first meeting after the Director becomes so interested;
    - if the Director becomes interested after a matter has been approved, at the first meeting after the Director becomes so interested; or
    - if an individual who has a conflict in a matter later becomes a Director, at the first meeting after the individual becomes a Director.

- In the case of an Officer, the disclosure must be made, at a minimum:
    - forthwith after the Officer becomes aware that a matter in which the Officer has a conflict is to be considered or has been considered by the Board;
    - if the Officer becomes interested after a matter has been approved by the Board, forthwith after the Officer becomes so interested; or
    - if an individual who has a conflict in a matter later becomes an Officer, forthwith after the individual becomes an Officer.

- In the case of a NDCM, the disclosure must be made, at a minimum:
    - at the committee meeting where a matter in which the NDCM has a conflict is first considered;
    - if the NDCM was not then interested in a matter, at the first committee meeting after the NDCM becomes so interested;
    - if the NDCM becomes interested after a matter has been approved, at the first committee meeting after the NDCM becomes so interested;
    - if an individual who has a conflict in a matter later becomes a NDCM, at the first committee meeting after the individual becomes a NDCM.

- If a Director or Officer has a conflict of interest in a matter that, in the ordinary course of the Corporation's business, would not require approval of the Board or members, the Director or Officer shall disclose the conflict of interest to the Board Chair or Vice Chair, or request to have entered in the minutes of Board meetings, the nature and extent of their interest forthwith after the Director/Officer becomes aware of the matter.

Continuing Disclosure

A Director/Officer/NDCM may provide a general notice to the Board disclosing their relationships and interests in entities or persons that give rise to conflicts.

Abstain from Discussions, Leave the Meeting and Do Not Vote

A Director/Officer/NDCM who has declared a conflict shall not attend any part of a meeting during which the matter in which they have a conflict is discussed, shall not attempt in any way to influence the matter, and shall not vote on any resolution to approve the matter.

Exceptions are made if the matter relates to a contract or transaction:

(a) primarily related to their remuneration as a Director of the Corporation or an affiliate of the Corporation;
(b) for indemnity or insurance under section 46 of the Act; or
(c) with an affiliate of the Corporation.

If no quorum exists for the purposes of voting on a resolution to approve a matter only because one or more Director/NDCM is not permitted to be present at the meeting due to a conflict, the remaining Directors/NDCMs are deemed to constitute a quorum for the purpose of voting on the resolution.

Referral

A Director/NDCM may be referred to the process outlined below where any Director/NDCM believes that they or another Director/NDCM:

(a) has breached their duties to the Corporation;
(b) is in a position where there is a potential breach of duty to the Corporation;
(c) is in a situation of actual or potential conflict of interest; or
(d) has behaved or is likely to behave in a manner that is not consistent with the highest standards of trust and integrity and such behaviour may have an adverse impact on the Corporation.

Process for Resolution

(a) The matter shall be referred to the Board Chair or where the issue may involve the Board Chair, to the Vice Chair, with notice to the Chief Executive Officer.
(b) The Board Chair (or Vice Chair, as the case may be) may either:
    (i) attempt to resolve the matter informally; or
    (ii) refer the matter to either the Executive Committee or to a special committee of the Board established by the Board Chair (or Vice Chair, as the case may be) which shall report to the Board.
(c) If the Board Chair or Vice Chair elects to attempt to resolve the matter informally and the matter cannot be resolved to the satisfaction of the Board Chair (or Vice Chair as the case may be), the Director/NDCM referring the matter, and the Director/NDCM involved, then the Board Chair or Vice chair 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 or other matter referred cannot be resolved to the satisfaction of the Board (by simple majority resolution) or if a breach of duty has occurred, a Director/NDCM may be asked to resign or may be subject to removal pursuant to the By-laws and the Act.

Perceived Conflicts

It is acknowledged that not all conflicts or potential conflicts may be satisfactorily resolved by strict compliance with the By-laws. 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 Corporation notwithstanding that there has been compliance with the By-Laws. In such circumstances, the process set out in this policy for addressing conflicts and breaches of duty shall be followed.

It is recognized that the perception of a conflict or breach of duty may be harmful to the Corporation even where no conflict exists or breach has occurred and it may be in the best interests of the Corporation that the Director/NDCM be asked to resign.

Monitoring

Method and Frequency:

1. Board Member review (annually)
2. Review of policy (annually)
3. Accreditation Canada Survey and report (timing aligned with Accreditation)

DIVERSITY AND INCLUSION: E-22

BOARD RESPONSIBILITY:	Ensure Board Effectiveness
COMMITTEE:	Governance and Nominating Committee
APPROVED BY:	Board of Directors
ISSUE DATE:	September 2022
REVIEWED/REVISED DATE:	September 2023

Purpose

The purpose of this Policy is to ensure that the Board of Directors possesses the diverse qualifications, skills and expertise required to fulfill its mandate. It also ensures that the Board of Directors practices inclusion by demonstrating that everyone's contributions are valued, which creates a culture that enables diversity to thrive. This policy emphasizes Bluewater Health's commitment to diversity and inclusion at all levels within the Hospital.

Policy

When assessing Board composition, identifying candidates, and recommending nominees to the Board, the Governance & Nominating Committee will consider candidates on merit, based on a balance of skills, qualities, experience, knowledge and background. This includes diversity considerations such as business and other experience, gender identification, age, disability, sexual orientation, geographic representation, Indigenous status, and ethnicity.

Determination of a candidate's skills, qualities, experience, knowledge, and background, will be based on voluntary self-identification by the candidate.

Monitoring

The Governance & Nominating Committee will annually:

1. discuss and review this Policy and recommend objectives for promoting Board diversity and inclusion for consideration and approval by the Board.
2. assess and report on its effectiveness in promoting a diverse Board, and in achieving any diversity and inclusion targets set by the Board.

The Board will enhance its compliance with this Policy through the delivery of ongoing information, training and resource support to develop Board capacity in diversity and inclusion knowledge.

Method and Frequency:

1. Board Evaluation
2. Accreditation Canada Survey and report (timing aligned with Accreditation)
3. Review of policy (annually)

COMMUNITY ENGAGEMENT AND COMMUNICATIONS: F-1

BOARD RESPONSIBILITY	Foster Relationships
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	January 2011
REVIEWED/REVISED DATE:	November 2022 – Version 4

Purpose

As part of its responsibility for fostering relationships and ensuring program quality and effectiveness, the Board of Bluewater Health (BWH) recognizes the importance of community engagement and communications so members of the community can be informed of and appropriately involved in the Hospital's planning and decision-making processes.

This policy sets out principles and processes to support the Board in fulfilling this responsibility and to support the achievement of BWH's purpose statement and strategic priorities and meet the community engagement requirements of the *People's Health Care Act.*

Policy

Community Engagement

The Board will ensure BWH establishes a community engagement strategy which includes:

1) guiding principles and a framework
2) processes and mechanisms for community engagement
3) a monitoring and evaluation process

The process and scope for community engagement will vary depending on the issue.

Communications

The Board will ensure that the CEO puts an effective communications and stakeholder-relations plan in place and will review this with the Board on an annual basis. The Board Chair is the spokesperson on behalf of the Hospital for matters related to Board governance. The Chief Executive Officer (CEO) or their delegate is the spokesperson on behalf of the Hospital for all hospital matters. The CEO and Board Chair will mutually determine their respective roles as may be required from time to time. No Director will be a spokesperson for the Board unless specifically delegated by the Board Chair following consultation with the CEO.

The Board will ensure the following information is posted on the hospital's website:

- Board of Directors' membership
- Corporate and Professional Staff By-laws of BWH
- BWH Board Policies
- BWH Strategic Plan

- Agenda packages and minutes from open Board meetings
- Articles in the local media on matters of interest to the communities served by BWH

The Board delegates responsibility and authority to the CEO to develop, implement, monitor and evaluate a communication and community engagement operational plan consistent with this policy.

Monitoring

The Governance & Nominating Committee will provide oversight for the strategy and plan by monitoring implementation and effectiveness and reporting to the Board on a regular basis.

Method and Frequency:

1. Review of policy (annually)
2. Advisory panel evaluations (annually)
3. Review of BWH's Global Communication and Community Engagement Plan (every three to five years, aligned with Strategic Plan review)
4. Board Evaluation

SERVICE INTEGRATION PLANNING: F-2

BOARD RESPONSIBILITY	Foster Relationships
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	April 2010
REVIEWED/REVISED DATE:	September 2023 – Version 4

Purpose

Bluewater Health (BWH) is responsible for identifying opportunities (separately and in conjunction with the Sarnia-Lambton Ontario Health Team, Ontario Health, and the Ministry of Health to integrate the services of the local health system in order to provide appropriate, coordinated, effective and efficient services.in accordance with applicable legislation.

In keeping with its responsibilities for ensuring program quality and effectiveness and fostering relationships, the Board will take an active role in collaborating with the Ministry of Health, Ontario Health, the Sarnia-Lambton Ontario Health Team, other health service providers and the community to identify and undertake community collaboration opportunities that improve healthcare services, enhance program performance, integrate service delivery in Sarnia-Lambton, are consistent with the Hospital's purpose statement, values and Strategic Plan, and are in the best interests of the community.

Policy

The Board directs the President and Chief Executive Officer (CEO) to:

1. collaborate with staff of Sarnia-Lambton Ontario Health Team partners, other health service providers, Ontario Health and the Ministry of Health to identify opportunities for community collaboration and integration of services within the local health system for the purpose of providing appropriate, coordinated, effective and efficient services
2. recommend specific community collaborations and integration initiatives for consideration by the Board
3. identify performance indicators to monitor specific community collaborations and integration initiatives
4. report to the Board as to the progress of approved community collaborations and integration initiatives and the outcomes of those initiatives, as needs arise

The Board will:

1. participate in appropriate governance and leadership forums
2. ensure that the Hospital's strategic plan and supporting goals and initiatives address legislated integration requirements
3. establish mechanisms for dialogue with other health service provider boards and other persons and entities as required, related to specific community collaborations and integration initiatives
4. monitor the progress of approved community collaborations and integration initiatives and the outcomes of those initiatives

Monitoring

Method and Frequency:

1. Review of policy (annually)
2. Review of report on progress/status of Bluewater Health's community collaborations (annually)
3. Board Evaluation
4. CEO Evaluation (annually)
5. Accreditation Survey and Report (timing aligned with Accreditation survey)

COMMUNITY ADVISORY PANELS: F-3

BOARD RESPONSIBILITY	Foster Relationships
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	April 2010
REVIEWED/REVISED DATE:	November 2022– Version 6

Purpose

As part of its responsibility for fostering relationships and ensuring program quality and effectiveness, the Board of Bluewater Health (BWH) recognizes the importance of community engagement so that members of the community can be informed of and appropriately involved in planning and decision-making processes for healthcare services.

BWH's community engagement strategy includes a variety of processes, mechanisms and initiatives. Its two advisory panels, the Community Advisory Panel (CAP) and Rural Health Advisory Panel (RHAP), are an integral part of that strategy. This policy establishes those advisory panels and sets out the guiding principles governing them.

Policy

The advisory panels will serve as two-way communication mechanisms between BWH and the communities it serves, and from informed representatives of these communities to BWH. They will consist of individuals who are broadly representative of the community, reflecting many backgrounds and experiences and the diverse communities and viewpoints that make up the BWH catchment population.

The process for selection of panel members is outlined in the CAP and RHAP Terms of Reference. The RHAP's focus will be on rural health issues with the panel members being drawn from the rural communities served by BWH. The hospital's President and Chief Executive Officer (CEO) and a member of the Board will serve as adjunct panel members. Other hospital staff and Professional Staff will participate on a regular basis or may be invited as guests to provide presentations on topics of interest and/or to address issues identified by the panels. The panels will be led by a facilitator, as designated by the CEO.

The panels will meet jointly three times per year and will act in an advisory capacity, providing the senior leadership of BWH with community specific issues, questions and suggestions related to the hospital's operations and health service delivery. The CEO will respond to the panels' advice and input and keep them apprised of the status of issues discussed and actions taken. The panels will report through the CEO to the Board. Meetings of the panels will be open to the public with public participation guidelines outlined in the CAP and RHAP Terms of Reference.

The effectiveness of the panels will be evaluated annually, based on a review of their purpose and outcomes.

Monitoring

Method and Frequency:

1. Review of policy (annually)
2. Terms of reference review (annually)
3. CAP and RHAP evaluations (annually)
4. CAP and RHAP Summary Report to the Board
5. Global Communications and Community Engagement Plan review (annually)
6. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)

SUPPORT AND RELATIONSHIPS WITH FOUNDATIONS: F-4

BOARD RESPONSIBILITY	Foster Relationships
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	November 2018
REVIEWED/REVISED DATE:	September 2023 - Version 1

Purpose

As part of its responsibility for fostering relationships and ensuring program quality and effectiveness, the Board of Bluewater Health recognizes strong and positive relationships between the hospital and its' supporting Foundations (BWH Foundation and Charlotte Eleanor Englehart Hospital Foundation) is essential.

Policy

1. The Board of Directors will support the Foundations in their endeavors, is encouraged to contribute financially to their fundraising efforts, and will be represented at Foundation events when requested by the Foundations.

2. Regular communications with the Foundations will be achieved as follows:

    a. Representatives of the Foundations will be invited to make presentations on their activities to the BWH Board on a periodic basis.
    b. A Board Director will be appointed to each Foundation as a representative of the BWH Board to attend Foundation meetings.

Monitoring

Method and Frequency:

1. Review of Policy (annually)
2. Period Foundation Reports to BWH Board
3. Board Evaluation
4. Accreditation Survey and Report (timing aligned with Accreditation Survey)

POLITICAL ACTIVITY: F-5

BOARD RESPONSIBILITY	Foster Relationships
COMMITTEE:	Governance and Nominating
APPROVED BY:	Board of Directors
ISSUE DATE:	February 2019
REVIEWED/REVISED DATE:	September 2023- Version 2

Application

This policy applies to all Directors (both elected and *ex officio*), Non-Director Board Committee members, the Chief Executive Officer, and the Chief of Staff (collectively referred to in this Policy as "Board Committee Members").

Purpose

The purpose of this policy is to ensure Board Committee Members have a shared understanding of the accepted parameters for partisan political activities.

Board Committee Members are expected to uphold the non-partisan nature of the work of the Hospital. As a publicly funded organization, it is imperative the Hospital maintain positive working relationships across the political spectrum.

Policy

The Hospital will not make direct contributions to political campaigns or to any elected official. With the approval of the Board Chair, the Hospital may purchase tickets to a political event, where the presence of Hospital management or the Board is deemed appropriate.

Board Committee Members retain their rights to participate personally in the political process through individual activities that do not imply endorsement by the Hospital.

Permitted activities

Examples of permitted activities include:

- Supporting a candidate or a political party by displaying political material such as a picture, sticker, badge, or button, or placing a sign on their lawn, where such support cannot be associated, or perceived to be associated, with the Hospital
- Attending political rallies, meetings, and fund-raising events
- Signing nominating documents for a candidate for partisan elected office
- Donating money to a political candidate or party, where such contribution cannot be associated, or perceived to be associated, with the Hospital
- Being a member of a political party registered federally in Canada, or in Ontario
- Organizing, managing, hosting, or providing candidate introductions at, political rallies, Meetings, or fund-raising events
- Holding a full-time public office that is appointed by the Lieutenant Governor-in-Council of Ontario or by the Governor General-in-Council

Activities permitted only with Board approval

Examples of activities that are not permitted without Board approval include:

- Undertaking political activities that could raise any question as to the independence of the Board Committee Members' judgement or ability to perform his or her duties
- Seeking to be a:
    - Member of Parliament of Canada
    - Member of Provincial Parliament of Ontario
    - Member of a municipal government
- Being employed by a political party registered federally in Canada, or in Ontario
- Being a keynote speaker at a federal or Ontario provincial political rally, meeting, or fund-raising event
- Being an officer of a federal, Ontario provincial, or municipal campaign

PROCEDURES

1. Board Committee Members who wish to engage in the activities that are not permitted by this policy without prior Board approval must inform the Board Chair in writing of their intent.
2. The Board Chair will make a recommendation to the Board as to whether the Board Committee Member should no longer serve in their role as a Board Committee Member.
3. The Board Committee Member will have the opportunity to address the Board but will recuse themselves from the deliberations and the vote by the Board on this matter.
4. The Board will determine whether the Board Committee Member should be requested to resign.
5. Where the Board has the authority to remove a Board Committee Member, it may take such actions as appropriate to effect the removal.
6. The Board Chair will communicate the decision to the Board Committee Member.
7. The Board Chair will report the Board Committee Member's resignation to the Board at the appropriate time.
8. The Board may fill a vacant Board Committee Member's position in accordance with the By-laws as applicable.

Monitoring:

1. Policy review (annually)
2. Accreditation Canada Survey and report (timing aligned with Accreditation cycle)
3. Election cycle